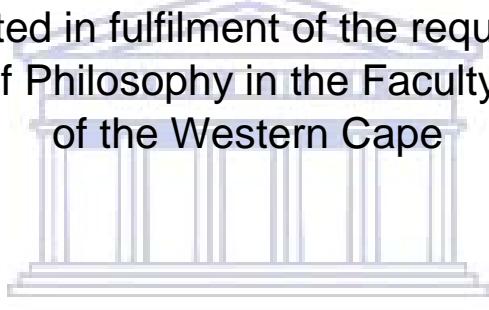


**ANALYSING HUMAN RIGHTS ACCOUNTABILITY
TOWARDS
ENDING PREVENTABLE MATERNAL MORBIDITY AND
MORTALITY IN UGANDA**

By
Agaba Daphine Kabagambe

A thesis submitted in fulfilment of the requirements for the
degree of Doctor of Philosophy in the Faculty of Law, University
of the Western Cape



Promoter
Professor Ebenezer Durojaye
Head of Project (Socio-Economic Rights) Dullah Omar Institute
Faculty of Law, University of the Western Cape

February 2017

DECLARATION

I Agaba Daphine Kabagambe, declare that *Analysing 'Human Rights Accountability' towards ending preventable Maternal Morbidity and Mortality in Uganda* is my original work and has not been submitted for examination or degree in any other University or institution of higher learning. While, numerous materials and resources have been referred to, they have been properly referenced and duly acknowledged.



ACKNOWLEDGMENTS

The completion of this thesis would not have been possible without the support of a number of people.

First, I am very appreciative of my supervisor Professor Ebenezer Durojaye for having selected me to pursue this PHD. His insightful and thought-provoking feedback has been very instrumental in enhancing my work both for the thesis and for assignments under the Socio-economic rights project. His quick response to the various drafts of my work not only allowed for their gradual improvement but also for the completion of my thesis on time. Also, his continuous guidance and support kept me on course throughout the difficult stages of the PHD process.

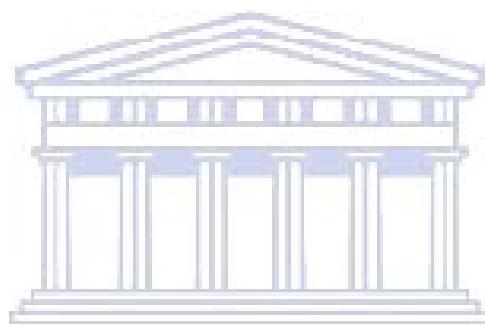
I am sincerely grateful for the management and staff of Dullah Omar Institute for Constitutional Law, Governance and Human Rights under the supervision of Professor Jaap De Visser for creating a very favourable working environment. I am also thankful for the technical support of my colleagues especially those in the Socio-Economic Rights Project-Gladys Mirugi-Mukundi and Keathélia Sapto. I would also like to thank my fellow PHD colleagues; Meseret Kifle, Shehaam Johnstone, Alois Madhekeni and Annette May for the emotional support and intellectual stimulation throughout this process.

I am especially grateful to all the administrative staff especially Nadia Cassiem, Virginia Brookes, Debbie Gordon and Mandy Cupido for their financial, technical and emotional support, which cushioned me from distractions, thus allowing me to concentrate on my work. I am also thankful for the researchers especially Maria Assim and Kristen Peterson whose words of encouragement often came in handy during the trying times of this tumultuous journey.

I am particularly indebted to my family for always believing in me and for constantly reminding me that I had what it took to successfully complete my PHD. Special thanks go to my parents for their financial and emotional support. I am also grateful for my siblings and my friends for being my rock throughout this journey.

DEDICATION

This work is dedicated to my family- my parents and my siblings.



UNIVERSITY *of the*
WESTERN CAPE

ABSTRACT

The persistence of preventable Maternal Morbidity and Mortality (hereafter MMM), in the developing world, despite ground breaking technological and scientific advances, is unacceptable. There is no cause of death and disability for men between ages 15 and 44 that comes close to the large scale of maternal mortality and morbidity.¹ Thus, the prevalence of high MMM ratios indicates the side-lining of women's rights. Surprisingly, the causal factors of preventable MMM and interventions needed to reverse the pervasively high numbers are now well known. Yet, hundreds of women continue to die daily and to suffer lifelong illnesses while giving birth. In Uganda, despite various regulatory, policy and programmatic strategies, the most recent survey revealed that the maternal mortality ratios were at a staggering 438 per 100,000 live births.²

This study attributes the continued prevalence of high MMM rates to lack of accountability that would ensure services and resources are being maximized and redistributed equitably. Lack of effective accountability mechanisms in place encourages unbridled financial, human and technical resource wastage, diversion, non-utilization and embezzlement of funds. It is not enough that medical equipment, personnel and finances are increasingly being allocated to the health sector by the Government. Without effective tracking and supervisory mechanisms, these additional financial, technical and human resource allocation will most likely not translate into reduced MMM rates.

Sadly, in Uganda, the role of accountability towards the operationalization of human rights is underappreciated. In fact, many health sector practitioners are unaware of the ways in which accountability can be implemented. Despite the recent infiltration of the term 'accountability' into laws and policies, it remains an elusive and fuzzy concept.

Further still, as demonstrated throughout the study, accountability has been popularized by international and regional human rights monitoring mechanisms such as the UN treaty bodies, African Commission but at the domestic level, great strides have yet to be made in infusing human rights accountability into laws, policies, programs and practices in a way that will reverse the high MMM. The domestication of accountability is vital because human rights ideals are only turned into actual implementable strategies at the national level. A direct focus on Uganda would allow for the undertaking of the country's own specific challenges within its domestic context.

¹ Report of the Office of the United Nations High Commissioner for Human Rights on Preventable Maternal Mortality and Morbidity and Human Rights A/HRC/ 14/39 (16 April 2010) Para 17.

² Uganda Bureau of Statistics *Demographic and Health Survey* (2011) Kampala, 236.

Therefore, the main purpose of this study is to analyse accountability mechanisms towards combating Maternal Morbidity and Mortality (MMM) in Uganda. The study elaborates upon an accountability framework for MMM that is human rights compliant. The framework relies on three major interrelated aspects; responsibility, answerability and enforcement. Subsequently, an attempt is made throughout the study, to advance the proposed framework to the administrative, legal and social structures operating within Uganda in a bid to find comprehensive accountability strategies for curbing preventable maternal deaths and morbidities.



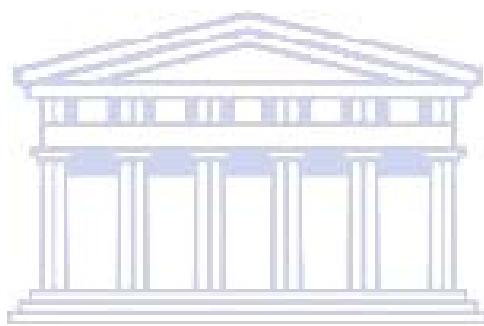
TABLE OF CONTENTS

DECLARATION	1
ACKNOWLEDGMENTS.....	2
ABSTRACT	4
LIST OF ABBREVIATIONS	10
CHAPTER ONE: INTRODUCTION.....	11
1.1 BACKGROUND TO THE STUDY	11
1.2 STATEMENT OF THE PROBLEM	13
1.2.1 A synopsis on Maternal Mortality and Morbidity	13
1.2.2 The impact of non-implementation of Accountability on MMM	16
1.3 RESEARCH QUESTIONS	20
1.4 LITERATURE SURVEY	21
1.5 RESEARCH METHODOLOGY	25
1.6 SCOPE/LIMITATIONS.....	25
1.7 STRUCTURE OF THE THESIS	27
CHAPTER TWO: ROLE OF ACCOUNTABILITY TOWARDS THE REDUCTION OF PREVENTABLE MATERNAL MORTALITY AND MORBIDITY.....	29
2.0 INTRODUCTION	29
2.1 UNDERSTANDING ACCOUNTABILITY	30
2.2 ACCOUNTABILITY FRAMEWORK FOR MATERNAL MORTALITY AND MORBIDITY	33
2.3 MAIN 'BUILDING BLOCKS' OF ACCOUNTABILITY.....	34
2.3.1 Responsibility	36
2.3.2 Answerability	40
2.3.3 Enforcement.....	41
2.4 PREVENTABLE MATERNAL MORTALITY AND MORBIDITY, VIOLATION OF WOMEN'S RIGHTS	44
2.4.1 Maternal Mortality and Morbidity as a form of discrimination	44
2.4.2 Feminist Perspectives on Maternal Mortality and Morbidity	48
2.5 FORMS OF ACCOUNTABILITY, THEIR USAGE TOWARDS COMBATING PREVENTABLE MATERNAL MORTALITY AND MORBIDITY.....	55
2.5.1 National Legal/Judicial Accountability.....	55

2.5.2 Administrative Accountability.....	58
2.5.2.1 Responsibility/Standards of performance	59
2.5.2.2 Answerability in the administrative structures.....	62
2.5.2.3 Enforcement/ Remedial Measures.....	63
2.5.3 Social Accountability	63
2.6 CONCLUSION	65
CHAPTER THREE: IMPLEMENTING ‘LEGAL ACCOUNTABILITY’ TOWARDS COMBATING MATERNAL MORTALITY AND MORBIDITY IN UGANDA	67
3.0 INTRODUCTION	67
3.1 APPLYING THE ACCOUNTABILITY FRAMEWORK TO THE LEGAL SECTOR	67
3.2 RESPONSIBILITY IN THE LEGAL SECTOR	68
3.2.1 International and Regional Level	69
3.2.2 Domestic Level (Ugandan Court System).....	77
3.3 ENFORCEMENT UNDER THE COURT SYSTEM.....	83
3.3.1 <i>CEHURD and Others vs. Attorney General (In the Constitutional Court)</i>	84
3.3.2 <i>CEHURD and others v the Attorney General (Constitutional Court Appeal)</i>	87
3.3.2.1 The ‘Political Question’ Doctrine.....	88
3.4 AN ANALYSIS OF THE MATERNAL HEALTH CASES.....	92
3.4 ANSWERABILITY FROM THE LEGAL PERSPECTIVE (Court System).....	99
3.5.1 Access to Justice	100
3.5.2 Tracking/ Monitoring/Supervision	106
3.6 UGANDA HUMAN RIGHTS COMMISSION (UHRC)	110
3.6.1 Responsibility Aspect	110
3.6.2 The Answerability Role of the Uganda Human Rights Commission.....	115
3.6.3 The Enforcement Aspect of the Uganda Human Rights Commission.....	117
3.7 CONCLUSION	120
CHAPTER FOUR: ROLE OF ADMINISTRATIVE ACCOUNTABILITY TOWARDS REDUCING MATERNAL MORTALITY AND MORBIDITY.....	122
4.0 INTRODUCTION	122
4.1 UGANDA’S HEALTH POLICY FRAMEWORK.....	122
4.2 RATIONALE FOR CONTEXTUAL ANALYSIS IN COMBATING MMM.....	124
4.3 ADMINISTRATIVE ACCOUNTABILITY.....	128

4.4 OPERATIONALIZATION OF THE ACCOUNTABILITY FRAMEWORK.....	128
4.4.1 RESPONSIBILITY.....	129
4.4.1.1 Monitoring/Supervision.....	131
4.4.1.2 Maternal Death Audits.....	134
4.4.1.3 Data Collection Mechanisms.....	139
4.4.2 ANSWERABILITY	141
4.4.3 ENFORCEMENT	146
4.4.3.1 Financial Resource Utilisation.....	147
4.4.3.2 Health Professional Associations	155
a) Health Service Commission	156
b) The Health Professional Councils	158
c) The National Drug Authority (NDA)	162
4.5 CONCLUSION	164
CHAPTER FIVE: THE ROLE OF SOCIAL ACCOUNTABILITY TOWARDS COMBATING MATERNAL MORTALITY AND MORBIDITY IN UGANDA.....	165
5.0 INTRODUCTION	165
5.1 UNDERSTANDING SOCIAL ACCOUNTABILITY.....	166
5.2 APPLICATION OF THE ACCOUNTABILITY FRAMEWORK TO SOCIAL ACCOUNTABILITY.....	167
5.2.1 Responsibility.....	168
5.2.2 Answerability	174
5.2.2.1 Awareness Raising/ Capacity Building	174
5.2.2.2 Tracking/Supervising/Monitoring Maternal Health Services.....	180
5.2.3 Instituting Remedial Mechanisms	190
5.3 CONCLUSION	197
CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS.....	199
6.1 SUMMARY OF FINDINGS	199
6.1.1 Accountability framework for Maternal Morbidity and Mortality (MMM).	199
6.1.2 Implementation of Legal accountability towards combating MMM in Uganda	201
6.1.3 Role of Administrative Accountability in Combating Maternal mortality in Uganda.	
205	
6.1.4 Implementing Social Accountability to avert MMM.....	208
6.2 RECOMENDATIONS.....	211
6.2.1 Legal Accountability	212

6.2.2 Administrative Accountability.....	213
6.2.3 Social Accountability	214
6.3 CONCLUDING REMARKS	215
BIBLIOGRAPHY.....	216



UNIVERSITY *of the*
WESTERN CAPE

LIST OF ABBREVIATIONS

AHPC	Allied Health Professional Council
CSOs	Civil Society Organizations
DLG	District Local Government
DHIS	District Health Management Information Soft Ware
DSC	District Service Commission
EmOc	Emergency Obstetric Care
HMIS	Health Management Information System
HSC	Health Service Commission
HSD	Health Sub-District
HUMCs	Health Unit Management Committees
MMM	Maternal Morbidity and Mortality
MDGs	Millennium Development Goals
MoH	Ministry of Health
MDR	Maternal Death Reviews
MDSR	Maternal Death Surveillance and Response
NDA	National Drug Authority
NODSP	National Objectives and Directive Principles of State Policy
SDGs	Sustainable Development Goals
UMDPC	Uganda Medical and Dental Practitioners Council
UNMC	Uganda Nurses and Midwives Council
VHTS	Village Health Teams

CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND TO THE STUDY

Research has established the causal factors of preventable Maternal Mortality and Morbidity (hereafter MMM) as well as the interventions needed to reverse the pervasively high numbers. Yet, MMM rates, especially in the developing world, continue to ravage lives of hundreds of thousands of women. The continued prevalence of maternal deaths, despite various policy, programmatic approaches devised over the years, calls for a shift in the strategies to combat the high rates. Furthermore, global and regional conferences, workshops or even the Millennium Development Goals (MDGs) have not been sufficient in devising measures aimed at substantially reducing preventable maternal mortality and morbidity. This is more evident in the developing world where women continue to die on a daily basis from preventable causes. In 2013, 289,000 women died as a result of pregnancy and child related complications. Majority of these deaths took place in low resource settings with 62 percent in Sub-Saharan Africa and 24 percent in Asia.³

The estimated lifetime risk for maternal mortality in developing regions is 1 in 3700 compared to that of developed regions, which is 1 in 160.⁴ These maternal deaths arose from preventable causes such as haemorrhage (excessive bleeding), sepsis (infections), unsafe abortions, prolonged or obstructed labour as well as hypertensive disorders (eclampsia).⁵ Delays in accessing health care also substantially contributed to these deaths. Subsequently, the global Maternal Mortality ratio (MMR) in 2013 was 210 per 100,000 live births, the developing region was at 230 while the developed region at 16. Sub-Saharan Africa had the highest MMR (510).⁶ Maternal deaths thus reveal numerous disparities between high and low income countries, the affluent and the poor women as well as gender disparities.⁷

For every maternal death about 20 more women are left with grave and sometimes permanent pregnancy related injuries which include; obstetric fistula, damage to

³ World Health Organization 'Global Health Observatory: Maternal and Reproductive Health'. Available at http://www.who.int/gho/maternal_health/en/ (accessed 28May 2014)

⁴ Estimates by WHO,UNICEF,UNFPA, the World Bank and the United Nations Population Division Trends in Maternal Mortality(1990 to 2013) Executive Summary' 2.

⁵ World Health Organization 'Global Health Observatory: Maternal and Reproductive Health'. Available at http://www.who.int/gho/maternal_health/en/ (accessed 28May 2014)

⁶ Trends in Maternal Mortality (1990 to 2013) Executive Summary' 2.

⁷ Cabal L and Stoffregen M, 'Calling a spade a spade: Maternal mortality as a human rights violation' (2009)16 *Human Rights Brief* 2.

reproductive organs often leading to infertility, severe anaemia and post-partum disability.⁸ These deaths also have far reaching consequences on the surviving children as well as the close community including neonatal mortality as well as the inability of the surviving children to fend for themselves.⁹ In order to bring recognition to MMM, a goal on maternal health was included in the now defunct MDGs. However, at the time of their expiration in 2015, maternal health was the least met goal. Only 10 countries had achieved the set target of reducing the maternal mortality ratio by 75 percent and achieving universal access to reproductive health¹⁰. Therefore, even though maternal mortality reduced by about 50 percent since 1990, in the developing world the maternal mortality ratio is still 14 times higher than that of the developed region.¹¹

In Uganda, despite several legal, policy and programmatic interventions, there has only been a slight decline in MMM for several years with 505 women per 100,000 in 2001 and 438 per 100,000 in 2006. The most recent survey revealed that, the figure (438) had remained stagnant.¹² Thus, Goal 3 of the recently adopted Sustainable Development Goals (SDGs) aims at ensuring healthy lives and promoting well-being for all. Some of the targets of this goal are: to decrease the global maternal mortality ratio to less than 70 per 100,000 live births by 2030; ensure universal access to sexual and reproductive health care services such as information and education, family planning; the inclusion of reproductive health in national policies and programmes and the increased recruitment, training and retention of skilled health workers especially in the developing world.¹³

Reproduction is a function of women, thus maternal mortality and morbidity directly impacts on the lives of women and adolescent girls. In fact, there is no cause of death and disability for men between ages 15 and 44 that comes close to the large scale of maternal mortality and morbidity.¹⁴ Yet, until very recently, reproductive health issues have traditionally been sidelined both in law and in practice in favor of other health issues, with some policy makers

⁸ Afurukwe-Eruchalu O, 'Accountability for non-fulfilment of human rights obligations: A key strategy for reducing maternal mortality and disability in sub-Saharan Africa' in Ngwena C and Durojaye E (Eds), *Strengthening the Protection of sexual and reproductive health and rights in the African region through human rights*, (2014) 121.

⁹ Afurukwe-Eruchalu O(2014) 121.

¹⁰ World Health Organisation 'WHO Guidelines for measuring Maternal Mortality from a Census' (2013) Available at <http://www.who.int/reproductivehealth/publications/monitoring/9789241506113/en/index.html> 1.

¹¹ 'Sustainable Development Goals: 17 Goals to transform our World'

<http://www.un.org/sustainabledevelopment/health/> (Accessed 25th February 2016)

¹² Ministry of Finance Planning and Economic Development *Special Theme: Accelerating progress towards improving Maternal Health* Millennium Development Goals Report for Uganda (2010)22.

¹³ 'Sustainable Development Goals: 17 Goals to transform our World'

<http://www.un.org/sustainabledevelopment/health/> (Accessed 25th February 2016)

¹⁴ Report of the Office of the United Nations High Commissioner for Human Rights on Preventable Maternal Mortality and Morbidity and Human Rights A/HRC/ 14/39 (16 April 2010) Para 17.

viewing maternal mortality as an inevitable consequence of reproduction in spite of the glaring evidence that it is a social injustice.¹⁵

Likewise, even though these injustices are meted out on women by virtue of their being female, they do not affect all them in the same way.¹⁶ Vulnerable women including the poor, the uneducated, the young, migrants, ethnic minorities are disproportionately affected by unintended pregnancies.¹⁷ These are pregnancies caused by lack of access to, and consistent use of effective contraception, child marriages and sexual violence. Even when vulnerable women resort to childbearing, they cannot afford quality health care services for themselves and their children, which may result in MMM as well as other social consequences. Therefore, non-prioritization and failure to put in place health care facilities for women's reproductive rights is a glaring example of gender inequality and discrimination.¹⁸

Several interventions have been undertaken, however, one aspect that is often ignored is the role of national level accountability in combating MMM. While the term 'accountability' has been popularized by international and regional monitoring mechanisms such as the UN treaty bodies, African Commission, at the domestic level, great strides have yet to be made in operationalizing human rights accountability into actual practices that will reverse the high MMM rates. This domestication of accountability is vital due to the fact that it is at the national level that human rights ideals are turned into implementable strategies.

Therefore, this study proposes the operationalization of 'human rights accountability' towards combating MMM. The study investigates the means through which accountability can be infused through various national/domestic level sectors specifically the legal, administrative and social structures with an aim of averting maternal deaths and morbidities.

1.2 STATEMENT OF THE PROBLEM

1.2.1 A synopsis on Maternal Mortality and Morbidity

The obligation to combat preventable maternal mortality and morbidity can be derived from a series of interrelated rights including; the right to the highest attainable standard of health, sexual and reproductive health rights, right to life, non-discrimination. Seen from a human rights perspective, the Ugandan health sector is in a crisis, with violations of the right to health considered a normal occurrence, especially for the most vulnerable parts of the

¹⁵ Cabal L and Stoffroegen M (2009) 4.

¹⁶ Htun M and Weldon SL 'Why do Governments promote women's rights? A framework for the comparative analysis of sex equality policy' (2010)8 *Perspectives on Policy* 210.

¹⁷ Blas E and Kurup AS (Eds) *Equity, Social Determinants and Public Health Programmes* (2010)178-183.

¹⁸ A/HRC/ 14/39 (2010)Para 17.

population. Uganda is party to all the critical international and regional human rights instruments that directly or indirectly provide for women's reproductive rights and has thus bound itself to realising maternal health for all women. Furthermore, article 33(2) of the 1995 Uganda Constitution provides that "The State shall provide the facilities and opportunities necessary to enhance the welfare of women to enable them realise their full potential and advancement".

Article 33(3) states that "The state shall protect women and their rights taking into account their unique status and natural maternal function in society." Additionally, several provisions within the National Objectives and Directive Principles of State Policy (NODPSP) section of the Constitution provide for health rights. Apart from the Ugandan Constitution, several legislation has been enacted over the years that aims at regulating the right to health. These include; the Nurses and Midwives Act, Cap 274, the National Drug Policy and Authority Act, the Allied Health Professionals Act, Cap 268 and the National Medical Stores Act, Cap 207. At the programmatic level, several policies have been adopted for combating maternal mortality such as; the National Health Policy II (2010), Health Sector Strategic Plan III 2010/11-2014/15, Road Map for accelerating the Reduction of Maternal and Neonatal Mortality in Uganda (2007-2015) and more recently the Reproductive Health Maternal, New Born and Child Health (RHMNCH), known as the Sharpened Plan 2013.

For the most part, apart from ratifying human rights instruments and setting out well elaborated policies, the Ugandan Government has a track record of merely paying lip service to such provisions. There is a general lack of understanding on how to translate human rights norms and principles from the various human rights documents assented to and adopted by the government, to their actual operationalization. The low awareness on human rights in Uganda can be surmised from the Convention on the Elimination of Discrimination against Women Committee's concluding observations to Uganda, where it registered its dissatisfaction with the inadequate knowledge on women's rights in the Convention.¹⁹

The Committee specifically pointed out the lack of knowledge within all the Government branches, including the judiciary, on issues such as substantive equality as well as human rights principles enunciated in its various General Recommendations. The Committee further pointed out that this lack of knowledge often trickles down to the lower levels, with the vulnerable women in the rural and remote areas being completely ignorant of their rights that

¹⁹ Concluding observations of the Committee on the Elimination of Discrimination against Women 'Consideration of the Combined 4th, 5th, 6th and 7th Report of Uganda, 47th Session, C/UGA/CO/7, 4-22 October 2010 Para 13-14.

are spelt out in the Convention and thus not being in position to claim these rights.²⁰ Therefore, it is argued that human rights norms are often reserved for reports written to international and regional monitoring bodies and human rights organisations, but the recommendations made are rarely actualized on the ground.

As a result, the health situation is dire as health care facilities are still extremely underfunded and ill-equipped. Every day about 16 women in Uganda die as a result of giving birth, this translates to almost 6,000 deaths every year.²¹ In 2011, the maternal mortality rate was noted to be 438 per 100,000 births, while under-five mortality rate was recorded at 137 per 1000 births.²² The proportion of births that were attended by skilled health personnel were 44 percent and only 47 percent of women received antenatal care. The poorest women suffered the most. The proportion of births attended by skilled health practitioners amongst 20 percent of the poorest women were 29 percent, while the same ratio of the wealthiest women was attended by a 77 percent coverage of skilled health practitioners.²³ The number of midwives in Uganda per 1,000 live births is 7 while the life time risk of death for pregnant women is 1 to 35.²⁴

These statistics fall way below the targeted goal which was to reach a MMR of 131 per 100,000 births and 100 percent attendance by skilled health practitioners by 2015. Furthermore, these statistics are mere estimates thus the actual numbers may be higher.²⁵ The most common causes of these deaths include; haemorrhage, sepsis, obstructed labour, hypertensive disorders²⁶ and clandestine abortions, which are more common among the teenagers.²⁷ Three types of delays also greatly contribute to maternal deaths; delay in seeking care, delay in reaching facilities and delay to receive the much needed care.²⁸

Surprisingly, the interventions that need to be taken in order to improve maternal health services are also elaborated upon in the policies, plans and programmes on maternal health that have been drafted or adopted by the Ugandan Government. The key interventions that must be in place for the reduction of maternal mortality and morbidity are; skilled birth attendance, emergency obstetric care (EmOC), access to good-quality and acceptable

²⁰ Consideration of the combined 4th, 5th, 6th and 7th Report of Uganda (2010) Para 13-14.

²¹ MDG Report for Uganda (2010) iv

²² MDG Report for Uganda (2010) 22.

²³ MDG Report for Uganda (2010) 24-26.

²⁴ United Nations Populations Fund *The State of the World's Midwifery: Delivering health saving lives* (2010)18.

²⁵MDG Report for Uganda (2010) 22.

²⁶ Joint UN Expert Technical Opinion *On Maternal Health and the Right to Health. In the matter of Constitutional Petition No.16 of 2011*. At the request of Centre for Health, Human Rights and Development(20 June 2011) 3-4

²⁷ Consideration of the combined 4th, 5th, 6th and 7th Report of Uganda (2010) Para 35.

²⁸ Joint UN Expert Technical Opinion(2011) 3-4

family planning services, safe abortion services and functional referral systems.²⁹ EMoC services are a series of life saving medical interventions that demonstrate the level of care at a health facility as well as its capacity to treat obstetric emergencies.³⁰ It is thus argued that the gaps in the legal, policy and programmatic framework are related to the failure to establish comprehensive accountability mechanisms. The maternal health-related policies do not adequately elaborate upon and put in place structures, bodies to supervise or track the implementation of these policies.

1.2.2 The impact of non-implementation of Accountability on MMM.

Inadequate financial, technical and human resources play a substantial role in perpetuating MMM, but the most important aspect, largely ignored, is effective accountability systems. Without accountability systems in place, any allocated resources cannot be maximised. The Medicines and Health Service Delivery Monitoring Unit reported that 60 percent of the facilities visited in 2015 had expired drugs, 69 percent of those in charge of government hospitals were not present and there was pervasive falsification of financial audit reports.³¹

It was reported that health workers mistreated and in some cases refused to attend to patients, machines had been left lying in medical stores for years without being used, and 26 percent of the health facilities had discrepancies between drugs dispatched by the National Medical Stores and those they received.³² Drug shortage is one vivid example of the implications of poor accountability mechanisms. Government health hospitals and the health centres sometimes report going for several months without receiving medical supplies, forcing patients to incur out of pocket expenses for private clinics.³³ Conversely, the National Medical Stores maintain that after receiving orders from health units they often promptly supply the required drugs and other supplies.³⁴ The lack of essential supplies for safe delivery such as gloves, needles and plasters also fosters the health workers to ask the

²⁹ Lobis S, 'The role of indicators and benchmarks in reducing maternal mortality: the case of emergency obstetric care indicators' in Hunt P and Gray T (Eds) *Maternal mortality, Human Rights and Accountability*, (2013) 31-37.

³⁰ Lobis S (2013) 31-37.

³¹ Mugerwa Y 'State House gives MPs hospitals rot evidence' *The Daily Monitor* 16 April 2016. Available at <http://www.monitor.co.ug/News/National/State-House-gives-MPs-hospitals-rot-evidence/688334-3159648-spi0qc/index.html> (Accessed 20 April 2016)

³² Mugerwa Y *The Daily Monitor* 16 April 2016.

³³ Mugerwa Y *The Daily Monitor* 16 April 2016.

³⁴ 'Resolve Drug shortage Problem once and for all', *The Daily Monitor*, 29 August 2016. Available at <http://www.monitor.co.ug/OpEd/Editorial/Resolve-drug-shortage-problem-once-and-for-all/689360-3360872-itof9e/index.html>. (Accessed 04 September 2016).

expectant mothers to come with their own supplies and failure to do so means they are not attended to.³⁵

This goes to show that lack of oversight/accountability mechanisms to guarantee that services and resources are put to their maximal purpose, substantially perpetuates MMM. The lack of effective supervisory structures encourages unbridled resource wastage, diversion, non-utilization and embezzlement of funds which directly contributes to the persistence of high mortality and morbidity rates. Therefore, it is vital to note that it is not enough that equipment, health personnel and finances are increasingly being allocated to the health sector. Without effective accountability (tracking and supervisory) mechanisms to ensure that the resources that are allocated to the health sector are put to the most efficient use, increased financial, technical and human resources will not translate into reduced MMM.

Yet, the role of accountability towards the operationalization of human rights is still underappreciated. Accountability is still largely in its infancy stage in Uganda with many practitioners unaware of its major elements and how it can be implemented. As elaborated upon under administrative accountability, limited understanding is seen within Uganda's legal and policy framework where it is often narrowed down to monitoring and evaluation. While monitoring is an integral element, accountability should be interpreted and implemented holistically taking into consideration its vital elements; responsibility, answerability and enforcement.

Within the reproductive health policies, a comprehensive accountability framework for the implementation of maternal health programmes running from the national to the local level is not clearly elaborated upon. This runs counter to the Technical Guidance on the Prevention of Maternal Mortality, which emphasizes that where the health system is decentralized, the government remains accountable for complying with human rights obligations relating to sexual and reproductive health.³⁶ One of these obligations is the implementation of accountability, which requires regular bottom-up diagnostic exercises aimed at identifying blockages in the system that hinder women from safely giving birth, and providing feedback aimed at prompting the taking of action to address these challenges/blockages.³⁷

³⁵ Edema D, 'Jinja Hospital Medics ask patients for Kits', *The Daily Monitor*, 10 June 2016. Available at <http://www.monitor.co.ug/News/National/Jinja-hospital-medics-ask-patients-for-kits/688334-3241970-14l0bo4z/index.html>. (Accessed 10 June 2016).

³⁶ United Nations General Assembly, 'Technical Guidance on the Application of a Human-Rights Based Approach to the Implementation of Policies and Programmes to reduce Preventable Maternal Morbidity and Mortality', Human Rights Council, Twentieth Session, A/HRC/21/22 (2 July 2012) Para 23, 53.

³⁷ Technical Guidance on MMM (2012) Para 23, 53.

The study makes a linkage between human rights accountability and maternal mortality and morbidity. It demonstrates that having strong accountability frameworks will substantially contribute to the reduction in maternal deaths. One of the most notable developments to date in the maternal health sector, in line with accountability, was the drafting of the UN Technical Guidance on Maternal Mortality and Morbidity. The Technical Guidance spelt out the different forms and levels of accountability that should be taken into consideration in order to prevent maternal mortality and morbidity and to ultimately bring about better maternal health conditions.³⁸ These include; private-actor accountability, donor accountability, professional accountability, legal accountability, social accountability, political accountability and administrative accountability. It is vital to note that these forms of accountability have sub-forms within them, for instance administrative accountability in the maternal health context takes into consideration institutional, private-actor, professional as well as health system accountability while international accountability involves donor accountability.³⁹

This study, lays specific focus on national level accountability mechanisms and specifically; legal accountability, social accountability and administrative accountability. Each of these forms of accountability are discussed in greater detail in the ensuing chapters, however, in the interim, it's vital to briefly define them. In the context of this study, legal accountability is about putting in place well established judicial systems through which violations of women's maternal health rights are adjudicated and remedied. Administrative accountability deals with establishing supervisory guidelines and norms within health facilities and within the Ministry of Health aimed at improving the performance of health systems. Social accountability is a vertical form of accountability which involves a vibrant and dynamic relationship whereby communities directly hold public officials and other service providers accountable for the execution of their obligations. It allows for direct participation in a more informed and constructive manner. Social accountability aims at improving transparency in service delivery right from the local to the national level.

It is acknowledged that despite the interrelated nature of each of the forms of accountability, there are distinct aspects of each of the forms which are worth exploring. Likewise, despite, the focus on these mechanisms, the various discussions touch on all the other accountability mechanisms mentioned above. This is due to the fact that, as it has already been pointed out, accountability operates in a circular manner. So, all the elements have to operate together for any success in reduction of MMM. These various forms of accountability also

³⁸Technical Guidance on MMM Para 16-17.

³⁹ Technical Guidance on MMM Para 16-17.

exist at various stages of the policy cycle and at each stage, a different form of accountability applies thus forming a 'circle of accountability'.⁴⁰

The Technical Guidance further emphasised that: accountability goes beyond monitoring; accountability should not be perceived as an afterthought, but rather as a continuous process which establishes internal norms and rules within the Ministry of Health and the health facilities;⁴¹ the implementation of accountability entails the establishment of standards for conduct that make subordinates accountable to superiors and ensures that an independent monitoring entity or individual is instituted.⁴²

The Guidance further points out the need for effective participation which involves women being aware of their entitlements in regard to sexual and reproductive health rights and thus being empowered to claim these rights. It also points out the need for the continuous tracking and evaluation of the implementation of maternal health policies using both quantitative and qualitative indicators. Last but not least, it emphasises that remedies should be put in place to give effect to the rights and these should not only be restricted to judicial mechanisms.⁴³

Thus, the various components of accountability mentioned in the Technical Guidance are in line with the responsibility, answerability and enforcement model of accountability, which is the approach used for this study. Recently, the International Committee on Economic Social and Cultural Rights (ESCR) adopted the General Comment on Sexual and Reproductive Health.⁴⁴ One of its core obligations is the need to periodically monitor and review the implementation of sexual and reproductive health services using participatory and transparent processes. Another core obligation is ensuring access to effective remedies for the violations of sexual and reproductive health rights which may be administrative or judicial.⁴⁵

The operationalisation of human rights accountability in the health administrative system is one of the most direct ways of the inclusion of rights based approaches in the health system. The prioritization of rights based approaches in health care cannot be undermined. From 1990 to 2015 (MDG period) Nepal substantially reduced its MMM rates by over 5 percent annually. One of the main reasons for the reduction of these rates, was the reframing of its

⁴⁰ Joshi A and Houtzager PP (2012) 148.

⁴¹ Technical Guidance on MMM (2012) Paras 18, 74.

⁴² Technical Guidance on MMM (2012) Paras 18, 74.

⁴³ Technical Guidance MMM (2012) Paras 17, 67-70.

⁴⁴ UN Committee on Economic, Social and Cultural Rights (CESCR), 'General Comment No. 22 on the Right to Sexual and Reproductive Health (Art.12 of the Covenant)', 2 May 2016, E/C.12/GC/22

⁴⁵ General Comment No. 22 on the Right to SRH, Para 49.

health policies to reflect a rights based approach. Plans and programmes addressing safe motherhood, gender, and neonatal health were gradually revised to strongly reflect human rights principles.⁴⁶

1.3 RESEARCH QUESTIONS

Lack of accountability in the health sector greatly affects health service delivery and subsequently contributes to the persistently high Maternal Mortality and Morbidity rates. Therefore, it is suggested that the adoption of an accountability framework will reverse the high rates of MMM. Furthermore, the application of this framework to the various forms of accountability: legal, administrative and social, will allow for the enhancement of strategies, leading to better outcomes. Accountability is also vital in ensuring financial, technical and human resources are maximised. Therefore, the purpose of this study is to examine the implementation of accountability towards combating preventable maternal mortality and morbidity in Uganda.

To this end, the main question that this study aims to answer is:

How can accountability be effectively implemented in order to reduce the prevalence of Maternal Mortality and Morbidity in Uganda?

Specifically, the study poses the following questions:

- What is the meaning of 'human rights accountability'?
- Which accountability framework can be used to combat MMM?
- What is the relationship between the persistence of MMM and the undermining/sidelining of women's rights?
- What is Uganda's legal, policy and programmatic landscape for MMM?
- Why is a 'contextual analysis' vital for the successful implementation of accountability in a bid to address MMM?
- How can the proposed accountability framework be applied to legal, administrative and social accountability mechanisms to substantially contribute to combating MMM in Uganda?

⁴⁶ Trends in Maternal Mortality (1990 to 2013) 27-28.

1.4 LITERATURE SURVEY

Accountability in the human rights context is still an unexplored theme. Despite the appearance of ‘accountability’ in almost all human rights documents, the attempts at elaborating upon it are still limited. Thus, for the most part it is still an elusive, fuzzy and confusing term. Earlier studies of accountability focused on public/political accountability.

Scholars like Dirks set out that accountability is the extent to which an individual or organization is bound to give account (either in form of a report, narration, description of an event) or to answer for conduct or performance of duties.⁴⁷ Jelmin emphasized that accountability is aimed at constraining power in order to prevent its abuse or misuse because without such restrictions there is often potential for democracies to remain corruptible and thus unable to deliver basic freedoms and entitlements.⁴⁸ Furthermore, that accountability may be forward looking (*ex-ante*) or it may be retrospective (*ex-poste*). Under retrospective accountability, public officials account for their actions after they have taken them while with forward looking accountability, strategies are monitored before their implementation.⁴⁹

In pointing out the significance of accountability, Schedler emphasized that power should be exercised in a transparent manner by demanding that those in power justify their acts and failure to do so should be sanctioned.⁵⁰ Schedler also asserted that accountability is a ‘radial’ concept in that one of the three dimensions; information, justification and punishment may not be present but this does not necessarily discount acts of accountability. For instance, many human rights commissions often use answerability or very ‘soft’ forms of accountability such as the exposure of human rights violations as their methods of accountability. On the other hand, others heavily rely on sanctions or punishment as their acts of accountability, like the idea of electoral accountability may sometimes be a form of punishing those politicians who have underperformed by ‘throwing them out’.⁵¹

In contrasting with Schedler’s reference to accountability as a radial concept, Lindberg contended that accountability is a classical concept, which follows a neat and simple set of rules.⁵² Thus, numerous sub-types of accountability may exist but they are merely nominal

⁴⁷ Dirks JM ‘Accountability, History and Archives: Conflicting Priorities or synthesized strands?’ (2003) 57 *Achivaria* 30.

⁴⁸ Jelmin K *Democratic Accountability in Service Delivery: A synthesis of Case Studies* International Institute for Democracy and Electoral Assistance (International IDEA), 2011 5, 7.

⁴⁹ Jelmin K (2011) 7.

⁵⁰ Schedler A ‘Conceptualizing Accountability’ in Schedler A, Diamond L and Plattner MF(Eds) *The Self-Restraining State: Power and Accountability in New Democracies* (1999) 13

⁵¹ Schedler A (1999) 17-18.

⁵² Lindberg SI ‘Mapping Accountability: Core Concepts and sub-types’ (2013) 79 *International Review of Administrative Sciences* 205

versions of the larger concept that is accountability. Sandberg further challenges the notion of accountability as a family concept which sets out that if, for example, accountability is composed of five criteria, then having four instead of five may compensate for the absent ones, as this may lead to an endless route of meaninglessness.⁵³

To this end, in the context of power, if all approaches that limit power are referred to as accountability, one may conclude that accountability plays a very minimal or no significant role. Consequently, too much laxity might lead to meaningless concepts and conclusions. On the other hand, there is also need for a balance as too much specificity may hinder interesting investigations.⁵⁴ Schedler also asserts that holding power accountable does not mean determining the way it is exercised but limiting its arbitrariness, preventing and redressing the abuse of power in order to keep it in line with established procedures. This is on the premise that power cannot be fully controlled and that even in a perfect situation it would continue to produce harm and other evils. Thus, even if agents of accountability were to expose it or punish it, they can't completely repair it or undo it.⁵⁵ These theories/concepts provide insight into the core elements of accountability. However, they were not steeped in human rights principles and were also not focused on health.

From a human rights perspective, Potts made a clear connection in the monograph, “*Accountability and the Right to the Highest Attainable Standard of Health*”.⁵⁶ Yamin also wrote on a similar subject in her article “*Beyond Compassion: The central role of accountability in applying a human rights Framework to health*”.⁵⁷ Additionally, a series of reports on accountability and health have been published. The Commission on Information and Accountability for Women and Children’s health published a report titled “*Keeping Promises, Measuring Results*” and another paper by the Working Group on “*Accountability for Results*”. Additionally, “*A Review of Global Accountability for Women and Children’s Health*” was produced by The Partnership for Maternal, New-born and Child Health. Even so, very few studies have analysed the contribution of accountability towards reducing preventable maternal mortality and morbidity. Freedman introduced the term ‘constructive accountability’ to emphasize that a rights based approach to the reduction of maternal mortality should not primarily be about fault finding, apportioning blame as well as punishment. That, a flexible system of entitlement and obligation should be created on the part of rights holders as well as the duty bearers.

⁵³ Lindberg SI (2013)206-207.

⁵⁴ Lindberg SI (2013)206-207.

⁵⁵ Schedler A (1999) 18-20.

⁵⁶Potts H, *Accountability and the Right to the Highest Attainable Standard of Health* (2008).

⁵⁷ Yamin AE, ‘*Beyond Compassion: The central role of accountability in applying a human rights Framework to health*’ (2008)10 *Health and Human Rights* 1-20.

This involves a series of actions; evidence-based human rights reporting, good management practices and ongoing community involved monitoring processes.⁵⁸ Yamin further posits that accountability is one of the most important factors in reducing maternal mortality. Accountability goes beyond merely identifying the violator and the violated and undertaking punitive measures with an aim of ending the violation. She emphasizes that accountability should be ‘transformative’ by making human rights norms operational for health planners, development partners, health practitioners and beneficiaries of the health services. This involves; holding donors accountable to human rights norms that apply to them, putting in place adequate legal remedies, continuous monitoring of policies and interventions, analysing budgetary allocations and putting in place a national strategy and plan of action.⁵⁹ Both Freedman and Yamin’s articles made part of the compilation of articles that were recently published in Hunt’s and Gray’s book “*Maternal Mortality, Human Rights and Accountability*”⁶⁰ These studies are utilized throughout the study to expound on the various forms of accountability.

The recent focus on social accountability both at the international and national level, as a result of increased advocacy by organizations and communities, has helped to bring to the fore the importance as well as the interconnection between accountability and maternal health.⁶¹ However, for accountability to be successful, it has to be viewed from various angles including administrative, political, legal accountability and not merely from the social angle. Yet, none of these studies elaborated upon how the various forms of accountability specifically; social accountability, administrative accountability and legal accountability can be implemented with the aim of combating MMM. A comprehensive report by Centre for Economic and Social Rights titled “*Who Will Be Accountable: Human Rights and the Post 2015 Development Agenda*”, illustrated how these various forms of accountability can be

⁵⁸ Freedman LP, ‘Averting maternal deaths and disability: Human rights, constructive accountability and maternal mortality in the Dominican Republic: A commentary’ (2003)82 *International Journal of Gynaecology and Obstetrics* 111-112.

⁵⁹ Yamin AE, ‘Toward Transformative Accountability: Applying a Rights Based Approach to Fulfil Maternal Health Obligations’ (2010) 7 *International Journals on Human Rights* 95-121.

⁶⁰ Hunt P and Gray T (Eds) *Maternal mortality, Human Rights and Accountability*, (2013).

⁶¹ Campbell C, Papp SA and Gogoi A ‘Improving maternal health through Social Accountability: A case study from Orrisa, India’ (2013)8 *Global Public Health* 1-28. Boydell Vand Keesbury J ‘Social accountability: What are the lessons for improving family planning and Reproductive Health Programs? A review of the Literature’ Evidence Project, (October 2014). Maru V, ‘Social Accountability and Legal empowerment’ (2010)12 *Health and Human Rights* 83-93. Hulton L et al, ‘Using evidence to drive Action: A revolution in accountability to implement quality care for better maternal and new-born health in Africa’, (2010)127 *International Journal of Gynecology and Obstetrics* 96-101. Lodenstein E et al, ‘A realist synthesis of the effect of social accountability interventions on health service providers’ and policy makers’ responsiveness’, (2013)2 *Systematic Reviews* 1-10.

used in the realization of development goals.⁶² However, the report was more general as it did not focus on MMM.

The Technical Guidance on Preventable Maternal Mortality and Morbidity mentioned a panoply of forms of accountability such as national legal accountability, administrative accountability, professional accountability that should be implemented from a human rights perspective towards combating preventable maternal mortality and morbidity.⁶³ However, at the Ugandan level, there is a deficiency of studies aimed at analysing the contribution of accountability towards combating maternal mortality and morbidity. Therefore, while international human rights bodies are vital in setting the international standard by which countries should abide, and sharing best practices that other countries can adopt, it is at the national/domestic level that these norms and principles are actualized or implemented. Due to the varying contexts of each of the countries, each country is tasked with ensuring that the laws, policies and programmes that are implemented reflect the local circumstances and the lived experiences of that country. Otherwise, all these human rights norms and principles may be developed but if they are not implemented in the various national contexts, they amount to nothing.

This is emphasized by Freedman who states that there is often a contrast between the framing of problems pertaining to sexual and reproductive health as well as solutions at the global/international level and the multifaceted reality of people who directly interact with health systems on ground.⁶⁴ She says that often, erroneous assumptions are made about how transformation occurs. Likewise, the power dynamics at the point of interaction (local contexts) between health institutions and service users are often overlooked or undermined.⁶⁵

For this reason, the major emphasis of this study is examining the implementation of accountability towards combating maternal mortality and morbidity in the domestic context, specifically Uganda. The study gives special attention to the role of the various forms of accountability towards combating preventable maternal mortality and morbidity in Uganda. In looking at national level accountability, specific focus is on the implementation of legal, administrative and social accountability. To this end, an accountability framework for the reduction of MMM in Uganda is devised. Even still, the international influence on the

⁶² United Nations Office of the High Commissioner *Who will be accountable: Human Rights and the Post 2015 Development Agenda* (2013).

⁶³ Technical guidance on MMM (2012).

⁶⁴ Freedman LP and Shaaf M, 'Act Global but think local: Accountability at the frontlines (2013)21 *Reproductive Health Matters* 103-112.

⁶⁵ Freedman LP and Shaaf M (2013) 103-112.

domestic context cannot be overlooked, thus certain references are made to developments at the international level throughout the study.

1.5 RESEARCH METHODOLOGY

The persistence of high maternal and morbidity rates in Uganda despite various legal, policy and programmatic interventions, necessitates an examination of the contribution of accountability mechanisms to combating preventable MMM. This thesis analyses how the different forms of accountability can be utilized in combating MMM. In infusing a human rights approach, the study proposes the operationalization of the responsibility-answerability-enforcement accountability approach to achieve this.

Ultimately the study demonstrates the central role of human rights accountability towards the realization of reproductive health rights and subsequently averting maternal deaths and morbidities. In order to achieve this objective, this thesis reviews both primary and secondary sources that are related to the study. The primary sources that are reviewed include; international legal instruments both binding and non-binding such as conventions/treaties, declarations, resolutions, general comments, commentaries to these instruments, reports from United Nations Special Procedures, and State Party Reports to the regional and international human rights instruments. At the domestic level, these include; constitutions, acts by parliament, bills passed, policies, government reports, Parliamentary Hansards, and drafting preparatory materials. The study also greatly relies on case law mostly from Uganda but also from other jurisdictions such as South Africa, India, Ghana, and Britain. It also includes case law from international and regional bodies such as the Committee on the Convention on all forms of discrimination against women (CEDAW) as well as the African Commission.

Secondary sources have also been vital sources of information including; books, articles in edited books, journal articles, newspaper articles, magazines, reports written by international and local organisations, organizational and other pertinent websites. Due to the topical and dynamic nature of the topic under review, the several developments at the international, regional and more importantly national level captured through various news outlets were continuously analysed and used to update the study. Similarly, illustrations from other countries such as Rwanda, Nepal, South Africa, Ethiopia, India, and Sri-Lanka were also very vital in deepening analysis of the study.

1.6 SCOPE/LIMITATIONS

The study attempts to bring together a series of interrelated yet very broad fields. In order to make a contribution, the study is very deliberate in zeroing in on specific aspects of each of

these fields. The study is specifically aimed at establishing a linkage between the implementation of accountability and the reduction of preventable maternal mortality and morbidity. While it is acknowledged that different disciplines have defined accountability, the focus of this study is to develop accountability from a human rights lens.

In each chapter, the study lays out its scope. From the outset, it is emphasized that the focus of the study is national level accountability (Uganda) and thus any reference to international or regional developments is aimed at strengthening national level accountability. The study also recognizes the existence of numerous forms of accountability but lays emphasis on legal, administrative and social accountability. In analysing these forms of accountability, it forwards the responsibility-answerability-enforcement theoretical framework within the human rights paradigm. Thus, every chapter is principally aimed at analysing the extent to which the various forms of accountability measure up to the framework.

Despite elaborating on legal, administrative and social accountability, it is recognised that aside from the fact that these areas have not been adequately expounded upon through research, this study is by no means an exhaustive exploration of these loaded aspects. Thus, it is hoped that the research contributes to the further exploration of human rights accountability through academic research.

The study focuses on maternal health from a rights-based perspective. Maternal health is one of the areas that fall under the right to health and its underlying determinants, however the study largely restricts itself to the right to health care pertaining to MMM. It is also emphasised that since MMM is an issue that directly affects women, a series of women's rights are implicated. It is further highlighted that, despite the interconnected nature of maternal and child health, seen through various documents both at the national, regional and international level, the focus of the study is the combating of maternal mortality and morbidity.

Last but not least, in analysing social accountability, the study acknowledges the diverse nature of this form of accountability. With social accountability, the challenge presented lies in the fact that it relies on social and community structures establishing accountability mechanisms. This poses a challenge as to where and how to proceed on account of the anonymity of social structures. Therefore, the study zeroed in on Civil Society Organisations (CSOs) as an avenue for advancing social accountability. It focuses on the role of organized structures, in this case, CSOs as channels that build the capacities of communities to better implement accountability with the aim of combating MMM. The justification for this is that since CSOs often document their interventions, the emphasis on them methodically allows

for the acquisition of, comparison of and analysis of information. It is clearly accentuated that CSOs are very diverse and the purpose is not to elaborate on the different forms that they take. Furthermore, the illustrations that are given are not a complete representation of all the strategies being undertaken by CSOs in Uganda to improve social accountability. Nonetheless, it is hoped that the research provides an in-road to implementing social accountability to reduce preventable MMM.

1.7 STRUCTURE OF THE THESIS

The study consists of six chapters. Chapter one is the introductory chapter which provides a background to the study, the problem to be examined, research questions, literature survey, methodology and the outline of the chapters.

Chapter two sets out a theoretical framework for accountability as well as maternal mortality and morbidity. The chapter defines ‘human rights accountability’ and sets out an accountability framework for MMM based on the main building blocks of accountability, responsibility-answerability and enforcement. These 3 elements are defined and their meaning in the context of the study is set out. In the subsequent chapters, the recommended framework is applied to the various forms of accountability.

In positing that the persistence of MMM is an indicator of the continued side-lining or undermining of women’s rights, the chapter briefly touches on feminist legal arguments and elaborates upon non-discrimination as set out in the various human rights documents. Furthermore, in laying the ground for the subsequent chapters, the chapter sets out and elaborates upon some of the main forms of accountability and their contribution towards combating preventable maternal deaths and morbidities. From the outset, the chapter emphasizes that the focus of the study is on national level accountability. To this end, the forms that are discussed are; national legal/judicial accountability, administrative accountability and social accountability.

Chapter three analyses the implementation of legal accountability towards combating MMM in Uganda. Specific emphasis is laid upon; Ugandan Courts of Law as well as the Uganda Human Rights Commission. In applying the accountability framework set out in Chapter two, to legal accountability, the Chapter sets out the major human rights documents in line with MMM that Uganda has assented to as well as the recommendations/observations to Uganda by the various human rights treaty bodies. The main cases on MMM that have gone to the Ugandan Courts are analysed to examine how they enforce the right to maternal health care. The unique and expansive role of the UHRC as a judicial/enforcement mechanism is also illustrated upon. Likewise, it analyses structures set up both by the Courts and UHRC to

ensure peoples' access to justice as well as tracking mechanisms aimed at ensuring that judicial services are being provided as expected in a bid to combat MMM.

Chapter four investigates the role of administrative accountability towards reducing MMM. The chapter builds upon the previous chapter by demonstrating how the suggested accountability framework can be operationalized within the health administrative structures. Uganda's health policy framework is briefly elaborated upon as well as the monitoring/supervisory mechanisms in line with reproductive health. A series of issues that have an implication on the implementation of administrative accountability are also examined. These are; maternal death audits, data collection methods, the allocation and utilization of financial resources towards maternal health.

The chapter also discusses the various regulatory institutions in line with maternal health such as; the Health Service Commission (HSC), National Drug Authority (NDA), Uganda Medical and Dental Practitioners Council (UMDPC), the Uganda Nurses and Midwives Council (UNMC). It stresses the need to prioritize the implementation of the existing maternal health related policies by putting in place strong accountability institutions. Hence, it emphasizes the need to form one body at the national level sorely focused on the monitoring/tracking of the implementation of maternal and infant mortality policies.

Chapter five examines social accountability. Specific focus is put on the role of CSOs in ensuring community involvement while holding the government accountable for the provision of maternal health services. In building on previous chapters, the responsibility-answerability-enforcement framework is used in examining various accountability initiatives. Thus, emphasis is put on capacity building of communities with the aim of enabling them to participate in tracking or supervising the implementation of maternal health programmes.

The chapter acknowledges that enforcement under social accountability is still under developed. Thus, critical thought needs to be put into strengthening the remedial aspect of social accountability. Some of the suggested avenues include the utilisation of various approaches together such as litigation, social mobilization and the media. It is also suggested that the complaints mechanism at the health facilities should be improved upon by establishing channels through which remedies are devised for the complaints raised.

Chapter six discusses conclusions and recommendations for the study. The chapter sums up the main findings of the thesis and provides vital recommendations on the inclusion of accountability throughout the various sectors as a way of combating maternal deaths and morbidities.

CHAPTER TWO: ROLE OF ACCOUNTABILITY TOWARDS THE REDUCTION OF PREVENTABLE MATERNAL MORTALITY AND MORBIDITY

2.0 INTRODUCTION

Accountability is one of the most commonly used terms in governance, politics and more recently human rights documents and yet there is a limited understanding of its meaning and context. It is used as a lofty term but it remains an elusive concept when it comes to defining and laying out procedures that guide its operationalization. As eloquently put by Bovens, the term 'accountability' is always reserved for the titles of governance texts and not often even mentioned within the texts. He compares it to a 'garbage can filled with good intentions' as it is often not used for purposes of analysis but rather for vague and fuzzy aspirations of governance.⁶⁶ He further contends that accountability is often interchangeably used with terms like equity, democracy, responsiveness, good governance, and transparency. These terms are also distinct terms, which on their own require interpretation and operationalization. Such concepts render accountability a very broad concept without determined boundaries. Therefore, it becomes very difficult to ascertain whether an institution is being accountable because accountability maybe everything and yet nothing.⁶⁷

Accountability is the backbone of human rights - without it they cannot be practically applied. Despite the appearance of accountability in almost every single human rights text, there are not many scholars who have extensively written on 'human rights accountability'. This is so, despite the vital role of accountability in the transformation of human rights ideals into implementable policies and programmes. One of the shortcomings of the defunct MDGs, was the lack of establishment of an accountability framework through which the targets and indicators would be measured. Therefore, in the recently adopted Sustainable Development Goals, accountability was included in Goal 16 on 'peace, justice and strong institutions'. The aim of this goal is to promote peaceful and inclusive societies for sustainable development, ensure access to justice for all and put in place efficient, accountable institutions at all levels.⁶⁸ The inclusion of this goal in the SDGs demonstrates a recognition of the role of accountability towards achieving sustainable development.

⁶⁶ Bovens M 'Public Accountability: A framework for the analysis and assessment of accountability arrangements in the public domain' Unpublished Paper, Utrecht School of Governance, Utrecht University, The Netherlands (2005) 4.

⁶⁷ Bovens M (2005) 5-6.

⁶⁸ 'Sustainable Development Goals: 17 Goals to transform our World'. Available at <http://www.un.org/sustainabledevelopment/peace-justice/> (Accessed 16 Feb 2016)

Therefore, this chapter elaborates upon an accountability framework for maternal morbidity and mortality based on the main building blocks of accountability; responsibility, answerability and enforcement. First, the chapter gives a background to accountability. It is argued that unless the three elements of accountability are effectively and complimentarily implemented, the high maternal mortality rates prevailing in many developing countries will persist. Then it explores the issue of maternal mortality and morbidity (MMM) while steeping it in a ‘women’s rights’ framework’.

It is contended that the continued side-lining of the high rates of MMM by states, is a clear indicator of the marginalised status of women’s position in society as well as the undermining of women’s rights. In order to build a basis for the next chapters, the last section sets out the major forms as well as remedies which include; legal, administrative, and social accountability mechanisms. In this section, it is emphasised that the focus so far has been on devising legal mechanisms. It thus stresses that in order to effectively combat preventable MMM, there is need to go beyond judicial remedies to other accountability mechanisms (administrative, social, political).

2.1 UNDERSTANDING ACCOUNTABILITY

For many years, accountability has been a central factor in different contexts such as politics, law, governance, business and development. However, its wide application sometimes renders it elusive and confusing. Generally, accountability is about holding actors responsible for their actions or inactions in light of standards of their behaviour and performance.⁶⁹ It is also the extent to which an individual or organization is bound to give account (either in form of a report, narration, description of an event) or to answer for conduct or performance of duties.⁷⁰ The major underlying attributes of accountability are; responsibility, answerability and enforcement⁷¹ which shall be expounded upon later on.

Accountability has a long history both in financial accounting and in political science but in more recent years it has become popular in public administration as well as international development.⁷² The genesis of the term ‘accountability’ is from classical accounting or from traditional bookkeeping, which can be traced from the reign of William 1 of England in the 1000s.⁷³ King William 1 often required all property owners to give ‘account’ of what they owned by using his agents to assess and list their properties. This was both for purposes of taxation but also in keeping with the foundations of royal governance. By the 12th century

⁶⁹ Yamin AE (2010) 7 97.

⁷⁰ Dirks JM (2003) 30.

⁷¹ Who will be accountable? Human Rights and the Post 2015 Development Agenda (2013) 10.

⁷² SI Lindberg (2013) 203.

⁷³ Bovens M (2005)2-3.

this system had developed into a highly centralized auditing and account giving system. It eventually shifted from financial accountability to public accountability especially in the latest twentieth century with the Thatcher Government in the United Kingdom as well as the Clinton-Gore administration in the United States. This was as a result of the introduction of the private sector management into the public sector. This necessitated the use of benchmarks and indicators to measure the performance of various public sectors which required extensive auditing processes.⁷⁴

Accountability has been pointed out as a central pillar for democratic governance. Early theorists and philosophers maintained that in forming a government, first the government had to be empowered to exert authority/power over the governed and then it was obliged to control itself. For this to happen, certain checks, institutional constraints and codes of conduct had to be in place to control, contain and to prevent the abuse of this power hence the term accountability.⁷⁵ Accountability also lays emphasis on the nature of obligation as vertical, horizontal and more recently diagonal. Horizontal accountability is often exercised when the major arms of government engage, for instance, the legislature may undertake executive oversight, or the judiciary may engage with the executive in order to put in place checks and balances aimed at preventing the misuse of power.⁷⁶ On the other hand, vertical accountability often originates from outside the state, when electorates hold politicians accountable through periodic elections, or through social accountability where citizens and civil society directly hold public officials accountable to their obligations.⁷⁷

Lastly, diagonal accountability has emerged as a result of the perceived weakness of horizontal and vertical accountability. Horizontal forms of accountability have been noted to have serious shortcomings, like mismanagement, influence by powerful politicians, and embezzlement of funds. Vertical accountability mechanisms such as the reliance on elections, which are held after a considerable amount of time, might not guarantee accountability.⁷⁸ Therefore, diagonal accountability integrates both methods to enhance accountability, for instance, the coming together of citizens to form an organized structure. Through participatory processes, these people may set up mechanisms to directly monitor government performance.⁷⁹ However, in slight contrast to public/political accountability

⁷⁴ Bovens M (2005)2-3.

⁷⁵ Schedler A (1999) 13.

⁷⁶ United Nations Development Programme *Reflections on Social Accountability: Catalysing Democratic Governance to accelerate progress towards the Millennium Development Goals* (July 2013) 3.

⁷⁷ *Reflections on Social Accountability: Catalysing Democratic Governance to accelerate progress towards the Millennium Development Goals* (July 2013) 3.

⁷⁸ Goetz AM and Jenkins R 'Hybrid forms of accountability: Citizen engagement in institutions of public sector oversight in India'(2001)3 *Public Management Review* 364-365

⁷⁹ Goetz AM and Jenkins R (2001)364-365

governance traditions, human rights mainly attach accountability in the relationship between the state and its citizens as well as others within its jurisdiction.⁸⁰ Therefore, it has to be viewed as a relational concept. In order to operationalize accountability, the human rights based approach (HRBA) focuses on identifying rights holders as well as the corresponding duty bearers.

The duty bearers are charged with both positive and negative obligations. It goes ahead to strengthen the capacities of the rights holders to claim their rights as well as duty bearers to fulfil their roles.⁸¹ In this context, the human rights legal standards become the standard of performance requiring the domestication of internationally recognised rights into benchmarks at the local level, which can be used to measure progress. An HRBA thus calls for the establishment of laws, policies, institutions and programmes to implement the rights as well as putting in place judicial, political, administrative and social redress mechanisms.⁸²

Accountability is integral to the enjoyment of all human rights and goes hand in hand with monitoring. Freedman and Yamin coined terms such as 'constructive'⁸³ or 'transformative'⁸⁴ accountability respectively aimed at shifting the focus of accountability from entirely focusing on 'blame' or 'punishment'. Instead, they prescribed developing a dynamic system comprising shared roles and responsibilities between rights holders and duty bearers, where shortcomings can be reviewed from time to time and remedied. Accountability goes beyond merely apportioning blame and punishing those responsible. For instance, in the case of maternal health, it is always difficult to establish the direct cause of a maternal death as a series of factors may have interplayed in the situation. These may include; low social status, unsafe abortion, poor health services, lack of reproductive health information, delays in accessing health care, traditional beliefs or customs.⁸⁵

Therefore, multiple actors might be responsible for a single maternal death. In such a case, it might not be feasible to identify a specific perpetrator.⁸⁶ This calls for the setting up of a comprehensive system of identifying past shortcomings in order to prevent similar

⁸⁰ Who will be accountable: Human Rights and the Post 2015 Development Agenda (2013) 17.

⁸¹ Darrow M and Thomas A 'Power, Capture and Conflict: A call for human rights accountability in development cooperation' (2005)27 *Human Rights Quarterly* 511-514.

⁸² Darrow M and Thomas A (2005) 511-514.

⁸³ Freedman LP 'Human rights, constructive accountability and maternal mortality in the Dominican Republic: a commentary' (2003)82 *International Journal of Gynecology and Obstetrics* 111-114.

⁸⁴ AE Yamin (2010) 95-231.

⁸⁵ Cabal L and Stoffroegen M 'Calling a Spade a Spade: Maternal Mortality as a Human Rights Violation' (2009)16 *Human Rights Brief* 4.

⁸⁶ Cabal L and Stoffroegen M (2009) 4.

occurrences in the future.⁸⁷ Thus, in order for accountability to be effected, various forms and levels of review and oversight have to be in place. The forms include but are not limited to; national legal accountability, social (civil society) accountability and administrative accountability.

2.2 ACCOUNTABILITY FRAMEWORK FOR MATERNAL MORTALITY AND MORBIDITY

In order to combat the persistently high MMM rates, this chapter advances an accountability framework for combating MMM. The framework is hinged on the Responsibility, Answerability and Enforcement (RAE) approach of accountability. The aim is to lay the ground for the subsequent chapters, which demonstrate how the proposed RAE accountability approach can be applied to the legal, administrative and community level structures to substantially reduce MMM in Uganda. The RAE framework is steeped in a human rights framework whereby responsibility can be understood as putting in place standards by which performance should be measured. As will be elaborated upon further on, responsibility requires that human rights standards are infused within accountability mechanisms. To this end, the principles underlying the right to health become the standards for the combating of MMM.

Answerability requires those in power to act in a transparent manner by ensuring that they continuously explain and justify their actions to those over whom the power is being exercised. For answerability to be realized, principles of effective participation and access to information should be adhered to. Enforcement is highlighted as the most distinguishing aspect of accountability. It is emphasized that in adhering to human rights standards, enforcement majorly plays the role of remedying gaps/bottlenecks within the system.

It is vital to note that responsibility, answerability and enforcement cannot be classified into distinct/separate elements but are rather overlapping. The lines that separate them are often blurry in practise. Therefore, the focus should not be on implementing them independently but rather ensuring that the distinct characteristics in each of these elements are complimentarily implemented towards the realization of accountability. Throughout the study, it is stressed that the success of accountability is hinged on the operationalization of the RAE framework, to the various sectors, continuously, in a co-ordinated manner and cyclically towards combating MMM. It is also stressed that the application of RAE to the Ugandan context requires the adoption of a contextual analysis to directly respond to the unique maternal health challenges facing Uganda.

⁸⁷ United Nations General Assembly 'Report of the Office of the United Nations High Commissioner for Human Rights on Preventable Maternal Mortality and Morbidity and Human Rights' A/HRC/ 14/39 (16 April 2010) Para 33.

2.3 MAIN ‘BUILDING BLOCKS’ OF ACCOUNTABILITY

As shown in chapter one, except for setting out accountability in broad terms there have been very few scholarly attempts aimed at elaboration on appropriate frameworks to be adopted for improving human rights accountability. Of these attempts was the one by the Commission on Information and Accountability established under ‘*Every Woman, Every Child*’ campaign. The Commission proposed the monitoring-review-remedy approach to accountability.⁸⁸ The monitoring-review-remedy approach has been criticized for its potential to focus more on results and not the process. Often, the methods pursued focus on the use of quantitative indicators and data collection with the belief that the results from these processes will inform policies leading to the required change.⁸⁹

This explains the results-based approaches prevalent in health rights initiatives that focus on achieving goals rather than analysing the inputs. These results-based approaches have been noted to achieve very little in terms of building capacity, especially when they don’t take into consideration the contexts in which they are being operationalized as well as the power dynamics operating therein.⁹⁰ Thus, it is forwarded that the application of the responsibility, answerability and enforcement framework allows for the completion of the ‘accountability circle’ which should run through all the project phases.

Some studies have alluded to the major building blocks of accountability (responsibility, answerability, enforcement). Schedler asserts that accountability is the requirement that power should be exercised in a transparent manner as well as demanding that those in power justify their acts.⁹¹ He says that answerability involves the right to receive all the necessary information and the duty of those in power to justify their actions. Also, that enforcement is an integral aspect of accountability as it emphasizes improper behaviour should not go unpunished, otherwise accountability would be viewed merely as window dressing and not a real restraint on power.⁹² In defining accountability, Joshi and Houtzager emphasize that there has emerged some form of agreement about the vital elements that make up the accountability relationship; set of standards upon which performance is measured, information and justification for the actions taken and sanctioning or recognizing behaviour where appropriate.⁹³

⁸⁸ Commission on information and accountability for women and children’s health, ‘Keeping Promises, Measuring Results, Final Report of the Commission (19 May 2011).

⁸⁹ Freedman LP and Shaaf M (2013) 103-112.

⁹⁰ Freedman LP and Shaaf M (2013) 103-112.

⁹¹ Schedler A(1999) 14-17

⁹² Schedler A (1999) 14-17

⁹³ Joshi A and Houtzager PP ‘Widgets or watchdogs? Conceptual explorations in social accountability’ (2012) 14 *Public Management Review* 151.

Hunt explains that accountability allows for individuals and communities to understand how those with responsibilities have implemented their duties, allows those with power to explain and justify the actions they have taken and where shortcomings have been identified, accountability calls for them to be redressed.⁹⁴ Yamin mentioned that accountability requires the combining of three elements; responsiveness, answerability and redress.⁹⁵ However, Yamin does not elaborate on responsiveness, so it's not clear whether she uses it to mean responsibility. Bovens defines accountability as a social relationship between an actor and a forum whereby the actor is required to give explanations for his conduct, the forum can ask questions and pass judgement and the actors' actions have to be sanctioned.⁹⁶ Similarly, a comprehensive report by Centre for Economic and Social Rights titled "*Who Will Be Accountable: Human Rights and the Post 2015 Development Agenda*", set out how the three building blocks of accountability can be applied towards the realisation of socio-economic rights.⁹⁷

The three elements are not distinct but rather have overlapping elements. They operate in a continuous manner; from policy makers putting in place standards of performance, to avenues being in place through which they can explain and justify decisions taken or not and then having systems in place to correct the shortcomings in the system.

Accountability is aimed at constraining power in order to prevent its abuse or misuse because without such restrictions there is often potential for democracies to remain corruptible and thus unable to deliver basic freedoms and entitlements.⁹⁸ However, for this to happen, the complex nature of power dynamics as well as its influence on service delivery has to be critically analysed. This involves identifying all power centres both within and outside government and continuously interacting, negotiating and agreeing with these centres upon a means of operation that is most likely to bring about meaningful change.⁹⁹ Furthermore, the rigid focus on results while side-lining the process is not in line with human rights principles as pointed out by the Technical Guidance on Maternal Mortality and Morbidity. The Technical Guidance emphasizes that accountability should not be merely a bunch of compliance mechanisms but rather a dynamic process running from the planning stage, resource allocation, involvement of the grassroots communities to the

⁹⁴ Hunt P and Backman G 'Health Systems and the right to the highest attainable Standard of health' (2008) 10 *Health and Human Rights* 89.

⁹⁵ Yamin AE (2010) 7, 97. 97

⁹⁶ Bovens M (2005) 7-9.

⁹⁷ Who will be accountable: Human Rights and the Post 2015 Development Agenda (2013)

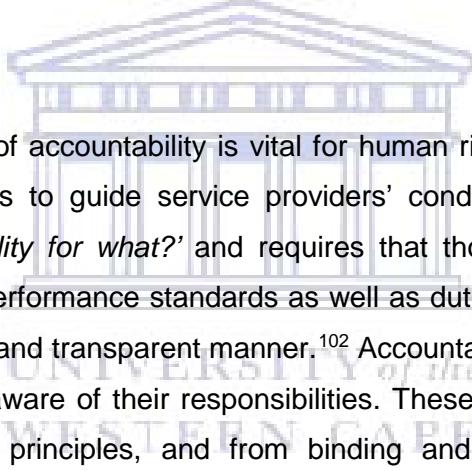
⁹⁸ Jelmin K (2011) 7.

⁹⁹ Freedman LP and Shaaf M (2013) 103-112.

implementation.¹⁰⁰ This is in line with the responsibility-answerability-enforcement approach proposed by this study.

In the health context, accountability provides an avenue for individuals and communities to understand how government has discharged its responsibilities. On the other hand, it enables the government to implement well-researched policies/programmes while justifying why it has undertaken those activities. Where there have been shortcomings, remedial measures should be undertaken to revise such bottlenecks.¹⁰¹ Therefore, in the human rights framework, the realization of accountability requires that these three elements are in place and implemented complimentarily. However, it is important that all three of these elements exist in some form of a cycle otherwise each of these terms on their own may not necessarily constitute accountability. For instance, if an organization sets out to put in place set standards of performance to guide its operationalization, on its own, this does not constitute accountability. But when put together with the other two elements this enables for accountability.

2.3.1 Responsibility



The ‘responsibility’ aspect of accountability is vital for human rights as it entails the setting out of particular obligations to guide service providers’ conduct. Responsibility is better understood as ‘accountability for what?’ and requires that those with authority or power establish comprehensive performance standards as well as duties to allow for their conduct to be assessed in an open and transparent manner.¹⁰² Accountability cannot be dispensed if those in authority are not aware of their responsibilities. These standards are derived from human rights norms and principles, and from binding and non-binding human rights documents. Maternal health is often derived from the right to the highest standard of mental and physical health. The right to health is all encompassing as it involves the right to a variety of services, goods, and facilities necessary for the attainment of the highest standard of health. It is an entitlement to an integrated and effective health system including health care that addresses national and local needs and takes into consideration the underlying determinants of health.¹⁰³

Several interventions play an important role in achieving the right to health and in the context of maternal health they include; skilled birth attendants, emergency obstetric care, primary health care services, improved human resource services, safe abortion services, family

¹⁰⁰ Technical guidance on Preventable Maternal Morbidity and Mortality (2012) Para 67-68.

¹⁰¹ Potts H (2008) 7.

¹⁰² *Who will be accountable: Human Rights and the Post 2015 Development Agenda* (2013) 10-13.

¹⁰³ Hunt P and J Bueno De Mesquita J, ‘Reducing Maternal Mortality: The Contribution of the right to the highest attainable Standard of Health’ University of Essex, Human Rights Centre, 2010 5

planning services, education as well as information on sexual and reproductive health.¹⁰⁴ Therefore, the normative content of maternal health can be drawn from various binding and non-binding human rights documents, most notably the International Covenant on Economic Social and Cultural Rights (ICESCR), General Comment 14 on the Right to Health, General Comment 22 on Sexual and Reproductive Health Rights, various UN resolutions on Maternal Mortality, General Comment 1 and 2 of the Maputo Protocol as well as the Technical Guidance on the Application of a Human-Rights Based Approach to the implementation of policies and programmes to reduce Preventable Maternal Morbidity and Mortality. These emphasise several norms and principles such as; non-discrimination, participation, the interdependent nature of rights, progressive realization, international assistance and cooperation, the duty to respect, protect and fulfil rights as well as to ensure the availability, accessibility, acceptability and quality of maternal health services.

The lack of availability, accessibility, affordability, acceptability and quality of health care services contributes to the ‘three delays’, which have been identified as some of the central causes of maternal mortality and morbidity.¹⁰⁵ Delay in seeking appropriate medical help for an obstetric emergency due to inability to afford the service, non-recognition of the emergency, gender in-equality and lack of access to information; delay in reaching an appropriate health facility due to distance, transport and infrastructure and delay in receiving sufficient medical attention once the facility is reached as a result of staff shortages, lack of medical supplies and basic services such as electricity and water.¹⁰⁶ These delays, which ultimately lead to maternal deaths and morbidity, violate a series of rights; women’s right to life, right to enjoy sexual and reproductive health, right to equality and non-discrimination and right to enjoy the benefits of scientific progress.

This was emphasised by the Committee on Economic, Social and Cultural Rights (CESCR) in its concluding observations to Indonesia in 2014. The committee stated its concern over the increasing maternal mortality rates in the country as a result of inadequate sexual and reproductive health services as well as cultural and legal barriers to the access of these services.¹⁰⁷ The state was urged to ensure availability and quality of maternal health care services and to include categories that were often excluded such as unmarried women, teenagers and married women who did not have the consent of their spouses. Furthermore,

¹⁰⁴ Hunt Pand Bueno De Mesquita J (2010) 5.

¹⁰⁵ A/HRC/ 14/39 (2010) Para 9.

¹⁰⁶ A/HRC/ 14/39(2010) Para 9.

¹⁰⁷ Economic and Social Council ‘Concluding Observations on the initial Report of Indonesia’ E/C.12/IDN/CO/1, 19 June 2014, Para 33.

in ensuring access to health care services, the Committee stated that provision should be made for pre-service and in-service training, accreditation and supervision of facilities.¹⁰⁸

In an effort to ensure availability, affordability and quality of services, the World Health Organization came up with an Essential Medicines List (EML) as a vital component of emergency obstetric services. This list includes implantable contraceptives, emergency contraception, oral hormonal contraceptives, barrier methods, injectable hormonal contraceptives, and post-partum haemorrhage prevention drugs (uterotonics) like, oxytocin and misoprostol. This is based on the recognition that over 30 percent of the world's population lacks access to essential medicines and thus 10 million deaths that occur annually could be avoided by increasing availability of medicines.¹⁰⁹ EMLs are very essential in responding to the common causes of maternal mortality and morbidity. National EMLs are often based on WHO EMLs and vary from country to country.¹¹⁰

However, research has shown that even when medicines are listed as essential at the national level, access is often not guaranteed. This may be attributed to the fact that countries often procure medicines that are not on their list, due to varying local needs based on diseases affecting a certain population at a certain time. This is worsened by poor recording of distribution processes. A survey in Uganda found that out of the 28 of the nationally listed medicines, only 55 percent could be found in the Government Health facilities and another survey in Tanzania found that only 52 percent of the examined health facilities obtained their medicines within the EML. Additionally in 2010, 75 of the 194 WHO member states had no website showing their national medicines regulatory authority.¹¹¹

States are called upon to respect, protect and fulfil maternal health rights. They are required to desist from putting in place discriminatory practices in relation to women's status and health needs.¹¹² The role of the private sector is also emphasised by obliging states to ensure equal access to health care services provided by third parties and to ensure that third parties do not in any way limit people's access to health related services and information.¹¹³ This involves preventing third parties from coercing women to undergo traditional practices such as female genital mutilation that might hinder them from enjoying their sexual and reproductive rights, ensuring that traditional or social practices do not interfere with access to

¹⁰⁸ Concluding Observations on the initial Report of Indonesia (2014) Para 33.

¹⁰⁹ Shaw D and Cook RJ, 'Applying human rights to improve access to Reproductive Health Services' 119 (2012) *International Journal of Gynecology and Obstetrics* 57

¹¹⁰ Lobis S (2013) 31-37.

¹¹¹ Shaw D and Cook RJ (2012) 57.

¹¹² A/HRC/ 14/39 (2010) Para 12.

¹¹³ A/HRC/ 14/39 (2010) Para 12

pre- and post-natal care as well as family planning and to protect all vulnerable groups in society especially women from all forms of gender based violence.¹¹⁴

It has been noted that privatisation and outsourcing of maternal health services often creates an authority vacuum without any state body being held responsible for ensuring sexual and reproductive health rights for all.¹¹⁵ In its observations to Egypt, the CESCR noted that the continued privatisation of the health care system had led to a substantial decline in the proportion of the state budget allocated to health care expenditure.¹¹⁶ This negatively affected the vulnerable sections of the population leading to increasing maternal mortality ratios, among other consequences. Egypt was advised to increase public spending on health with an aim of ensuring access for all to health services, essential medicines, immunisation against infectious diseases and access to reproductive, maternal and child health care.¹¹⁷ Likewise, in order to fulfil maternal health, states are called upon to put in place effective legislative structures and adopt a national health policy with a detailed plan for the realization of health rights.¹¹⁸

States are also required to take positive steps to enable individuals and communities to enjoy the right to health, especially when due to circumstances beyond their control they are unable to realize the right by themselves.¹¹⁹ For example, while responding to the Albanian State Report in 2013, the CESCR expressed its concern over the inadequate budgetary allocations to health care services especially in the rural areas, the high infant mortality rates as well inadequate information on sexual and reproductive health.¹²⁰

In addition, states are required to progress as expeditiously and effectively as possible towards the full realization of the right to health. Any retrogressive measures are strongly discouraged except after all available alternatives and resources have been maximised.¹²¹ Amongst the minimum obligations, those that directly relate to maternal health are; ensure right of access to health facilities, goods and services on a non-discriminatory basis especially for vulnerable groups, to provide essential drugs as provided under the WHO Action Programme on Essential Drugs, ensure equitable distribution of all health facilities,

¹¹⁴ UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4

¹¹⁵ Kismodi E et al 'Human Rights Accountability for maternal death and failure to provide safe legal Abortion: the significance of two ground-breaking CEDAW decisions', (2012)20 *Reproductive Health Matters* 35.

¹¹⁶ Economic and Social Council Concluding Observations on the combined second to fourth periodic reports of Egypt E/C.12/EGY/CO 2-4 (13 December 2013) Para 21.

¹¹⁷ Concluding Observations on the combined second to fourth periodic reports of Egypt (2013, Para 21).

¹¹⁸ General Comment 14 Para 36-37

¹¹⁹ General Comment 14 Para 36-37

¹²⁰ Economic and Social Council 'Concluding Observations on the Combined second and third periodic reports of Albania' E/C.12/ALB/CO/2-3 (18 December 2013) Para 32-33.

¹²¹ General Comment 14 Para 43-44

goods and services and to adopt and implement a national public health strategy. Among those of comparable priority is to ensure reproductive maternal and child health care, train health personnel on human rights, provide education and access to information for the major health problems.¹²²

2.3.2 Answerability

Answerability is the requirement that power should be exercised in a transparent manner as well as demanding that those in power substantiate their decisions.¹²³ Answerability is the right to receive all the necessary information and the duty of those in power to justify their actions. Thus, rights holders either directly or through established agencies working in their behalf, acquire information from the concerned duty bearers.¹²⁴ This information includes policy papers, plans, programmes and budgets. After the reporting of the information, explanations and justifications for the actions taken are made. Therefore, at this stage, the rights holders/agencies go beyond what was done to why it was done. This type of dialogue can occur at all levels such as the various levels of health facilities, parliament committee meetings.¹²⁵ In order to implement answerability, supervision/monitoring and tracking of programmes and policies have to be undertaken. This requires that public authorities and institutions put in place measures to monitor their adherence to set standards.¹²⁶

Participation is an integral element of answerability. It involves the right to access information, freedom of speech, freedom of assembly and association.¹²⁷ Participation of people should be continuous in all the project phases; formulation, implementation and monitoring and evaluation. Potts and Hunt stress that participation is often misunderstood as educating or consulting. Both are integral elements of participation, but there is more involved. Education or capacity building is the process of equipping people with information and skills in a particular field in order to enable them effectively participate in decision making.¹²⁸ While, consulting is the process of collecting ideas and perspectives for a proposed project from the people. This is merely an information collection stage. While the people's views might be heard, it doesn't necessarily mean that they have effectively participated. Participation is a full process in and of itself, so in order to be effective, institutional arrangements have to be put in place throughout all the project phases to ensure

¹²² General Comment 14 Para 43-44

¹²³ Schedler A (1999) 14-17

¹²⁴ Brinkerhoff DW 'Accountability and health systems :toward conceptual clarity and policy relevance' (2004) 19 *Health policy and planning* 372

¹²⁵ Brinkerhoff DW(2004) 19 372

¹²⁶ Who will be accountable? Human Rights and the Post 2015 Development Agenda (2013) 13-15.

¹²⁷ Potts H and Hunt PH 'Participation and the right to the highest attainable standard of health '(2008). Project Report. Human Rights Centre, Essex.

¹²⁸ Potts H and Hunt PH (2008).

the people's involvement is meaningful. Capacity building initiatives should be in place both for the policy makers as well as the rights holders. Lastly, if participation has not gone as expected, there should be remedial measures aimed at correcting the mishaps and to hold the policy makers accountable.¹²⁹

Effective participation requires a favourable environment where citizens can meaningfully engage with and challenge policies. For this to be realised, citizens require the freedom to join associations, community-based groups and unions; to feel they are in a safe space where they can demand for their rights without fear of repercussions.¹³⁰ This can only be possible in a context where duty bearers adhere to and respect freedom of speech, assembly and association provided for within the International Covenant on Civil and Political Rights (ICCPR) as well as the African Charter on Human and Peoples' Rights (African Charter). It is only when policy makers respect these freedoms that they will be in position to be responsive to the citizen demands and correct shortcomings that have been identified. Such a healthy environment also allows for open dialogue on policies before action is taken, such that people understand, appreciate and participate in the implementation of these policies.

Theoretically, answerability builds on responsibility in that if standards of performance are clearly spelt out, then the policy makers can easily be answerable for these standards. However, in actuality the relationship between demand for answerability on the part of the citizens on one hand and the responsiveness of state entities on the other hand, is often a complex one with a series of interacting factors.¹³¹ In most instances acquiescing on the part of the policy makers might require losing power, which may not occur easily thus requiring communities to mobilize themselves to demand for change. But this process should not be principally looked at as an adversarial one with losers and winners. Rather, it as a collective problem-solving mechanism, aimed at identifying practical solutions to complex problems. Such a process often requires the openness and willingness to compromise on the part of both parties.¹³²

2.3.3 Enforcement

Enforcement requires that public authorities and institutions put in place sanctions for those who do not abide by set standards and ensure that the adequate remedial and corrective

¹²⁹ Potts H and Hunt PH (2008).

¹³⁰ Who will be accountable? Human Rights and the Post 2015 Development Agenda (2013) 13-15.

¹³¹ Who will be accountable? Human Rights and the Post 2015 Development Agenda (2013) 13-15.

¹³² Who will be accountable? Human Rights and the Post 2015 Development Agenda (2013) 13-15.

measures are in place.¹³³ Seen from a human rights angle, enforcement emphasizes the right to a remedy including legal, administrative, political and social ones. In the *LC v Peru* case, the CEDAW Committee noted that even though the Convention does not expressly mention the ‘right to a remedy’, it is implicit in articles 12 and 2 (c) which mention that State Parties should put in place procedures aimed at the protection of the women’s rights on an equal basis with those of men. These should include; legal avenues, national tribunals as well as public institutions aimed at protecting women against any form of discrimination. Furthermore, article 2(f) calls upon the state to take all necessary measures including legislation, to modify, abolish existing laws, customs, practices, regulation that are discriminatory towards women.

The Committee pointed out that the failure by the state to establish legislation recognizing abortion on grounds of sexual abuse, rape and where the continuation with the pregnancy posed a health risk to the mother, was a violation of article 2(c) and (f) of the convention.¹³⁴ Similarly, in the *Alyne v Brazil* case, the Committee pointed out that the state had failed to provide adequate judicial remedies and protection by not initiating proceedings to hold responsible those who had failed to provide timely and adequate medical care for Ms. Alyne da Silva. Thus, the Committee emphasised that adequate sanctions must be imposed on health professionals who violate women’s reproductive health rights. ¹³⁵

Sandberg emphasised that enforcement is the ‘crux’ of accountability. That, enforcement is an integral aspect of accountability as it ensures that improper behaviour should not go unpunished otherwise accountability would be viewed merely as window dressing and not a real restraint on power.¹³⁶ Sandberg’s explanation of enforcement is slightly in contrast with the approach emphasized in this study which is not about apportioning blame but remedying gaps in the system. Schedler argued that in some instances, the lack of enforcement does not render accountability non-existent.¹³⁷ He further asserted that accountability is a ‘radial’ concept in that one of the three dimensions; information, justification and punishment may not be present, but this does not necessarily discount acts of accountability.¹³⁸ For instance, many human rights commissions often use answerability or very ‘soft’ forms of accountability such as the exposure of human rights violations as their methods of accountability. On the other hand, others heavily rely on sanctions or punishment as their acts of accountability,

¹³³ Who will be accountable? Human Rights and the Post 2015 Development Agenda (2013) 15-16.

¹³⁴ *L.C v Peru* Para 8.16-9.

¹³⁵ Committee on the Elimination of Discrimination against Women ‘*Alyne da Silva Pimentel Teixeira v Brazil*’, C/49/D/17/2008, 10 August 2011, Para 7.8 and 8(2).

¹³⁶ Lindberg SI (2013)206-207..

¹³⁷ Schedler A et al (1999) 14-17.

¹³⁸ Schedler A et al (1999) 14-17.

like the idea of electoral accountability may sometimes be a form of punishing those politicians who have underperformed by ‘throwing them out’.¹³⁹

Other scholars disagree with this notion by emphasizing that enforcement in whatever form it exists is the bedrock of accountability and its non-existence may indeed render accountability invalid. Bovens emphasizes that the existence of sanctions in some form is an integral element of accountability in its strictest sense otherwise it turns into an information giving process.¹⁴⁰ He further asserts that sanctions may be formal like penalties, compensations, reparations, fines, and disciplinary measures, or maybe informal like the resignation of a public figure, requiring one to make a public apology, publicly announcing the unaccountable acts of the public figure, which is sometimes known as ‘name and shame’.¹⁴¹

As human rights scholars started giving normative content to accountability, they emphasized that enforcement should not be focused on finding fault and punishing those responsible as health systems are complex entities with interlinked factors that often contribute to a maternal death. Yamin asserted that the traditional model of human rights monitoring which identifies a violation, a violator and then a remedy is counterproductive for combating maternal mortality and morbidity.¹⁴² Emphasis on this model sometimes leads to health systems unfairly targeting ‘front line workers’, who may be summarily dismissed in case of a maternal death without under taking comprehensive investigations to ensure that they are responsible for the death. Freedman further emphasised that enforcement/remedial measures in the human rights context should not be used to ‘scape goat’ or lay blame on individuals but rather to correct and improve the shortcomings in the system.¹⁴³

This does not imply that professional standards will not be enforced and that there is no space for individual punishment, as there will be cases when individuals act unethically and contribute to a maternal death. However, if a health worker is not in position to avert a maternal death, placing the entire blame on them diverts attention from the several systematic and management problems that may have contributed to that death.¹⁴⁴ Therefore, enforcement in the human rights sense entails conducting comprehensive investigations aimed at ascertaining the gaps that may have contributed to a maternal death, and devising evidence-based measures to correct these mishaps. It not a fault-finding or

¹³⁹ Schedler A et al (1999) 17-18.

¹⁴⁰ Bovens M (2005) 8.

¹⁴¹ Bovens M (2005) 8.

¹⁴² Yamin AE (2010) 95-231.

¹⁴³ Freedman LP (2003) 111-114.

¹⁴⁴ Yamin AE (2010) 95-231.

punishment driven venture. Accordingly, sanctioning or punishing of behaviour should be evidence based.

2.4 PREVENTABLE MATERNAL MORTALITY AND MORBIDITY, VIOLATION OF WOMEN'S RIGHTS

2.4.1 Maternal Mortality and Morbidity as a form of discrimination

The issue of non-discrimination lies at the heart of preventable maternal mortality and morbidity. Human rights treaties, resolutions and declarations have emphasised that the persistence of MMM is linked to discrimination against women on numerous grounds including sex, social standing, and race among others. In General Recommendation 24 of the CEDAW Committee, it was emphasised that while biological contrasts between women and men may lead to differences in health status, many social factors determine variances between the health conditions of women and men.¹⁴⁵ In order to overcome gender inequality, states were asked to put in place measures aimed at addressing biological, social and economic health concerns that are specific to women especially those pertaining to their reproductive health rights.¹⁴⁶ Therefore, discrimination is a central factor underlying high maternal mortality and morbidity rates.

General Comment 14 emphasizes article 2.2 and 3 of the ICESCR by requiring states to refrain from any discrimination in access to health care, which negatively impacts the enjoyment of the right to health.¹⁴⁷ It re-echoes General Comment 3 that even in times of severe resource constraints, the disadvantaged members of society must be given priority by adopting low cost measures for them. States have a special obligation to avail the necessary health insurance and health care facilities to those who cannot afford them and to desist from disproportionately giving priority to expensive curative health services that only benefit a small fraction of the population as opposed to those that benefit a larger population.¹⁴⁸

They must also ensure that their laws, policies and practices give priority to women's health related needs such as access to emergency obstetric care and other sexual and reproductive services.¹⁴⁹ In the same way, states are called upon to address underlying factors that directly or indirectly affect women and girls and increase the risk for maternal

¹⁴⁵ UN Committee on the Elimination of Discrimination against Women (CEDAW), *CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, 1999, A/54/38/Rev.1, chap.1, Para 6.

¹⁴⁶ CEDAW General Recommendation 24 Para 11-12.

¹⁴⁷ General Comment 14 Para 18-19

¹⁴⁸ General Comment 14 Para 18-19

¹⁴⁹ A/HRC/ 14/39 (2010) Para 17.

mortality and morbidity.¹⁵⁰ These include; gender based violence against women and girls and other social cultural practices such as prohibiting women from eating certain foods, female genital mutilation, ostracizing women who give birth in health care facilities as opposed to their homes and hindering girls from accessing education.¹⁵¹

Different groups of women face higher risks of preventable MMM depending upon their race, age, colour, language, ethnicity, and social origin or any other status. When a woman faces discrimination on more than one basis, it is referred to as multiple discrimination, and it further heightens their inability to enjoy a series of rights, including the right to health.¹⁵² These huge disparities also occur within countries between women with high income and those with low income as well as between women in urban centres and those in rural areas.¹⁵³ Additionally, the risk of maternal mortality and morbidity is highest amongst adolescent girls below the age of 15 as a result of pregnancy related complications.¹⁵⁴

These factors were emphasized in the *LC v Peru* case brought to the CEDAW Committee where it was established that the victim faced multiple discrimination on the basis of age, gender and social status.¹⁵⁵ The case concerned a 13- year old girl coming from an impoverished background who, over a period of 4 years was repeatedly raped by various men. Upon realising that she was pregnant, she attempted suicide by jumping from a roof of a building. She did not die and was immediately taken to the hospital where the doctor said that she was at a risk of permanent paralysis and therefore required immediate realignment of her spine. This operation could only be done after her pregnancy was terminated¹⁵⁶.

Despite the fact that the Peruvian law permits abortion in instances where the mother's life is at risk, the medical board refused to authorise the termination.¹⁵⁷ Thus, after several months, she miscarried and it was only then that the doctors carried out the surgery, but due to the enormous delay she became paraplegic (paralysis from the neck downwards except for partial movement in the hands). The committee found that the state had violated articles 1,2c and f of the CEDAW all of which call upon states to refrain from discriminating against women in all areas as well as article 12, which calls upon states to eliminate discrimination

¹⁵⁰ Technical guidance on Preventable Maternal Morbidity and Mortality Para 14.

¹⁵¹ Technical guidance on Preventable Maternal Morbidity and Mortality Para 14

¹⁵² A/HRC/ 14/39, Para 19-21.

¹⁵³ World Health Organization Media Centre 'Maternal Mortality' Available at <http://www.who.int/mediacentre/factsheets/fs348/en/> (accessed 30 June 2014)

¹⁵⁴ World Health Organization Media Centre 'Maternal Mortality' Available at <http://www.who.int/mediacentre/factsheets/fs348/en/> (accessed 30 June 2014)

¹⁵⁵ Committee on the Elimination of all forms of Discrimination against women, *L.C v Peru*, C/50/22/2009, 4, November 2011.

¹⁵⁶ L.C v Peru Para 2.1-2.15

¹⁵⁷ L.C v Peru Para 2.1-2.15

against women in health care. The committee called upon the state to ensure that all the relevant provisions of the CEDAW as well as those of General Recommendation No. 24 pertaining to reproductive health are observed.¹⁵⁸ Therefore, interventions aimed at averting preventable maternal mortality should investigate the underlying issues, such as discrimination, that perpetuate these deaths. Realising the need to promote and prioritize women's rights is very vital for the improvement of women's health.

Startlingly, none of the attention given to MMM over the years, throughout the various conferences, workshops and the MDGs has been sufficient to substantially reduce deaths. Women continue to die on a daily basis from preventable causes. Nonetheless, conferences like the International Conference on Population and Development (ICPD) and the Fourth World Conference on Women (Beijing Conference) have made some strides. The ICPD came up with a 20-year Programme of Action (POA), which set out that reproductive health rights including maternal health and family planning, reduction of maternal mortality and morbidity, women's empowerment and gender equality should be put into consideration while formulating population and development programmes.¹⁵⁹ The POA defined reproductive health as 'a state of complete, physical, mental and social wellbeing' and not merely the absence of disease, in all matters relating to the reproductive system and to its functions and processes. Under the POA, all states were called upon to avail reproductive health services, using the primary health care system, to all individuals of the suitable ages by the year 2015.

Services are family planning, adequate information on reproductive health, safe delivery and postnatal care. In addition, the states must ensure safe abortion, where it is recognized, early diagnosis and treatment of complications arising from pregnancy and doing away with harmful practices such as female genital mutilation.¹⁶⁰ Similarly, the Beijing Conference came up with the 'Beijing Declaration and Platform for Action'.¹⁶¹ The Declaration dedicated a section to women and health which called upon states to ensure improved access to health care services such as emergency obstetric care, effective family planning methods

¹⁵⁸ L.C v Peru Para 8.15-8.18, 9.

¹⁵⁹ United Nations *Report of the International Conference on Population and Development: Programme of Action on the International Conference on Population and Development* (5-13 September 1994) Cairo, A/CONF.171/13/Rev.1 Para 7.1- Para 8.25.

¹⁶⁰ Programme of Action on the International Conference on Population and Development Para 7.2, 7.6.

¹⁶¹ UN WOMEN, Fourth World Conference on Women, Action for Equality, Development and Peace *Platform for Action*, Beijing, China September 1995. Available at <http://www.un.org/womenwatch/daw/beijing/platform/> (accessed 14 July 2014).

and the right of both the women and men to be informed of the available family planning methods.¹⁶²

Before the expiration of the MDGs, countries had agreed on uniform targets to be reached by 2015. However, statistics showed that the goals on maternal health were the least met. Even though maternal mortality reduced by about 50 percent since 1990, in the developing world, the maternal mortality ratio is still 14 times higher than that of the developed region.¹⁶³ To date, only half of the women in the developing region receive the adequate amount of health care that they need. Statistics also show that even though contraceptive use increased in the 1990s, it declined in the 2000's.¹⁶⁴ To this end, Goal 3 of the recently adopted Sustainable Development Goals aims at ensuring healthy lives and promoting wellbeing for all ages. Some of the targets of Goal 3: To decrease the global maternal mortality ratio to less than 70 per 100,000 live births by 2030; ensure access to sexual and reproductive health care services universally such as information and education, family planning as well as the inclusion of reproductive health in national policies and programmes and to increase the recruitment, training and retention of skilled health workforce especially in the developing world.¹⁶⁵

Statistics of maternal deaths depict huge inequities as a huge percentage of maternal deaths occur in developing countries.¹⁶⁶ Moreover, vulnerable women including the poor, the uneducated, the young, migrants, ethnic minorities are disproportionately affected by unintended pregnancies.¹⁶⁷ These unintended pregnancies are a result of lack of access and inconsistent use of effective contraception, child marriages, and sexual violence. Once vulnerable women resort to abortion, they often use clandestine methods because they cannot afford safe abortion services. These women also lack access to medical care in case of complications arising from the unsafe abortions. Therefore, it is no surprise that unsafe abortions account for 13 percent of maternal deaths worldwide.¹⁶⁸ When vulnerable women resort to childbearing, they cannot afford quality healthcare services for themselves and their children, which may result in maternal mortality, morbidity as well as other social consequences.

¹⁶² Beijing Platform for Action Para 89- 105

¹⁶³ 'Sustainable Development Goals: 17 Goals to transform our World'

<http://www.un.org/sustainabledevelopment/health/> (Accessed 25th February 2016)

¹⁶⁴ 'Sustainable Development Goals: 17 Goals to transform our World'

<http://www.un.org/sustainabledevelopment/health/> (Accessed 25th February 2016)

¹⁶⁵ 'Sustainable Development Goals: 17 Goals to transform our World'

<http://www.un.org/sustainabledevelopment/health/> (Accessed 25th February 2016)

¹⁶⁶ A/HRC/ 14/39 Para 14.

¹⁶⁷ World Health Organization 'Equity, Social Determinants and Public Health Programmes', 2010 178-183.

¹⁶⁸ Equity, Social Determinants and Public Health Programmes (2010) 178-183.

Hence, reproduction is a function of women thus access to reproductive services is a women's rights issue. Maternal mortality and morbidity directly impacts on the lives of women and adolescent girls. Therefore, non-prioritisation and the failure to put in place healthcare facilities and services for women's reproductive rights, demonstrates gender inequality and discrimination.¹⁶⁹

2.4.2 Feminist Perspectives on Maternal Mortality and Morbidity

The aim of this section is not to go into an in-depth analysis of feminist perspectives on MMM as that would require an elaborate inquiry, which is beyond the scope of this study. Rather, it uses some illustrations to demonstrate how the side-lining of women's rights contributes to MMM. The aim of this section is to draw a linkage between the side-lining of women's rights and MMM thus justifying the focus of the study on MMM. This section lays a basis for the subsequent chapters which link accountability to MMM.

Cabal and Stoffroegen assert that the persistence of high maternal mortality rates can partly be attributed to the fact that maternal health is a women's rights issue.¹⁷⁰ They contend that such issues have traditionally been pushed away in favour of mainstream human rights, with some policy makers viewing maternal mortality as an inevitable consequence of reproduction, in spite of hard evidence that it is a social injustice.¹⁷¹ Eboh asserts that the reproductive role is viewed as the sole function of a woman and without her reproductivity, a woman's life is seen as unsatisfactory or unfulfilled. Many women are socialized to think that their role of childbearing is incompatible with their pursuit of self –actualization.¹⁷² Kismodi further points out that the Committee in the *LC vs. Peru* case, found the decision to postpone the therapeutic abortion and the surgery was influenced by the belief that the protection of the fetus should prevail over the mother's health. Subsequently, by conditioning access to medical care on the carrying to term of an unwanted pregnancy, LC's reproductive function was placed above her fundamental rights.¹⁷³

Cook and Dickens also state that, too frequently, the risks attached to child birth such as poor health, death as a result of obstructed labour, haemorrhage, and over exhaustion are still justified as destiny or the will of the higher powers.¹⁷⁴ Thus, maternal mortality is still partly viewed as a misfortune rather than a social injustice that can be remedied through

¹⁶⁹ A/HRC/ 14/39 Para 17.

¹⁷⁰ Cabal. L, and Stoffroegen M (2009) 4.

¹⁷¹ Cabal. L, and Stoffroegen M (2009) 4.

¹⁷² Eboh MP, 'The woman being: its nature and functions' (2016)26 *Journal of the International Society for Universal Dialogue* 15.

¹⁷³ Kismodi E et al (2012)35.

¹⁷⁴ Cook RJ and Dickens BM 'Human Rights to safe motherhood' (2002)76 *International journal of Gynecology and Obstetrics* 225-231

improved access to reproductive health care and revision or implementation of existing laws.¹⁷⁵ Htun and Weldon further stress that the subject of women's reproductive health is still highly polarizing because it deals with issues of sexuality and morality. Many tribal, religious and traditional entities are aware that their power lies in controlling reproduction and kinship. Thus, they are often unwilling to let go of societal positions that encourage male dominance and female subordination.¹⁷⁶ This perpetuates the belief that if women enjoy sexual relations, are in charge of determining the number of children they want to have, avert unwanted pregnancy and avoid sexually transmitted diseases, then family security and sexual morality will be in danger. This can be seen in laws that aim to control women's behaviour and deny them access to reproductive health services.¹⁷⁷

Cook stresses that though maternal mortality and morbidity may be escalated by pregnancy, it often has its roots in socioeconomic, cultural and medical conditions that devalue women's autonomy regarding their reproductive health decisions. This partneristic behaviour is manifested in laws, policies and practises promoted by governments that punish women because of their unique reproductive role. Thus, such laws unfairly discriminate women on the basis of their sex. For instance, countries that outlaw abortion only punish women because they are the only ones that bear the consequences of an unwanted pregnancy, failed contraception and in certain instances sexual violence. Consequently, in some instances, adolescents have sought very dangerous and unsafe abortions in order to avoid expulsion from school on grounds of pregnancy.¹⁷⁸

Similarly, statistics reveal that countries that outlaw abortion inadvertently encourage an upsurge in clandestine and unsafe abortions.¹⁷⁹ When faced with an unplanned pregnancy, women all over the world, regardless of the legal restrictions, are most likely to opt for an induced abortion.¹⁸⁰ This justifies the high, maternal mortality ratio as a result of unsafe abortions in countries with such restrictions. On the contrary, in the countries where abortion is legal, counselling is provided before and after the termination of the pregnancy about access to more effective contraceptives and some are given out free of charge. This information has helped reduce abortion rates in countries where abortion is legal, which is

¹⁷⁵Cook RJ and Dickens BM (2002) 225-231.

¹⁷⁶ Htun M and Weldon SL (2010)8 210.

¹⁷⁷ Htun M and Weldon SL (2010)8 210.

¹⁷⁸ Cook RJ 'International protection of women's reproductive rights' (1991- 1992)24 *Journal of International law of politics* 645.

¹⁷⁹ Finer L and Fine JB 'Abortion law around the world: Progress and pushback' (2013)103 *American Journal of Public Health* 585-589.

¹⁸⁰ Finer L and Fine JB (2013) 585-589.

not the same case with countries that outlaw abortion whereby women are not free to access comprehensive information that may help them avert future unwanted pregnancies.¹⁸¹

It is asserted by Cook that cultural and religious beliefs and practices may be another way through which women are denied the enjoyment of reproductive health rights.¹⁸² One such practice is female circumcision, based on the assumption that women are the primary custodians of societal morality. This does not bear in mind the extent to which circumcision impedes the ability of these women to enjoy sexual and maternal health rights. To date, several countries do not consider the coercion of women by their husbands into sexual relations as a violation of their rights. Many women also often lack the autonomy to decide the number and spacing of their children.¹⁸³

Therefore, as emphasised by Bartlett, feminist legal approaches focus on transforming laws, to dismantle the subjugation and inferior treatment of women.¹⁸⁴ These approaches aim at adjusting traditional methods of perceiving the law, which tend to overlook injustices to women. This implies asking the ‘woman question’, which involves analysing why the law falls short of considering the values and situations unique to women. Thus, some features of the law which may appear neutral on the surface may indeed be ‘male’, upon comprehensive investigation.¹⁸⁵ By asking the ‘woman question’, these approaches aim to expose such features and devise means of correcting them. Without asking such a question, differences between women and men may be taken for granted and not examined. In bringing to light the effect of laws that do not openly discriminate against women, attention is drawn to political, social, cultural and economic structures and how these embody norms that view women as different thus subordinate.¹⁸⁶ Subsequently, feminist legal theories assert that usually when the law is perceived as being neutral or universal, the point of view is male-dominated. They emphasise the need to consider women’s lived experiences and thus treat them as authorities of their own reality.¹⁸⁷

In asserting Bartlett’s position, Cook and Dickens maintain that despite its assertion to objectivity and neutrality, the law often covers up particular hierarchies and veiled power.¹⁸⁸ Also, that it cannot be assumed that those who hold political, legal and administrative power will be good guardians of that power. Leaders cannot often be trusted to act in the interests

¹⁸¹ Finer L and Fine JB (2013) 585-589.

¹⁸² Cook RJ (1991- 1992) 24 645.

¹⁸³ Cook RJ (1991- 1992) 24 645.

¹⁸⁴ Bartlett KT ‘Feminist legal methods’, (1990) 103 *Harvard law Review* 837-849.

¹⁸⁵ Bartlett KT (1990) 837-849.

¹⁸⁶ Bartlett KT (1990) 837-849.

¹⁸⁷ Painter GR, ‘Feminist Legal Theory’, 8(2015) *International Encyclopaedia of social and Behavioural Sciences* 919-925.

¹⁸⁸ Cook RJ and BM Dickens (2002) 225-231.

of their citizens especially women, who are political minorities. Therefore, there is need for various levels of review and accountability aimed at checking power. Likewise, the conditions for legal authority and legitimacy are often social constructs rather than universal standards that need constant scrutiny in order to be deconstructed.¹⁸⁹ While commenting on the negative aspects of the law, Cook quotes Racheal Pine who had this to say,

At times it seems that the law's ignorance of its actual impact is one of the most severe threats to basic civil liberties. When justice is blind to the fruits of scientific and social research, and to the demonstrable effects of a statute in operation, rules of law are divorced from the empirical world. Courts are thus rendered impotent in the exercise of their duty to safeguard fundamental, constitutional guarantees, for rights may be violated in innumerable ways not apparent by speculation.¹⁹⁰

Cook and Dickens further point out that laws enacted by most governments do not prioritise women's reproductive rights.¹⁹¹ To date in the developing world, the woman's principal role is to bear children, mostly sons, and serve as a strong basis for the family. They further point out that where laws exist aimed at protecting women's reproductive health rights, they are often not efficiently implemented. For instance, in countries where legal marriage has been set out in the documents but is not adequately enforced, child marriages are very rampant and usually result into adolescent pregnancies.¹⁹² These early pregnancies usually have numerous adverse consequences on the lives of the young mothers and may lead to high maternal mortality and morbidity. Laws that are silent on women's reproductive health also contribute to maternal deaths and morbidity. In order for laws and policies to be comprehensive in protecting women's rights, they have to avail preventative and curative health reproductive services and allow women the chance to have reproductive self-determination.¹⁹³

Likewise, it is asserted that there's a direct relationship between poverty and maternal death because the communities with higher maternal mortality rates are also the impoverished ones. Sheppard argues that the law is often implicated in the problem of poverty rather than in the solution.¹⁹⁴ Human rights and constitutional law frameworks often treat poverty as an issue that is too pervasive and thus beyond legal/judicial intervention. Regulatory regimes are often organized in such a way that they preserve inequitable description of wealth and

¹⁸⁹ Cook RJ and Dickens BM (2002) 225-231.

¹⁹⁰ Cook RJ (1991- 1992) 676.

¹⁹¹ Cook RJ and Dickens BM (2002)76 225-231.

¹⁹² Cook RJ and Dickens BM (2002)76 225-231.

¹⁹³ Cook RJ and Dickens (2002) 225-231.

¹⁹⁴ Sheppard C, "Bread and Roses": Economic Justice and Constitutional Rights (2015)5 *Oñati Social-Legal series* 225-245.

property. He adds that this explains the purported contention of the centrality of the positive versus negative rights and the continued assertions of judicial incapacity to adjudicate socio-economic rights.¹⁹⁵

In furthering Sheppard's argument, Liebenberg contends that the preference for civil and political rights advances the patriarchal notion that human rights are aimed at protecting individuals against state interference and safe guarding their life as well as liberty.¹⁹⁶ This notion serves and benefits the male interest since men predominantly hold positions of political, economic and social power. By focusing on the individual, this perception of human rights ignores social aspects of society characterised by historical oppression and marginalisation of women.¹⁹⁷ This is manifested through systematic denial of women's access to basic services due to their subordinate status in society. In justifying the connection between socio-economic rights and women rights, Ellen Wiles has this to say:

Civil and political rights have been disproportionately prioritized by patriarchal political and legal systems because their purpose is to afford protection for men in public life, and socio-economic rights which affect life in the private sphere, the World of women have been neglected¹⁹⁸

This same conviction was held by the drafters of the Convention on Elimination of all Forms of Discrimination against Women (CEDAW). They argued that protection of women's civil and political rights is futile without socio-economic rights as it is in this area that discrimination against women is most evident and therefore, it is where women mostly require safeguarding of their rights.¹⁹⁹ In light of this, the recognition of socio-economic rights coupled with the taking of specific measures to redress the socio-economic imbalances in society, is vital for effecting social transformation thus uplifting the status of women in society.²⁰⁰

In cementing the issues raised above, Tamale asserts that laws that restrict or outlaw the termination of unplanned pregnancies and subsequently force motherhood on women, perfectly demonstrate the gender roles that the patriarchal capitalist state has made for

¹⁹⁵ Sheppard C (2015) 225-245.

¹⁹⁶ Liebenberg S 'Social and Economic Rights: A critical challenge' in S Liebenberg (Ed) *The Constitution of South Africa from a Gender Perspective* (1995) 80-81.

¹⁹⁷ Liebenberg S (1995) 80-81.

¹⁹⁸ Wiles E 'Aspirational Principles or Enforceable Rights? The future of Socio Economic Rights in National Law' (2006) 22 *American University International Law Review* 49.

¹⁹⁹ Charlesworth H and Chinkin C *The boundaries of International Law: A feminist Approach* (2000) 217

²⁰⁰ S Liebenberg 'Social and Economic Rights: A critical challenge' in S Liebenberg (ed) *The Constitution of South Africa from a Gender Perspective* (1995) 91.

women.²⁰¹ These roles are principally reproduction, child care and caring for homes. Such laws ensure that little time is left for women to achieve goals outside the home thus preserving the status-quo of the private/domestic arena for women with the public/political arena for men that are prevalent in African Societies.²⁰² The oppression of women becomes even more pervasive on the African Continent. Tamale and Onyango maintain that, unlike their Western counterparts, women in the South are faced with numerous forms of oppression.²⁰³

On the one hand, the patriarchal and exploitation forces are influenced by international global forces such as Transnational Corporations, International Financial Institutions, and International Human Rights Organizations. On the other hand, these are influenced by the communitarian and extended family multifaceted relations that is distinct from the individualized nature of relationships that are representative of the Western societies.²⁰⁴ They further assert that the prevailing style of feminism is still largely representative of the partnerlistic, affluent and white nature that often dominates international relations. This is characterized by the unequal access to the international institutions where decision making occurs. The result is a cosmetic form of participation for African women. Subsequently, the decisions that are arrived at are inherently Western both in their formulation and implementation.²⁰⁵

Obiora also takes the same stance in asserting that custom denotes varying meanings when applied to non-Western contexts and when applied to the West.²⁰⁶ Therefore, whatever is considered universal has historical attachments to the West, a player that has mastered the art of turning the particular into the universal without consideration of the profound differences that are prevalent outside its hemisphere. Ultimately an inquiry into what appears to be universal quickly reveals that it is particular and dictated by powerful and self-serving systems that function to the exclusion of others.²⁰⁷

Nonetheless, Obiora emphasises that a balance must be found, in order to avoid the seemingly partnerlistic and colonial western feminism on the one hand, and the extreme

²⁰¹ Tamale S, 'Exploring the contours of African Sexuality: Religion, law and Power', (2014)14 *African Human Rights Law Journal* 150-177.

²⁰² Tamale S (2014)150-177.

²⁰³ Oloka-Onyango J and Tamale S, "The personal is political, "or Why Women's Rights are indeed Human Rights: An African Perspective on International Feminism' (1995)17 *Human Rights Quarterly* 691-731.

²⁰⁴ Oloka-Onyango J and Tamale S (1995) 691-731.

²⁰⁵ Oloka-Onyango J and Tamale S (1995) 691-731.

²⁰⁶ Obiora LA 'Feminization, Globalization and Culture: After Beijing' (1997)4 *Indiana Journal of Global Legal Studies* 395.

²⁰⁷ Obiora LA (1997) 395.

cultural relativist position on the other hand.²⁰⁸ That in certain instances, the claim that human rights are Western individually constructed ideals, is used as an excuse to deny communities' claims and assertions. Therefore, states may exploit the cultural and community discourses that permit human rights violations. In such cases, failure to adhere to human rights standards is as a result of absence of political will and not because of the cultural differences. That when political systems are undemocratic, their negative stance on human rights is a direct result of the need to justify repression and authoritarianism. Ultimately, in order to reconcile the contrasting positions, there is need for continued dialogue and functional alliances. Besides, the rallying point of these seemingly contrasting sides is a process of checks and balances aimed at controlling the power of the ruling elites thus offering insulation for the individual. These systems thus bind rulers to respect the human dignity of those over whom they exercise authority.²⁰⁹ This justifies the need for strengthening accountability systems.

To this end, a legal feminist approach maintains that the law is not immune to patriarchal forces as well as external influence. That, it is characteristic of the social and historical context in which it operates. For instance, the formulation of the law in Africa is still largely characterized by the colonial elements from which it was derived, whose aim was to control and easily manage the colonial subjects. As further elaborated in chapter 3 (legal accountability), several aspects of this law were retained to date, such as restrictive penal code provisions and customary law, both of which serve to continue oppressing women. Attempts at revising laws have, for the most part, also excluded women thus have largely remained a product for the continued male dominance.²¹⁰ In order to make the law applicable to the unique context of African women, it is vital to view the law from the historical, social and political context in which it came to be.

This is also in contrast with the answerability principle of accountability, which emphasises the treatment of women as active agents who are entitled to be effectively involved in decisions that affect their sexual and reproductive health.²¹¹ The issue of women's participation is examined under social accountability. Therefore, in order to make the law more 'women' inclusive, it is vital to reimagine a new order where laws are formulated and implemented in more local, inclusive and contextual manner to directly respond to the challenges facing women in African countries.²¹² This contextual approach is also one that is

²⁰⁸ Obiora LA (1997)355-406.

²⁰⁹ Obiora LA (1997)355-406.

²¹⁰ Oloka-Onyango J and Tamale S (1995) 691-731.

²¹¹ Technical Guidance on MMM Para 17.

²¹² Oloka-Onyango J and Tamale S (1995) 691-731.

emphasised by Freedman as elaborated upon under administrative accountability. Hence, as set out in chapter one, the focus on the national context allows for the capturing of the specific/contextualized nuances that are unique to women's reproductive health rights in Uganda.

It is further submitted that one way of highlighting women's unique experiences is by focusing on challenges/issues that specifically affect women. Currently, there is no single cause of death and disability for men between 15 and 44 that is close to the scale of maternal mortality and morbidity.²¹³ Therefore, by focusing on maternal mortality and morbidity, this study aims at contributing to bringing to the fore women specific issues. The improvement of women's health significantly contributes to a qualitative improvement in other aspects of their lives, thus ultimately improving their status in society.

The approach that is forwarded for reducing preventable MMM is the strengthening of accountability processes. Accountability processes are especially needed for identifying and addressing the ways in which laws, policies and programmes side-line women's reproductive health rights. Subsequently, the study demonstrates how the application of various forms of accountability; social, legal and administrative, will substantially combat preventable maternal deaths and morbidities.

2.5 FORMS OF ACCOUNTABILITY, THEIR USAGE TOWARDS COMBATING PREVENTABLE MATERNAL MORTALITY AND MORBIDITY.

In this section, the emphasis is on how accountability mechanisms contribute to averting maternal deaths and morbidities. This section lays ground for the subsequent chapters, which examine, in greater detail, the extent of each of these mechanisms (legal, social, administrative) in the reduction of MMM specifically in Uganda.

2.5.1 National Legal/Judicial Accountability.

One of the contributions of human rights accountability has been the emphasis on remedying violations through formal justice systems, which forms a vital aspect of horizontal accountability. It is for this reason that rights holders will primarily think of going to courts of law when their rights have been violated.²¹⁴ With the increasing judicialisation of economic, social and cultural rights such as the right to health, courts have been able to receive cases and provide remedies. However, human rights accountability should not be perceived as a product only to be understood and interpreted by lawyers. This is because law is derived and interlinked with social cultural and political developments. Thus it should be

²¹³ A/HRC/ 14/39 Para 17.

²¹⁴ Who will be accountable? Human Rights and the Post 2015 Development Agenda (2013) 39-42.

interpreted in terms of the interrelationships between law, social sciences, political and cultural fields.²¹⁵ It is for this reason that scholars have noted that in order for litigation to be successful, it has got to go hand in hand with social, political as well as administrative mobilization.

Courts are increasingly declaring maternal deaths a human rights violation and are thus giving normative content to the prevention of maternal mortality and morbidity. One of the ground breaking cases in line with maternal mortality was the *Alyne da Silva Pimentel v. Brazil* case brought to the CEDAW Committee.²¹⁶ The case concerned a 28-year old Brazilian woman who died in 2002 when she was six months pregnant as a result of prolonged delays in accessing emergency obstetric care, poor quality maternity services as well as negligence on the part of the health workers.²¹⁷ The CEDAW Committee emphasised that maternal deaths arising from preventable causes are a violation of women's right to life. It further stated that Alyne had faced multiple forms of discrimination based on her sex, her status (she was a poor woman), her descent (African) and that the state had failed to put in place effective judicial remedies to establish responsibility for Alyne's death.²¹⁸

The Committee recommended that Brazil ensure affordable access for all women to emergency obstetric care, offer adequate compensation to the family of the deceased and ensure that health facilities are adequately funded and well equipped.²¹⁹ Additionally, the successful litigation of maternal health-related cases in national courts of law has improved lives of thousands of people and averted preventable deaths. Like the case brought to the South African court by *Treatment Action Campaign* demanding for the availing of nevirapine to expectant mothers in order to reduce mother-to-child transmission of the HIV virus.²²⁰ The government was asked to not restrict essential drugs to a few centres but to ensure that all expectant mothers living with HIV have access to this essential drug. This case led to the averting of thousands of maternal deaths, prevention of mother-to-child transmission and the adopted policy became a reference point for other developing countries grappling with similar challenges.²²¹

²¹⁵Darrow M and A Tomas A 'Power, Capture and Conflict: A call for human rights accountability in development cooperation' (2005)27 *Human Rights Quarterly* 484-485.

²¹⁶ Committee on the Elimination of Discrimination against Women. *Alyne da Silva Pimentel v. Brazil*, Decision CEDAW/C/49/D/17/2008. 27 September, 2011.

²¹⁷ *Alyne da Silva Pimentel v. Brazil* Para 2.1-2.14.

²¹⁸ *Alyne da Silva Pimentel v. Brazil* Para 7.7-7.8

²¹⁹ *Alyne da Silva Pimentel v. Brazil* Para 8.

²²⁰ *Minister of Health and Others v Treatment Action Campaign and Others (No 2)* (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002)

²²¹ *Minister of Health and Others v Treatment Action Campaign and Others*.

Another such case was the one concerning *Shanti Devi* which was brought to the high court of Delhi.²²² Shanti gave birth at home without a skilled birth attendant and lost her life due to post-partum haemorrhage as a result of a retained placenta. It was determined that her death was a result of lack of access to adequate health care due to her socio-economic condition. Her status led to her inability to access the needed services which was compounded by tuberculosis, anaemia and repeatedly giving birth under unsafe conditions, as she had three children.²²³ The court ordered that her family be compensated for the violation of her rights, for a comprehensive maternal health audit to establish the circumstances surrounding her death and for the family to receive the benefits they were entitled to under the National Maternity Benefit Scheme.²²⁴

Nonetheless the judicialisation of maternal health rights is hampered by several factors, most important being that very few countries have provided for such rights (socio-economic rights) as justiciable rights in their constitutions. These are often reserved for sections on National Objectives and Directive Principles of State Policy (NODPOSP).²²⁵ Also, the complexity of cases which fall under the ambit of socio-economic rights requires well informed judges who are willing to transformatively interpret cases before them, taking into consideration the prevailing socio-economic conditions and using other jurisdictions that have a successful precedent. However, some legal practitioners lack the capacity or are unwilling to interpret such cases in a way that will benefit society. As a result, some scholars have affirmed that the formal judicial mechanisms may have contributed to increasing the gap between the middle income group and the poor. This is because, the marginalised sections of the population are often unable to access the courts on account of cost, delays in adjudicating these cases and uncertainty on the outcome of the cases.²²⁶

This is also in line with the position of feminist legal scholars such as Tamale, Cook and others mentioned in the previous section, which states that the law may appear neutral on the surface but a critical analysis reveals that such laws indeed are blind to the socio-economic conditions of considerable groups of people, notably women.²²⁷ Also, in countries riddled with lack of transparency in the judicial bodies, as well as corruption, the powerful

²²² *LaxmiMandal v. Deen Dayal Harinagar Hospital & Ors*, W.P.(C) Nos. 8853 of 2008.

²²³ Shaw D and Cook R, 'Applying Human Rights to improve access to reproductive health services' (2012) 119 *International journal of Gynecology and Obstetrics* 55-59.

²²⁴ *LaxmiMandal v. Deen Dayal Harinagar Hospital & Ors*.

²²⁵ Chapter Six of the 1992 Constitution of the Republic of Ghana is reserved for the Directive Principles of State Policy while the first section of the 1995 Constitution of the Republic of Uganda is reserved for the National Objectives and Directive Principles of State Policy.

²²⁶ Nash R 'Financing access to justice: Innovating possibilities to promote access to all' (2013)5 *Hague Journal on the rule of law* 96-118.

²²⁷ Krishnan JK et al 'Grappling at the grassroots: Access to justice in India's lower tier' (2014)27 *Harvard Human Rights Law Journal* 152-198.

elites may use the courts to their advantage, most times to the detriment of the marginalized sections of the population.²²⁸ Therefore, it is emphasised that, while traditional judicial mechanisms are vital for accountability, they are not the only means, and their success may depend on other accountability mechanisms. Consequently, in the maternal health context, states should put in place comprehensive remedies operating both at the national and local level for those whose sexual and reproductive health rights have been violated. These remedies may take the form of judicial and quasi-judicial forms such as National Human Rights Commissions. Independent and statutory regulatory bodies can include; ombudspersons, auditors general, anti-corruption commissions.²²⁹ The implementation of legal accountability towards curbing preventable maternal deaths and morbidity in Uganda is expounded upon in chapter three.

2.5.2 Administrative Accountability

Scholars have asserted that the human rights framework often ignores the administrative side of accountability and yet it is the most direct method of measuring a government's performance. Legal or political sanctions may not do much to deal with entrenched inefficiency, mismanagement of public funds and a general breakdown in service delivery, which is the core function of administrative bodies.²³⁰

This calls for the effective monitoring of the work of administrative structures, which includes designing and implementing social policies. Therefore, health systems must have transparent and accessible accountability mechanisms setting out how those with responsibilities within the health system have executed their roles and responsibilities. Also, the human rights accountability mechanisms that are in place are often external ones such as civil society, ombuds offices, parliament and media, all of which may contribute very little to improving the internal management processes.²³¹ Yet, in actual fact the quality of supervision within the administrative structures is probably the most assured means of improving administrative performance. This is due to the fact that no amount of external monitoring will improve administrative systems if they are already non-operational or inefficient.²³²

In focusing on improving administrative accountability within health systems, it is crucial to adopt contextual- based approaches that directly respond to the challenges facing a

²²⁸ Krishnan JK et al (2014) 152-198.

²²⁹ The Partnership for Maternal, New-Born and Child Health '*Human Rights and Accountability: Knowledge summary: women's and children's health*'23 (2013)23.

²³⁰ Who will be accountable? Human Rights and the Post 2015 Development Agenda (2013) 37-38.

²³¹ Who will be accountable? Human Rights and the Post 2015 Development Agenda (2013) 37-38.

²³² Who will be accountable? Human Rights and the Post 2015 Development Agenda (2013) 37-38.

particular health system.²³³ This calls for the need to focus on system strengthening rather than focusing on individualized interventions. Several compounding factors including health workforce, drug supply, poor information systems and health financing are often responsible for weak health systems and ultimately contribute to the system's inability to deliver services for those in need.²³⁴

A contextualized approach is one that facilitates the capacity of all people including the poor and the marginalized to make their claims and have them satisfied. In certain instances, donors' fixation with short-term successes has led to the pursuing of disease specific interventions that are not in line with national priorities thus frustrating adherence to human rights norms and principles. Thus, at the national level, there is need to focus on systemic as well as contextually grounded strategies that are more likely to achieve more sustainable change.²³⁵ It is also vital to stress that the various forms of accountability feed into each other and thus are not exclusive.

In line with the main blocks of accountability mentioned above, administrative accountability is aimed at ensuring that administrative structures/mechanisms are responsible, answerable and have enforcement channels in place.

2.5.2.1 Responsibility/Standards of performance

Administrators can make use of human rights norms and principles which give them an opportunity to use standards that are already well established. At the administrative level, laws, policies and programmes are turned into action, therefore this is the point at which accountability should be heavily focused. Some of the most vital processes that should be in place to ensure that administrative accountability within the maternal health sector is dispensed include; plan of action, health professional associations, committee charged with monitoring and supervising implementation of maternal health related policies and funding for maternal health services.

One of the vital issues under administrative accountability is formulating a comprehensive plan of action. This was emphasised by the Technical Guidance on maternal mortality as well as general comment 14.²³⁶ Effective planning goes beyond merely designing plans to ensuring participation, transparency and inclusion of marginalized groups. It also helps to

²³³ Freedman LP et al, 'Transforming the Health Systems to improve the lives of women and children', (2005)365 *Lancet* 997-1000.

²³⁴ Travis P et al, 'Overcoming Health Systems constraints to achieve the Millennium Development Goals', *Lancet* 364(2004) 900.

²³⁵ Freedman LP et al (2005) 997-1000.

²³⁶ General Comment 14 on Health Para 43(f). A big part of the United Nations Technical Guidance on preventable maternal mortality and morbidity is focused on the Strategic Plan of Action.

address the principle of progressive realization of human rights as well as maximise the utilisation of the available resources.²³⁷

There is also a need for setting up a national committee principally charged with women's health.²³⁸ One of the challenges facing monitoring and supervision, is to do with the fact that accountability is so haphazard within the administrative structures that the ministry of health, which is charged with formulating and implementing policies is usually the same body that is charged with monitoring and supervising these policies. This creates a conflict for the ministry of health - it will be reluctant to record the shortcomings of the system. The Commission on Information and Accountability for Women and Children's Health observed that the challenge with most countries is making women and children's health a national priority.²³⁹ The Commission recommended that countries establish National Health Commissions for women's and children's health.²⁴⁰ The general comment on health also emphasized the need for setting up national mechanisms charged with monitoring the implementation of national health policies and plans of action,²⁴¹ in this case the maternal health related ones.

Furthermore, in the context of maternal health, Maternal Death Audits (MDAs) should be mandatorily carried out. MDAs are a very vital indicator pertaining to maternal mortality, thus, should provide reliable and accurate data.²⁴² Maternal death reviews and audits should be carried out going beyond the health facility to the home, community and Government policies. Maternal death reviews require the following essential elements; a comprehensive record of all the deaths, good attribution of the reason of death and knowledge of the pregnancy status of the women that have died.²⁴³ Human rights emphasise the fundamental role of MDAs in addressing maternal mortality as they are one of the ways of identifying causal factors for maternal mortality and morbidity. After identifying causal factors, shared responsibility rather than ascription of blame, is undertaken in order to prevent future reoccurrence of the same situation.²⁴⁴

²³⁷ Hunt P and Backman G 'Health Systems and the right to the highest attainable Standard of health' (2008) 10 *Health and Human Rights* 88-90.

²³⁸ Commission on information and accountability for women and children's health: Working group on accountability for results *Draft Final Paper* (19th April 2011).

²³⁹ Working group on accountability for results *Draft Final Paper* (19th April 2011).

²⁴⁰ Commission on information and accountability for women and children's health, 'Keeping Promises, Measuring Results, Final Report of the Commission (19 May 2011).

²⁴¹ General comment 14 Para 56.

²⁴² Working group on accountability for results *Draft Final Paper* (April) 2011 3.

²⁴³ Mills S *Maternal Death audit as a tool: Reducing Maternal Mortality* HDNHE, World Bank, March 2011,1.

²⁴⁴ Technical Guidance on MMM Para 75(c).

Skilled birth attendants are at the centre of eradicating maternal mortality and morbidity. The presence of competent birth attendants before, during and after child delivery, significantly contributes to averting maternal deaths²⁴⁵ However, it is vital to emphasize that health workers are both duty bearers as well as rights holders. As duty bearers, health workers are required to respect the rights of the health system users by upholding principles of confidentiality and privacy.²⁴⁶ Therefore, acts of abuse, neglect and disrespect of women's right to access care should be thoroughly investigated and action taken to remedy these acts. As rights holders, sufficient working conditions including salary and benefits, disciplinary measures as well as forums aimed at allowing them to freely voice their opinions/grievances, are necessary towards establishing health systems that address maternal mortality and morbidity.²⁴⁷

Another vital aspect under administrative accountability is the issue of funding. Funding of maternal health services is the engine for averting maternal deaths. Amongst the reasons for the high maternal mortality rates, are the low resources within countries. General Comment 2 of the Maputo Protocol calls upon states to allocate adequate financial resources to the strengthening of public health services in order to ably provide sexual and reproductive health services.²⁴⁸ It further emphasizes allocating specific budget lines for reproductive health services as well as the putting in place of mechanisms to track health budget expenditures.²⁴⁹ General Comment 14 also points out that developing countries should seek for international assistance and cooperation in cases where they are falling short. However these sources should not replace government spending²⁵⁰

Moreover, it is not a guarantee that once resources towards maternal health are improved, the maternal mortality ratios will be automatically reduced. The available resources have to be strategically utilized so that the areas that are critical are those that are prioritized. This is due to the fact that resources can never be fully sufficient but have to be maximised. This explains why countries with the same income per capita may have varying levels of maternal mortality ratios. Therefore, if established, the committee on women's health would monitor a series of budget related issues; effective accountability mechanisms (judicial and non-

²⁴⁵ Graham WJ, Bell JS and Bullough CHW 'Can skilled attendance at delivery reduce maternal mortality in developing countries?'(2001).

²⁴⁶ Technical Guidance on MMM (2012) Para 66.

²⁴⁷ Technical Guidance on MMM (2012) Para 66.

²⁴⁸ African Commission on Human and Peoples' Rights, *General Comment No.2 on article 14 1(a), (b), (c) and (f) and article 14.2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' on the Rights of Women in Africa*. Available at <http://www.achpr.org/instruments/general-comment-two-rights-women/> (Accessed 27 October 2016) Para 62.

²⁴⁹ *General Comment No.2 of the Maputo Protocol*, Para 62.

²⁵⁰ ICESCR, General Comment 14 Para 38-40.

judicial), whether the budget caters for the vulnerable, marginalised sections of the population. Budgetary allocations to sexual and reproductive rights should be seen to be increasing, any reductions should be justified and the budgets should be allocated in line with the work plans which set out responsibilities for the various government departments.²⁵¹

2.5.2.2 Answerability in the administrative structures

Answerability allows for the executive and health officials to explain and justify the actions taken while implementing maternal health related policies. The policy makers have to first justify decisions taken to the various hierarchical structures including: health professional associations and to the bodies charged with monitoring and supervising the implementation of health policies. However, the challenge is, often, numerous monitoring and supervision bodies may exist which leads to the duplication of reporting, non-harmonization of collected data. This hampers the process of collecting accurate data which can be used to improve policies and address gaps in the system. Therefore, as emphasised above, there is need for the formation of a national commission on women's health which would help to harmonize the various monitoring and supervisory bodies.²⁵²

Furthermore, policy makers need avenues to communicate the decisions taken to the public. The citizens may be represented by civil society organizations, community-based organisations or through community dialogues. As emphasised before, these fora should not merely be about 'window dressing' but should foster effective participation. Thus, rights pertaining to information, assembly and association, should be adhered to. In the budget formulation process, engagement processes should be established either in form of public hearings for the citizens, civil society organizations and academic institutions to be able to identify specific needs in their community and contribute to the decision making for the budget.²⁵³

The main access of the communities to the administrative structures is through the health facilities. However, some health facilities might be so detached from the people that they keep the women away. This can be attributed to; harsh treatment of the mothers by the health workers, costs that the communities might not be able to afford. Therefore, health facilities should be organized in such a way that they are open and responsive to communities. Some of the facilities that ought to be in health centres to make them more open to communities include; periodic meetings, counselling services, vital sexual and reproductive health information provided in a confidential manner, complaints mechanisms

²⁵¹Technical Guidance on MMM (2012) Para 44-52, General Recommendation 25, General comment 14.

²⁵² Who will be accountable? Human Rights and the Post 2015 Development Agenda (2013) 37-38.

²⁵³ Technical Guidance on MMM (2012) Para 48.

such as public hearings, patients' committees, suggestion boxes, toll free lines, public mail boxes, email addresses, interactive websites, telephone hotlines and putting in place a department or individual charged with complaints handling.²⁵⁴

2.5.2.3 Enforcement/ Remedial Measures

At the administrative level, there must be, in some shape or form, remedial measures to correct shortcomings. It should be noted that the health workers themselves also have rights, which if not fulfilled will impede their ability to effectively provide essential healthcare. Therefore, remedial mechanisms should not be used to 'scapegoat', or merely apportion blame to the healthcare workers. However, where negligence and malpractice by the health professional has been proven after a due process, the appropriate sanctions against the worker should be undertaken in order to repair the damage caused. This is regardless of whether they are tenured or not. Some of the remedial measures in place often involve disciplinary committees set up within the professional associations or at the health facility level, dismissal, suspension, public shaming especially in the case of executives. Due to the interconnected nature of accountability, legal claims often aim to change and improve administrative structures.²⁵⁵

Yet, many administrative structures in the health sector do not set about establishing effective enforcement/remedial mechanisms. Thus, accountability is often weak as the body that avails services might be the same body that regulates and monitors the implementation of those services. In some cases, accountability is interpreted merely as a tool to ensure that the funds were utilised the way they were meant to be utilised. This is a simplistic way of looking at accountability. On the contrary, a comprehensive process ensures that maternal health services are gradually improving while putting into consideration the rights of the marginalized groups.²⁵⁶

Administrative accountability is discussed in greater detail in chapter four which discusses its implementation in a bid to address MMM in Uganda.

2.5.3 Social Accountability

Social accountability is a vertical form of accountability which involves a vibrant and dynamic relationship whereby communities use various means to hold public officials and other service providers accountable for the execution of their obligations. Unlike other forms of vertical accountability such as 'electorates holding leaders accountable', social accountability

²⁵⁴ Who will be accountable? Human Rights and the Post 2015 Development Agenda (2013) 37-38.

²⁵⁵ Hunt P and Backman G (2008) 89.

²⁵⁶ Hunt P and Backman G (2008) 89.

is an on-going process which is not only exercised during elections.²⁵⁷ It allows for direct participation in a more informed and constructive manner. Social accountability aims at improving transparency in service delivery right from the local to the national level.

One way of doing this is through providing information to communities on issues such as the budgets, government policies and international human rights frame work. Providing information to citizens serves as the first step towards ensuring their participation in government programmes.²⁵⁸ Social accountability has evolved overtime from methods such as community score cards, report cards, community participatory planning tools, community monitoring to transformative and broader democratic methods such as gender budgeting, monitoring compliance with guidelines of international human rights bodies and budget tracking. Due to the diverse nature of social accountability, it is one mechanism that engages numerous accountability methods and at various levels.²⁵⁹

Consequently, a four-stage approach is sometimes used to highlight the major stages while undertaking social accountability.²⁶⁰ The first stage is capacity building of community members, which involves raising their awareness on pertinent issues in order for them to be able to effectively engage with government processes. The next stage involves collecting information on government's policies, strategies, laws, programmes and translating it to simplify for the lay person, and then using various modes of communication including the media to disseminate this information. The third stage is involvement in accountability engagements with government, including score cards, budget analysis, monitoring government activities using structures that are already in place by the government or creating new strictures to allow for comprehensive engagements. The fourth stage involves the use of the results or commitments from the engagements with the government to carry out advocacy, lobbying and organize protests in order to ensure operationalization of these commitments. Thus social accountability mechanisms enhance policy formulation as well as policy outcome.²⁶¹

Within the maternal health context, social accountability involves civil society and community monitoring of health systems including finances, condition of health facilities, conduct of healthcare workers and other factors that may hinder women's enjoyment of their sexual and reproductive rights. Some of the methods used include; community score cards, community

²⁵⁷ United Nations Development Programme *Reflections on Social Accountability: Catalysing Democratic Governance to accelerate progress towards the Millennium Development Goals* (July 2013) 2-4.

²⁵⁸ UNDP (2013) 2-4.

²⁵⁹ UNDP (2013) 2-4.

²⁶⁰ UNDP (2013) 2-4.

²⁶¹ UNDP (2013) 2-4.

watchdogs, citizen report cards, budget tracking.²⁶² Social accountability is further expounded upon in chapter five which focuses on implementing social accountability towards reducing MMM in Uganda.

2.6 CONCLUSION

Accountability is the crux of a human rights based approach thus its role towards upholding human rights can no longer be overlooked, especially in reversing the persistently high MMM rates. Worse still, a percentage of maternal deaths are still unaccounted for as they may be narrowed down to fate or the will of the higher powers, rather than an injustice. Scholars are increasingly discussing the role of accountability in human rights but very few have attempted to make the linkage between accountability and maternal mortality, especially by expounding on the various elements and forms of accountability.

In order to establish a theoretical approach for the subsequent chapters, this chapter elaborates upon an accountability framework for combating MMM. Under this framework, accountability is defined as constituting three major elements; responsibility (duties and standards), answerability (justifying decisions taken) and enforcement (remedial measures). The contribution of each of these elements towards the substantial reduction of preventable MMM is demonstrated. It is further emphasised that these elements only constitute accountability if implemented jointly rather than separately as well as cyclically. Under enforcement, it is stressed that accountability in the human rights sense is not 'blame-focused' but rather serves an overall purpose of identifying what does not work and looking for practical solutions to remedy it. Therefore, this chapter sets out a normative/theoretical basis upon which the subsequent chapters are hinged.

The chapter also stresses that the success of accountability is dependent on undertaking a comprehensive contextual analysis. It is further pointed out that the persistence of high maternal mortality rates especially in the developing world is a result of discrimination on the basis of sex, social class, race and sometimes even age. In countries where maternal mortality rates are still high, women are largely seen as reproducing machines whose role is to bring children in this world, most times at the expense of their own lives. Laws and policies are used to control women's decision to have children, the frequency and how many children they can have. These laws unfairly discriminate women solely based on the basis that they can reproduce. For instance, laws that criminalize abortion shift the entire blame to the woman for failed contraception or an unplanned pregnancy. These do not end up

²⁶² Lodenstein E et al (2013).

reducing abortions but instead drive women to seek unsafe alternatives and thus, these laws are detrimental to the lives of the women.

For that reason, it is emphasised that the failure by states to eradicate preventable maternal deaths and morbidities is a violation of women's rights. The application of continuous comprehensive contextually-based inquiries enables for the identification of appropriate approaches to respond to the unique challenges in each context. To this end, the operationalization of accountability allows for such continuous inquiries and the remedying of gaps in the system towards the reduction of preventable maternal mortality and morbidity.

Finally, in looking at the forms of accountability, it is acknowledged that while there are numerous forms, the emphasis is put on national mechanisms which are; legal accountability, administrative and social accountability. It is stressed that administrative accountability is vital for combating MMM as it is the most direct way of monitoring maternal health and preventing death or sickness. The need to infuse human rights in the administrative structures is thus emphasised. Human rights accountability has to be exercised throughout the entire project phase, that is; project formulation, project implementation as well as monitoring and evaluation stage.

This requires putting in place a comprehensive plan of action, an accountability body which is in position to track budgetary allocations and implementation, conduct comprehensive maternal deaths audits and monitor the health workforce. Within the administrative structures, the role of political mechanisms is also emphasised. Nonetheless, it is stressed that accountability can only be successful if the various legal, administrative, political and social accountability mechanisms are working together towards the elimination of maternal mortality and morbidity.

CHAPTER THREE: IMPLEMENTING LEGAL ACCOUNTABILITY TOWARDS COMBATING MATERNAL MORTALITY AND MORBIDITY IN UGANDA.

3.0 INTRODUCTION

As elaborated upon in chapter two, accountability consists of three elements; responsibility, enforcement and answerability. This chapter examines how each of these elements are implemented in the Ugandan legal sector towards combating maternal mortality and morbidity (MMM). This chapter and the subsequent ones, attempts to show that if accountability is implemented from a human rights lens, there is a great possibility of substantially reducing the high maternal mortality and morbidity rates in Uganda. The implementation of accountability will ultimately contribute to transforming human rights from ideals on paper to implementable strategies.

The chapter also reveals that despite strides made to improve the legal sector, a lot still needs to be done to ensure that the judicial sector adequately plays its role towards reducing the high MMM rates in Uganda. One sure way of going about this is to realize the role of accountability as one of the human rights principles in combating MMM and thus take deliberate steps to operationalize it. Ultimately, the study emphasises, that within the human rights context, various efforts going beyond legal remedies to administrative and community-level interventions, should be undertaken to interpret and implement accountability.

The chapter lays special emphasis on the Courts of Law as well as the Uganda Human Rights Commission. The Courts of law are a primary accountability mechanism, which not only monitor the state's adherence to human rights but also redress human rights violations. On the other hand, the Uganda Human Rights Commission is the principal organ charged with the promotion and protection of human rights²⁶³. However, while major emphasis is put on these two organs, reference is made to other judicial organs throughout the chapter especially those that have a role to play in improving accountability.

3.1 APPLYING THE ACCOUNTABILITY FRAMEWORK TO THE LEGAL SECTOR

The application of the Responsibility-Answerability-Enforcement (RAE) framework to the legal sector requires the contextualisation and domestication of the principles espoused in chapter two. Therefore, this section is aimed at elaborating upon the operationalisation of accountability in the Ugandan legal sector using the RAE framework. In elaborating upon the responsibility aspect of the accountability framework, this chapter points out the international and regional human rights documents catering for MMM that have been adopted by Uganda.

²⁶³ Jeong-Woo K and Francisco OR 'National Incorporation of Global Human Rights: Worldwide expansion of National Human Rights Institutions, 1966-2004' (2009)87 *Social Forces* 1324.

It emphasises that by adopting these human rights documents; Uganda has committed itself to take all measures to combat MMM. At the domestic level, it is emphasised that while, the constitution does not explicitly provide for the right to health in its bill of rights, several provisions read together and other regulatory instruments adopted by Uganda, demonstrate its obligation to avert maternal deaths and morbidities.

To elaborate upon the enforcement aspect, the chapter examines major cases that have gone before the Ugandan Courts of Law directly relating to MMM and how they have been adjudicated. The answerability feature is used to examine supervisory mechanisms within the judicial sector aimed at enhancing the role of courts in ensuring access to justice for MMM. The RAE approach is also applied to the Ugandan Human Rights Commission (UHRC) with the aim of ascertaining how it implements its accountability role towards combating MMM.

3.2 RESPONSIBILITY IN THE LEGAL SECTOR

Responsibility is one of the major elements of accountability. Responsibility means duty-bearers are to put in place guidelines or standards by which performance can be measured.²⁶⁴ Legal accountability structures are the means through which violations of women's maternal health rights are addressed using well established legal systems. It has also already been established in chapter two that these standards must be in line with human rights norms and principles. Therefore, that the standards of performance must be non-discriminatory, participatory and in the case of maternal health related rights, ensure services are of good quality, accessible, available and acceptable.

Human technical and financial resources must also be put aside for the realisation of maternal health rights. In the legal context, standards of performance are rules which guide performance of the judicial structures and the extent to which these affect the way maternal health rights are adjudicated. Legal accountability mechanisms involve judicial (the most common of which being Courts of Law) and quasi-judicial structures (Human Rights Commission and other tribunals). Thus, the judiciary acts as an accountability agent for the decisions taken by the executive and the legislative arms of government. The African Commission General Comment on article 14, 1 (d) and (e) sets out that the implementation of accountability requires access to timely and efficient redress mechanisms in instances where women's sexual and reproductive health rights have been violated.²⁶⁵

²⁶⁴ Joshi A and Houtzager PP (2012) 151.

²⁶⁵ African Commission on Human and Peoples' Rights, *General Comments on article 14 1(d) and (e)* of the Protocol to the African Charter on Human and Peoples' on the Rights of Women in Africa. Available at <http://www.achpr.org/instruments/general-comments-rights-women/> (Accessed 27 October 2016), Para 34.

Standards of performance can be derived from international and regional human rights treaties, the Ugandan Constitution as well as other laws and legislation that have been enacted or adopted by Uganda to promote and protect maternal health rights. In order to expound on the responsibility aspect, this section expounds upon international, regional and national laws adopted by Uganda. The aim is to ascertain whether they are adequately utilized to provide remedies for the reduction of maternal mortality and morbidity.

3.2.1 International and Regional Level

Uganda has ratified all the critical international and regional treaties aimed at the promotion and protection of human rights specifically those aimed at combating Maternal Mortality and Morbidity. As elaborated on in chapter two, maternal health is derived from the rights to health catered for principally in the International Covenant on Economic Social and Cultural Rights (ICESCR) as well as several other non-binding documents such as General Comment 14, General Comment 22 on Sexual and Reproductive Health Rights and the United Nations Technical Guidance on Maternal Mortality and Morbidity. Uganda signed and ratified the International Covenant on Economic Social and Cultural Rights (ICESCR) in 1987.²⁶⁶ However it has not signed, ratified and acceded to the Optional Protocol to the Convention, which came into force in 2008 and was adopted by the states in 2013.

The Optional Protocol allows for State Parties to bring complaints/communications before the committee on violations pertaining to economic social and cultural rights after exhausting domestic remedies.²⁶⁷ Article 12 of the ICESCR obliges states to ‘recognize everyone’s right to enjoyment of the highest standard of physical and mental health’. Article 12(2) (a) of the ICESCR goes further to emphasize that in order to fully realize the right to health, states should provide for the reduction of still-birth rate and of infant mortality. Non-discrimination and equality principles are also vital for the realization of maternal health rights and are provided for by article 2(2) and 3 of the ICESCR.

The Committee on Economic Social and Cultural Rights (CESCR) thus stressed that failure by the states to take all the necessary steps to reduce maternal mortality, violates a series of human rights.²⁶⁸ Yet, it was not until December 2012, that Uganda submitted its initial state report to the Committee on Economic Social and Cultural Rights (CESCR).²⁶⁹ In its first

²⁶⁶ Office of the High Commissioner United Nations Human Rights, ‘Status of Ratification Interactive Dashboard’. Available at <http://indicators.ohchr.org/> (Accessed 12 June 2016).

²⁶⁷ Optional Protocol to the International Covenant on Economic Social and Cultural Rights A/RES/63/117, 10 December 2008.

²⁶⁸ General Comment No. 14 Para 44.

²⁶⁹ Committee on Economic Social and Cultural Rights , ‘Consideration of Reports submitted by States Parties under articles 16 and 17 of the International Covenant on Economic Social and Cultural Rights: Initial reports submitted by Parties due in 1990,Uganda’, E/C.12/UGA/1, 6 December 2012.

concluding observations to Uganda, the CESCR pointed out that the insufficient recognition of the right to health, by including it in the bill of rights, creates a gap to its efficient implementation.²⁷⁰ It further noted the prevalence of unsafe abortions that are a major cause of maternal mortality and morbidity partly as a result of high teenage pregnancies. The CESCR thus called for the wide dissemination of information on sexual and reproductive health targeting schools and adolescent girls as well as facilitating access to contraceptives. It also asked for the revision of the restrictive laws and policies on abortion.²⁷¹

Maternal health rights are also women's rights. Maternal Mortality and Morbidity is a problem primarily experienced by women. As has been emphasised in chapter two, currently, there is no cause of death/disability for men between the ages of 15 to 44 that is close to the large scale of Maternal Mortality and Morbidity.²⁷² Furthermore, on average everyday 16 women in Uganda die before, during and after child delivery bringing the total up to 6000 women annually.²⁷³ This calls for the prioritization of not only maternal health rights but women's rights generally in a bid to overturn these circumstances. Article 12(1) of CEDAW calls upon states to pursue all appropriate measures to eliminate discrimination against women in health care in order to ensure access to health care especially those related to family planning. 12(2) goes ahead to call upon States to ensure adequate services for women in relation to pregnancy, confinement and post-natal period, providing free services where necessary and ensuring proper nutrition during pregnancy and in the process of lactation.

General Comment 24 of the CEDAW gave normative content to article 12 of CEDAW by emphasising that states should submit comprehensive reports to the committee including steps taken to; put in place appropriate legislative, administrative, judicial, budgetary and other measures to the maximum of available resources to ensure that women realize their right to health care. To this end, states should address biological, socio-economic and psychosocial conditions specific to women that hinder them from effectively enjoying their health rights.²⁷⁴

They should refrain from obstructing action taken by women in realization of their health goals and allocate resources for programmes targeting adolescents. They are required to put in place sanctions for violations of rights by private persons and organizations and to implement a comprehensive national plan aimed at promoting women's health throughout

²⁷⁰ Committee on Economic Social and Cultural Rights 'Concluding Observations to Uganda', E/C.12/UGA/CO/1, 8July 2015.

²⁷¹ CESCR *Concluding Observations to Uganda* (2015).

²⁷² A/HRC/ 14/39 Para 17.

²⁷³ Millennium Development Goals Report for Uganda (2010) IV.

²⁷⁴ CEDAW General Recommendation 24

their lifespan. States should therefore prioritize the prevention of unwanted pregnancy through; family planning, education and information, safe motherhood programmes and where possible amend legislation criminalizing abortion. Also, monitor the provision of health services for women, infuse gender –sensitive courses on women's health in training curricular for health workers and ensure that women's rights to privacy, autonomy, choice, informed consent and confidentiality are respected within health systems.²⁷⁵

At the African level, the African Charter on Human and Peoples' rights (The African Charter) was a ground breaking regional document in that it provided both for civil and political rights as well as economic social and cultural rights in one document. This was emphasised in the Preamble, which set out that in recognising the right to development, the African Charter acknowledged civil and political rights cannot be achieved without looking at social and economic rights.²⁷⁶ Article 16 of the African Charter states that everyone shall have the right to enjoy the best attainable state of physical and mental health and that State Parties shall undertake measures to protect the health of their people by ensuring that they receive medical attention when they are sick.

Another ground breaking document, at the African level, is the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), which designated a separate section (article 14) for sexual and reproductive. Article 14(2)(c) expressly provided for the right to medical abortion in instances of rape, incest, sexual assault and where the continuation of the pregnancy will cause mental and physical harm to the life of the mother and foetus. The inclusion of this clause was very commendable and forward-looking considering the conservative/restricted stance of several African countries, like Uganda, to abortion.

Furthermore, article 14(2) of the Maputo Protocol called upon states to provide adequate, accessible, affordable health services by availing information/education to women especially those in rural areas and establishing pre-natal, delivery, post-natal health and nutrition services. Several provisions of article 14 were given normative content by the African Commission on Human and People's Rights using General Comments. These include General Comment 1 elaborating upon article 14 1(d) and (e) on HIV/AIDS²⁷⁷ as well as General Comment 2 on articles 14.1(a) right to control their fertility (b) right to choose whether or not to have children and child spacing (c) right to choose any method of

²⁷⁵ CEDAW General Recommendation 24

²⁷⁶ Organization of African Unity (OAU), African Charter on Human and Peoples' Rights ("Banjul Charter"), 27 June 1981, CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982).

²⁷⁷ General Comments on article 14 1(d) and (e) of the Maputo Protocol.

contraception, article 14.2(a) education and information and (c) medical abortion.²⁷⁸ In pointing out the importance of article 14 of the Maputo Protocol, Durojaye and Ngwena emphasise that the human right to reproductive health is meaningless if women faced with unwanted pregnancies are forced to either become mothers or to resort to unsafe abortions. Additionally, going through with giving birth poses an extra burden on vulnerable/impoverished women when it comes to accessing health care services including emergency obstetric care services which may ultimately contribute to their untimely death or life-long illnesses.²⁷⁹

Nonetheless, from the above, one can deduce that Uganda has ratified most if not all the appropriate international and regional human rights documents aimed at combating preventable MMM ratios. However, commitment to human rights is seen from the extent to which a government is willing to continuously, rigorously and widely disseminate human rights information to all its stakeholders and ensure that policy makers are equipped with human rights skills to be in a position to mainstream them in all their documents. Yet, for the most part, apart from ratifying human rights instruments and setting out well elaborated documents, the Ugandan Government has a track record of merely paying lip service to human rights. The CEDAW Committee pointed out the lack of knowledge amongst all the government branches on women's rights that are set out in the Convention, on principles such as substantive equality and the various general recommendations.²⁸⁰ Therefore, there is need for the Ugandan Government to give priority to ensuring that its laws, policies and programmes are in line with human rights principles enunciated in these various documents that it has endorsed.

In order to fulfil the various treaty obligations mentioned above, Uganda adopted a constitution that caters for women's rights as provided for by Article 32 (affirmative action) and Article 33 (women's rights) as well as other provisions that have implications on women's rights. Several gender responsive laws and policies aimed at uplifting women's rights have also been adopted. These include; National Health Policy, Health Sector Strategic Plan, Sharpened Plan on the Reduction of Maternal and Child Mortality, National Development Plan, the Domestic Violence Act, 2010²⁸¹, the Prohibition of Female Genital

²⁷⁸ General Comments on article 14 1(d) and (e) of the Maputo Protocol.

²⁷⁹ Ngwena C and Durojaye E (Eds), *Strengthening the Protection of sexual and reproductive health and rights in the African region through human rights* (2014) 5.

²⁸⁰ Committee on the Elimination of Discrimination against women *Concluding observations of the Committee on the Elimination of Discrimination against Women, Uganda*, C/UGA/CO/7, 47th Session (4-22 October 2010) Para 14.

²⁸¹ No. 3 of 2010

Mutilation Act, 2010²⁸² among others. Uganda signed the Convention on Elimination of all Forms of Discrimination against Women (CEDAW) in 1980 and ratified it in 1985.²⁸³

To-date, Uganda has submitted 4 periodic reports to the CEDAW Committee; the initial report was submitted in 1992, the second in 1999, the third in 2002 and the fourth in 2009.²⁸⁴ However, the persistently high maternal mortality rates despite all the legal and policy framework indicates the need to strategically shift the emphasis from formulation to the implementation as well as the continuous supervision/tracking as well as undertaking enforcement measures to ensure the implementation of these policies/programmes.

Uganda ratified the African Charter on the 27 May 1986.²⁸⁵ However, it was not until 1 April 2000 that it submitted its first periodic report to the African Commission on the implementation of the African Charter covering the period from 1986-2000 with subsequent reports being submitted in 2006, 2008, 2011 and the most recent one 25 September 2013.²⁸⁶ In its 2011 concluding observations to Uganda, the African Commission on Human and Peoples' Rights commended Uganda for the construction of six regional health centres in Lira, Mubende, Jinja, Moroto, Masaka and Mbale. Though, the Commission noted with concern the lack of adequate information in the report on the maternal and infant mortality rates in Uganda and thus urged the Government of Uganda to provide information to that effect in the next periodic report.²⁸⁷ Additionally Uganda was among the countries that adopted the Abuja Declaration on HIV/AIDS, Tuberculosis and other related Infectious Diseases in which countries committed to allocating 15 percent of their annual budget to the improvement of the health sector.²⁸⁸ Yet, as will be elaborated upon under administrative accountability, Uganda's budgetary allocations to the health sector over the past 4 years have never even reached the 10 percent mark.

²⁸² No. 5 of 2010

²⁸³ United Nations Human Rights Office of the High Commissioner, 'Status of Ratification Interactive Dashboard', Available at <http://indicators.ohchr.org/> (Accessed 12 June 2016)

²⁸⁴ Committee on the Elimination of Discrimination against Women, '*Combined fourth, fifth, sixth and seventh periodic report of State Parties: Uganda*', CEDAW/C/UGA/7 (25 May 2009) Para 10.

²⁸⁵ Concluding observations of the African Commission on the 2nd Periodic Report of the Republic of Uganda': Presented at the 45th ordinary session of the African Commission on Human and Peoples' Rights held in Banjul the Gambia from 13 to 27 May 2009.

²⁸⁶ 'State Reports and Concluding Observations'. Available at <http://www.achpr.org/states/reports-and-concluding-observations/> (Accessed 26 August 2015)

²⁸⁷ African Commission on Human and Peoples' Rights 'Concluding observations on the 4th Periodic Report of the Republic of Uganda': Presented at the 49th ordinary session of the African Commission on Human and Peoples' Rights held in Banjul the Gambia from the 28th April to 12th May 2011 Paras 3, 14 and 15.

²⁸⁸ African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases* OAU/SPS/ABUJA/3, Para 26.

On the other hand, Uganda signed the Maputo Protocol on 18 December 2003 but it was not until July 2010 that it ratified the Protocol.²⁸⁹ Upon ratification, Uganda entered reservations to Article 14 (1) (a) which calls upon states to respect and protect women's right to control their fertility and (2) (c) of the Maputo Protocol, on medical abortion mentioned above²⁹⁰ Uganda interpreted Article 14(1) (a) to mean that women had the right to control their fertility regardless of their marital status. While 14(2) (c) was interpreted as conferring an individual right to abortion and thus requiring the State Party to provide access to the procedure. Thus, it maintained that it was not bound by this article unless it complied with domestic legislation pertaining to abortion.²⁹¹

The religious groups, which had been strongly opposed to these clauses also wrote several petitions protesting their conversion into Ugandan law.²⁹² Despite, recommendations from the Commission requesting Uganda to withdraw this reservation and to revise its legislation on termination of pregnancy, to-date, Uganda has not withdrawn its reservation to the Maputo Protocol²⁹³ At the domestic level, while laws do not completely outlaw abortion, they are considered to be restrictive. Article 22(2) of the constitution provides that no one shall terminate the life of an unborn child except when authorised by the law. Yet, there is generally no law to guide the enforcement of Article 22(2). The Penal Code Act²⁹⁴ sets out several provisions related to termination of pregnancy. These are;

Any person who, with intent to procure the miscarriage of a woman whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means, commits a felony and is liable to imprisonment for fourteen years.²⁹⁵

²⁸⁹ FIDH 'Uganda becomes the 28th State party to the Maputo protocol'. Available at <https://www.fidh.org/International-Federation-for-Human-Rights/Africa/uganda/Uganda-becomes-the-28th-State> (Accessed 25 August 2015).

²⁹⁰ Statement by Mrs. Hannah Forster, Executive Director, African Centre for Democracy and Human Rights Studies and Chairperson of the NGO Forum Steering Committee, at the official opening of the 50th Ordinary session of the African Commission on Human and Peoples' Rights, 24th October 2011, Gambia.

²⁹¹ JL Asuagbor 'Status of implementation of the African Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa', Commissioner, Special Rapporteur on the Rights of Women in Africa, African Commission on Human and Peoples' Rights, 60th Meeting-Commission on the Status of Women (18 March 2016) Para 5.

²⁹² The Maputo Protocol 'A clear and present danger: The fight against the Maputo Protocol', Human life International, 2011.

²⁹³ Report of the joint promotion mission undertaken to the Republic of Uganda' 25-30 August 2013, presented at the 55th Ordinary Session of the African Commission on Human and Peoples' Rights, held from 28 April -12 May 2014, in Luanda Republic of Angola, 60.

²⁹⁴ Cap 120 laws of Uganda

²⁹⁵ Section 141 ibid.

Any woman who, being with child, with intent to procure her own miscarriage, unlawfully administers to herself 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, commits a felony and is liable to imprisonment for seven years.²⁹⁶

Any person who unlawfully supplies to or procures for any person anything, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or not with child, commits a felony and is liable to imprisonment for three years.²⁹⁷

On the surface, these provisions seem to outlaw abortion, however when read together with section 224 of the Penal Code, which sets out, "A person is not criminally responsible for performing in good faith and with reasonable care and skill, a surgical operation upon any person for his or her benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time, and to all the circumstances of the case". Therefore, section 224 permits termination of pregnancy if it is aimed at safeguarding the life and health of the pregnant mother. Thus, Twinomugisha argues that this section can protect a health worker if he/she can prove that the medical abortion was done with reasonable care and in good faith to save the life of the mother.²⁹⁸

Even so, these penal code provisions are restrictive and archaic. The provisions of Uganda's Penal Code Act were imported from the Penal Code of India in 1950 which was an improvement of the 18th century British penal law. However, while colonial masters such as Britain have struck out such provisions from their penal laws, they remain firmly entrenched in Uganda's penal code.²⁹⁹ Ngwena points out the irony in the fact that African countries clamoured for self-rule and autonomy but have maintained restrictive abortion provisions.

Yet, they have the freedom to reform them in order to address the challenge of unsafe abortions, a major contributor to mortality and morbidity.³⁰⁰ Furthermore, the case of *Rex V Bourne*³⁰¹ decided in 1938 ruled that the performing of an abortion to preserve both the life of the pregnant woman as well as her physical and mental health was within the realm of

²⁹⁶ Penal Code Act, Section 142,

²⁹⁷ Penal Code Act, Section 143

²⁹⁸ BK Twinomugisha *Fundamentals of Health Law in Uganda* (2015) 49.

²⁹⁹ Tamale S, 'Exploring the contours of African Sexuality: Religion, law and Power', 14(2014) *African Human Rights Law Journal* 163

³⁰⁰ Ngwena C, 'An appraisal of abortion laws in Southern Africa from a Reproductive Health Rights Perspective', 32(2004) *Journal of Law, Medicine and Ethics* 708-717.

³⁰¹ [1939] 1 K. B. 687 or 3 All E. R. 615 (1938)

lawful abortion.³⁰² Subsequently, the British Abortion Act of 1967 took into consideration the grounds established by the *Rex v Bourne Decision* but also recognized socio-economic circumstances as grounds for abortion. Even so, despite being a British colony and thus using the common law system, former British colonies like Uganda have not revised their laws to reflect such developments in the laws they inherited.³⁰³

Accordingly, it is stressed that Uganda's law on abortion should be clear as activists assert that such ambiguous provisions create room for confusion and uncertainty. It discourages health workers from conducting medical abortions for fear of being imprisoned.³⁰⁴ Further still, providing for termination of pregnancy only when the mother's life is in danger, excludes many categories of people, for instance the numerous teenage mothers who end up having unsafe abortions due to the fact that they don't have the financial means to cater for the pregnancy. This is emphasized by General Comment 2 of the Maputo Protocol which sets out that apart from the potential physical injury, both in the short and long run, as a result of denial of access to safe abortion services, mental suffering is another direct consequence, which is worsened by the socioeconomic condition of the woman. It further asserts that, maternal mortality is often a risk especially for adolescent mothers who opt for unskilled service providers or use dangerous objects and procedures.³⁰⁵

It is also vital to note that the restricting of abortion does not reduce it or stop it but rather drives it underground, thus increasing maternal mortality and morbidity rates as a result of unsafe abortion.³⁰⁶ It is for reasons such as these that the abortion figures are staggering. Around 13 percent of maternal mortality rates are attributed to unsafe abortions. Additionally, in 2008 it was estimated that almost all (97 percent) of abortions that occur in Africa are unsafe.³⁰⁷ About 1,200 women die from unsafe abortion and 85,000 seek treatment for abortion related complications.³⁰⁸ In Uganda, it is estimated that 54 out of 1000 abortions occur under unsafe conditions amongst women in their reproductive ages. Subsequently, 148,500 women experience abortion related complications annually.³⁰⁹

³⁰² *Rex V Bourne*, 1 King's Bench 687, 3 All E.R.615 (Central Criminal Court, London, 1938).

³⁰³ Ngwena C (2004) 708-717.

³⁰⁴ Guttmacher Institute, 'Abortion in Uganda', Fact Sheet, January 2013. Available at <https://www.guttmacher.org/fact-sheet/abortion-uganda> (Accessed 08 July 2016).

³⁰⁵ General Comment No.2 of the Maputo Protocol Para 38-39.

³⁰⁶ Zampus C and Todd-Gher J, 'Abortion and the European Convention on Human Rights: A lens for abortion and advocacy in Africa' in Ngwena C and Durojaye E (Eds), *Strengthening the Protection of sexual and reproductive health and rights in the African region through human rights* (2014) 80.

³⁰⁷ Zampus C and Todd-Gher J (2014) 80.

³⁰⁸ Reducing Morbidity and Mortality from Unsafe Abortion in Uganda: Standards and Guidelines (2015).

³⁰⁹ Moore AM, Kibombo R and Cats-Baril D 'Ugandan opinion leaders' knowledge and perceptions on unsafe abortions' (2013) *Health Policy and Planning* 1.

On the other hand, Uganda's policy framework has been forward-looking, for instance, the revised 2012 National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights expands the conditions of termination of pregnancy to allow for termination if the mother has HIV, rape, incest and fetal anomaly. Also, in 2015, the Ministry of Health launched the 'Standards and guidelines for the reduction of Maternal Mortality and Morbidity due to unsafe abortion in Uganda'.³¹⁰ Therefore, it remains to be seen how courts in Uganda can treat this conflict if a health worker went ahead to follow policy provisions which are outlawed by the penal code. In addition, several steps need to be undertaken towards reducing unsafe abortion which include; making the laws on abortion clear and doing away with restrictive provisions that maybe interpreted as outlawing abortion, opening up more honest and realistic dialogue about sex for young people that is focused on accessing contraceptives to prevent unwanted pregnancies and withdrawing reservations to the Maputo Protocol.

3.2.2 Domestic Level (Ugandan Court System)

The point of departure for setting out the standards of performance for the Ugandan legal sector is to first elaborate upon Uganda's judicial structures. In their operations, judicial officials have to bear in mind that they are primarily answerable to the rights holders. From the onset, Article 1(1) of the Ugandan Constitution sets out 'All power belongs to the people who shall exercise their sovereignty in accordance with this Constitution'. Furthermore, Article 126(1) states that 'Judicial power is derived from the people and shall be exercised by the courts established under this constitution in the name of the people and in conformity with the law and with the values, aspirations and norms of the people'.³¹¹

Articles 127 also emphasises that parliament shall make laws aimed at ensuring the participation of people in the administration of justice by the courts. Therefore, in order to be answerable to rights holders, judicial officials have to adhere to the principles set out in Article 126(2); 'Justice shall be applicable to all despite their social economic status.' It further states that there should be adequate compensation to the victims for the suffering undergone, justice should not be delayed, encourages the promotion of reconciliation between parties and emphasises the administration of substantive justice devoid of undue regard to technicalities.³¹²

³¹⁰ Centre for Health Human Rights and Development Launching *the Standards and guidelines on unsafe abortions to confront the Public Health Crisis in Uganda* (5 June 2015). Available at <http://www.cehurd.org/2015/06/launching-the-standards-and-guidelines-on-unsafe-abortions-to-confront-the-public-health-crisis-in-uganda/>. (Accessed 8 July 2016).

³¹¹ Constitution of the Republic of Uganda, 1995 'Chapter Eight: The judiciary, Administration of Justice'.

³¹² Uganda Constitution (1995) Article 126(2).

In the *Attorney General vs Susan Kigula and 147 others*³¹³ - a case that challenged the constitutionality of the death penalty – the judge used article 126 (1) of the constitution, in asserting that the reason for the inclusion of this provision was deduced from the people's resolve as shown in the Preamble of the Constitution. He noted that in the Preamble, the people recalled the traumatic history of Uganda characterized by constitutional and political instability. Thus, by including this provision, they demonstrated their resolve to reimagine a better future for themselves based on ideals of unity, inclusion, social justice, peace, freedom, democracy and progress.³¹⁴ The constitution goes ahead to set out the courts of judicature with the Supreme Court as the highest and final court of appeal and thus any party that is aggrieved by the decision of the Court of Appeal may appeal to the Supreme Court against the decision in question.

The decisions by the Supreme Court are binding on all subordinate courts. However, it may depart from its earlier decision if it deems appropriate to do so.³¹⁵ Next in hierarchy to the Supreme Court, is the Court of Appeal which deals with appeals from the High Court of Uganda. It is important to note that the Court of Appeal also sits as the Constitutional Court when required and thus adjudicates any question dealing with the interpretation of the constitution.³¹⁶ Below the Court of Appeal is the High Court of Uganda, which has unlimited original jurisdiction in all matters but also receives appeals from lower courts on any matter.³¹⁷ These are the courts of superior record set up by the constitution. Other subordinate courts include; the Magistrates' Courts, the Local Council Courts, Qadhis' Courts, Military Courts as well as tribunals including those established under the Land Act, Communications Act, Tax Appeals Tribunals Act and Electricity Act.³¹⁸

The Magistrates' Courts Act³¹⁹ establishes the Magistrates Courts that deal with the majority of civil and criminal cases. They include, the Chief Magistrates Court, Magistrate Grade 1 Magistrate and Grade 11 Magistrate in that order.³²⁰ The Magistrates Court Act also divides Uganda in magisterial areas, which currently stand at 26 and are spread out throughout Uganda.³²¹ Appeals from the Magistrates Courts are referred to the High Court, which is also

³¹³ Supreme Court Constitutional Appeal No. 3 of 2009

³¹⁴ *Susan Kigula and 416 Others v The Attorney-General* (2005) AHRLR 197 (Ug CC 2005) Para 13-15.

Available at <http://www1.chr.up.ac.za/index.php/browse-by-country/uganda/1170.html> (Accessed 02 July 2016).

³¹⁵ Uganda Constitution (1995) Article 132.

³¹⁶ Uganda Constitution (1995) Article 137.

³¹⁷ Uganda Constitution (1995) Article 139.

³¹⁸ Brenda Mahoro 'Uganda's Legal System and Legal Sector', Globalex'. Available at http://www.nyulawglobal.org/globalex/Uganda.html#_High_Court (Accessed 11 July 2016).

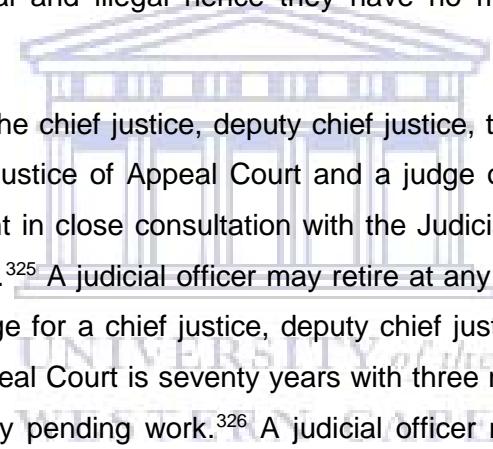
³¹⁹ Cap 16 Laws of Uganda, 2000

³²⁰ Magistrates' Court (Amendment) Act 2007, Section 2-6

³²¹ Brenda Mahoro 'Uganda's Legal System and Legal Sector', Globalex. Available at http://www.nyulawglobal.org/globalex/Uganda.html#_High_Court (Accessed 11 July 2016).

charged with the supervision of these Courts. Another type of court that is worth mentioning are the Local Council Courts (LC) established by the Local Council Courts Act, 2006 and supervised by the Magistrates Courts. These are established from the lowest level, which is the village, to the sub-county level. Thus, when one is dissatisfied with the decision of any of these courts, one may appeal right up to the Magistrates Court and may even go beyond.³²²

From this description, it is very easy to assume that courts are easily accessible, however that is far from the case. The Courts at the lower levels (Local Council Courts and Magistrates Courts) which are often more accessible to the communities, are fraught with numerous challenges including understaffing, underqualified staff, insufficient physical structures and pervasively high levels of corruption. Corruption is especially rampant in the lower Local Council courts despite being the first point of contact for the vulnerable/rural women.³²³ It should also be noted that Uganda has not held local council elections for LC I and II, who have made up the local council courts since 2006. The present office holders were ruled unconstitutional and illegal hence they have no mandate to carry out lawful decisions³²⁴.



As regards appointment, the chief justice, deputy chief justice, the principal judge, a justice of the Supreme Court, a justice of Appeal Court and a judge of the High Court are to be appointed by the President in close consultation with the Judicial Service Commission and with parliament's approval.³²⁵ A judicial officer may retire at any time after attaining the age of sixty. The retirement age for a chief justice, deputy chief justice, justice of the Supreme Court and a justice of Appeal Court is seventy years with three months allowance to enable them to fully complete any pending work.³²⁶ A judicial officer may only be removed from office as a result of their inability to perform their duties as a result of an infirmity or sickness, misbehaviour or misconduct, incompetence but only in accordance with the provisions of article 144 of the constitution.

Turning to maternal health, it has already been illustrated that the combating of preventable maternal mortality and morbidity requires the combining of several rights including women's right to health, right to life, right to non-discrimination and equality, and most of these rights are provided for by the constitution. For instance, Article 33 provides that women shall be

³²² The Local Council Courts Act, 2006 Para 3-5.

³²³ 'The hierarchy Composition and functions of Courts in Uganda'. Available at <http://lawschoolguide.blogspot.co.za/2011/03/heirachy-composition-and-function-of.html> (Accessed 05 July 2016).

³²⁴ See Rubaramira Ruranga vs. AG constitutional petition No. 21 of 2006

³²⁵ Uganda Constitution (1995) Article 142.

³²⁶ Uganda Constitution (1995) Article 144.

afforded full and equal dignity as men and thus the state shall undertake to protect women's rights bearing in mind their unique status as well as their natural maternal functions. Article 22 provides for the right to life while Article 24 calls for the respect for human dignity and protection from inhuman treatment. However, the most vital right is that of health, which is not provided for in the bill of rights but rather set out in the various parts of the 'National Objectives and Directive Principles of State Policy'. This presents a lacuna in the law as happened in the *CEHURD and Others vs. Attorney General Case*³²⁷, which is discussed in greater detail in the next section. The right to health can also be imputed under Article 45 of the constitution, which provides for application and recognition of other rights not included in the constitution but provided for in international instruments ratified by Uganda.

In its first concluding observation to Uganda, the CESCR clearly pointed out the need for the inclusion of the right to health in Uganda's bill of rights as well as in other laws where necessary.³²⁸ The Technical Guidance on Maternal Mortality and Morbidity also emphasised that amongst the steps that need to be taken in order to empower women to claim their rights is the express recognition of the right to health, including sexual and reproductive health, in constitutions and other legislations. This should be accompanied by the putting in place of effective accountability mechanisms in case these rights have been violated.³²⁹

Similarly, the recently adopted General Comment 22 on Sexual and Reproductive Health Rights calls upon states to enshrine the right to sexual and reproductive health in the justiciable parts of the constitution at the national level as well as emphasising to the lawyers, judges and prosecutors that this right can be enforced.³³⁰ This also buttresses Cook and Dicken's assertion that the patriarchal nature of the laws can be seen from their failure to effectively address women's rights, most notably their reproductive health rights. In doing so, maternal mortality and morbidity is mostly viewed merely as misfortune or bad luck rather than as a gross injustice or human rights violation that needs to be urgently remedied.³³¹ The health provisions in the Directive Principles include; Objective XIV (b) which calls upon the state to ensure that it fulfils the fundamental rights of all Ugandans to social justice and economic development by 'ensuring that Ugandans enjoy rights and opportunities and have access to health services...' Objective XV points out that the 'state should recognise the

³²⁷ *In the Constitution Court of Uganda, Kampala 'Centre for Human Rights and Development (CEHURD) and others v Attorney General', Constitutional Petition No. 16 of 2011, Decided 5 June 2012.*

³²⁸ CESCR 'Concluding Observations to Uganda (2015).

³²⁹ Technical guidance on Preventable Maternal Morbidity and Mortality' Twentieth Session (2 July 2012) Para 12.

³³⁰ Committee on Economic Social and Cultural Rights, 'General Comment No. 22 on the Right to Sexual and Reproductive Health (article 12 of the International Covenant on Economic and Social and Cultural Rights), E/C.12/GC/22, 2 May 2016 Para 64.

³³¹ Cook RJ and Dickens BM (2002) 225-231.

significant role that women play in society'. Objective XX emphasises that 'the state should take all practical measures to ensure the provision of basic services to the whole population'.

In 2005, an amendment to the constitution in terms of Article 8A was added which elevated the status of the directive principles. The amendment (8A (1) points out that 'Uganda shall be governed based on principles of national interest and common good enshrined in the 'National Objectives and Directive Principles of State Policy' (NODPSP).³³² Article 8A (2) mandated parliament to make laws for enforcement of the national objectives and principles of state policy. Still, over 10 years have passed since this amendment was made and no law has been made to give it effect. Honourable Margaret Zziwa justified the inclusion of this clause by stating that³³³

In order to strengthen the culture and spirit of nationalism, it is important to have the minimum interests or the minimum elements....to be the guiding principles of state policy. And these interests must be stated in the justifiable part of the Constitution in order to give them a permanent feature, which must be implemented by all Government agencies.

In the *Salvatori Abuki and another vs. Attorney General*, a series of NODPSP were read into Article 24 (human dignity and protection from degrading treatment) of the constitution.³³⁴ The judge stated that if the banishment order was implemented, the petitioner would be rendered homeless, thus depriving him of the right to food, shelter and other basic necessities that are necessary for an adequate standard of living, as set out in Article 25 of the UDHR. Thus, the judge maintained that the order violates Article 24 of the constitution.³³⁵ In relation to maternal health, the court ruled in the *CEHURD and others vs. Nakaseke District Local Government*, that by failing to promptly attend to Nanteza Irene, the actions or lack thereof, of the health worker and the hospital had led to her death from obstructed labour and thus had violated her maternal health rights as well as her right to basic medical care.³³⁶ This case is also discussed in greater detail in the next section.

Taking into consideration amendment 8A, with the various international and regional human rights treaties that Uganda has assented to, concluding observations to Uganda, the interdependent nature of human rights, Uganda's Constitution and the case law on maternal

³³² The Constitution (Amendment) Act 2005 Insertion of Article 8A.

³³³ Parliament of the Republic of Uganda (2005) *Hansard Report* August 15. The motion got 94 votes in favour of it, 3 members abstained and 0 were against. Available at <http://www.parliament.go.ug/new/index.php/documents-and-reports/daily-hansard> (accessed 20 October 2013).

³³⁴ *Salvatori Abuki and another v Attorney General* (Constitutional Case No.2 of 1997) UGCC 5 (13 June 1997),

³³⁵ *Salvatori Abuki and another vs... Attorney General*.

³³⁶ *In the High Court of Uganda, Kampala 'Centre for Health, Human Rights and Development and Others v Nakaseke District Local Government', Civil Suit No 111 of 2012, Decided 30 April 2015.*

health related rights, one can argue that the right to prevent maternal deaths and disability from preventable causes can be adjudicated before the Ugandan Courts of law. However, as detailed in the next section, in the *CEHURD and Others vs. Attorney General Case*, the Constitutional Court ruled that health issues were out of its jurisdiction and thus could only be decided by the legislature or the executive.³³⁷ Needless to say the Constitutional Court's decision was appealed to the Supreme Court and was overturned.³³⁸

Moreover, the contention about 'directive principles' is not restricted to Uganda. Globally, this is an on-going discussion whereby some scholars maintain that in an ideal situation, all the constitutional provisions should be justiciable as well as enforceable.³³⁹ Therefore, even if the justiciability of directive principles is still in question, courts have played a great role in ensuring that all clauses in the constitution are made to be enforceable. The courts rely on the argument that rights are interdependent and thus some cannot be achieved without others. This is so in the case of India whereby rights provided for in the justiciable parts of the constitution are used to enforce those in the directive principles. In the case of *Olga Tellis & 2 ors vs. Bombay Municipal Corporation & ors*, concerning the forceful eviction as well as the demolition of the structures of the slum dwellers, the India Supreme Court maintained that the right to life is inclusive of the right to livelihood because no person can live without the basic means of living. Thus the court turned the right to livelihood, which is in the directive principles of state policy into an enforceable right. Therefore, even if the court declined to provide the remedies requested by the applicants, lawyers and scholars have gone on to use it in as an example of using constitutionally recognised civil and political rights in advocating for social rights.³⁴⁰

Likewise, in the *A.P. Pollution Control Board vs. Prof M.V Nayadu*, the court broadly interpreted article 21 (right to life) of the Indian Constitution as encompassing the right to water. The court emphasised that it was incumbent upon the state under Article 21 of the Indian Constitution to ensure access to clean drinking water for the Indian population.³⁴¹ Ghana took a much bolder step by directly declaring the 'directive principle of state policy' as justiciable. This was in the case of *Ghana Lotto Operators Association vs. National Lottery Authority* which was decided by the Supreme Court in 2008. The court held that the Economic Social and Cultural rights spelt out in chapter six of the Ghanaian Constitution,

³³⁷ CEHURD and Others v Attorney General (Constitutional Court).

³³⁸ In the Supreme Court of Uganda, Kampala, 'Centre for Health Human Rights and Development (CEHURD) and others v The Attorney General', Constitutional Appeal No 1 of 2013, Decided 30 October 2015.

³³⁹ Okeke GN and Okeke C 'The justiciability of the non-justiciable Constitutional Policy of Governance of Nigeria' 2013)7 IOSR Journal of Humanities and Social Sciences 11.

³⁴⁰ Olga Tellis & ors. Vs. Bombay Municipal Corporation & ors. Etc. July, 10, 1985 scr 51.

³⁴¹ A.P.Pollution Control Bd.v.Prof.M.V.Nayudu, 2000 S.C.A.L.E.354, Para 3.

which provides for the directive principles of state policy, are themselves assumed to be justiciable.³⁴²

Apart from the Uganda Constitution, several legislation has been enacted over the years that aims at regulating the right to health. Those that are directly related to combating maternal mortality and morbidity include; the Nurses and Midwives Act Cap 274, which regulates the Uganda Nurses and Midwives Council, the National Drug Policy and Authority Act, which regulates the National Drug Authority, the Allied Health Professionals Act, Cap 268, which regulates the Allied Health Professional Association, and the National Medical Stores Act, Cap 207, which regulates the National Medical Stores. Since all this legislation regulates an institution or a professional association, they are discussed in greater detail in chapter four on administrative accountability.

3.3 ENFORCEMENT UNDER THE COURT SYSTEM

Enforcement is the process of instituting sanctions or putting in place adequate remedial/corrective measures for those who do not abide by set standards.³⁴³ In the human rights context, enforcement is not punishment-driven but rather aimed at correcting gaps within the system with an aim of making it more responsive to people's needs. In principle, enforcement is the crux of the legal system. The ability to provide remedies to those whose rights have been violated is the core of legal accountability. While human rights principles are often adopted at the international level, their implementation occurs at the domestic level through setting up strong national legal accountability machinery. This is also emphasized by human rights law that state that the governments ought to put in place adequate legal remedies for women whose reproductive health rights have been violated.

General Comment 22 on Sexual and Reproductive Health Rights calls upon states to ensure that all individuals have access to justice and the effective remedy, in instances where their sexual and reproductive health rights have been violated. These remedies may include but are not limited to, rehabilitation, compensation, restitution, guarantees of non-repetition.³⁴⁴ Similarly article 137(3) of the Ugandan Constitution states that any person who claims that an act of Parliament or any other law or anything done by a person or authority is not in line with the constitutional provisions may petition the Constitutional Court for a declaration to the effect or for redress.

³⁴² *Ghana Lotto Operators Association and others v National Lottery Authority* (2009)3 SCGLR 235.

³⁴³ Bovens M (2005)8.

³⁴⁴ CESCR, 'General Comment No. 22 ', Para 64.

Article 137(4) then states that whereupon the Constitutional Court, after the determination of the petition under clause (3) decides that there is need for redress, the court may grant an order for redress or refer the matter to the High Court to determine the suitable redress. Article 50 of the Uganda Constitution gives broad aspects of enforcement of rights by courts. It provides that any person or group of persons who alleges that a right has been violated or is about to be violated should petition court for redress. Courts in Uganda have interpreted this provision to include a number of issues. One important requirement is that for a person to petition court under Article 50, that person or group of persons need not be victims in themselves. This means an eye witness or any other bystander can petition court.

Second is a requirement that the right need not be violated. A person can petition court if he/she sees a right is about to be violated. These broad provisions give a wide range of powers for court to entertain any form of human rights violation.³⁴⁵ This section elaborates upon the cases that have been brought to courts on maternal mortality and morbidity. In looking at these cases it is emphasised that enforcement has to be comprehensive and does not end with the delivery of the judgment but goes beyond, to the implementation of the decisions given by the courts towards correcting the violation in question.

This section first lays out the facts of the maternal health cases and then an analysis is made of the litigation of these cases putting into consideration abounding discussions on litigating right to health issues.

3.3.1 CEHURD and Others vs. Attorney General (*In the Constitutional Court*)

Hoping to secure the justiciability of the ‘right to health’, the Centre for Health and Human Rights’ (CEHURD) brought a Maternal Health case (*CEHURD v Attorney General*) to the Constitutional Court of Uganda in 2011.³⁴⁶ The case was about the deaths of two expectant mothers in two different referral health centres. They were alleged to have died as a result of negligence on the part of health workers as well as insufficient basic maternal health commodities. Owing to the fact that the right to health is not guaranteed in the bill of rights, the petitioners relied on the directive principles where health is mentioned (objective 1(1), xiv (b), xx, xv, vii (b)), amendment 8A and also derived the right to health from other protected constitutional provisions; right to life (Article 22), rights of women (Article 33), rights of children (34) and freedom from degrading and inhuman treatment (Article 24 and 44(a)) and Article 287 (international agreements, treaties and conventions).³⁴⁷

³⁴⁵ Article 50 of the Ugandan Constitution.

³⁴⁶ CEHURD and others v Attorney General (2011)

³⁴⁷ CEHURD and others v Attorney General (2011) Para 1, 2, 4, 5.

The petitioners also relied on Article 45 of the constitution, which states, 'The rights, and guarantees relating to the fundamental and other human rights and freedoms and duties, declarations specifically mentioned in this chapter (bill of rights) shall not be regarded as excluding others not specifically mentioned' as well as article 137 (jurisdiction of the Constitutional Court) already set out in the above section. Thus, they alleged that the government's failure to provide basic maternal health commodities in government health facilities coupled with the unethical conduct of health workers towards expectant mothers were in contravention with the constitution.

That, the unacceptably high maternal (435 per 100,000) and new-born mortality (29/1000) rates as a result of; inadequate human resource, frequent stock-outs of essential medicines, non-provision of essential emergency obstetric care services at health centres (iii and iv), inadequate budgetary allocations to the health sector, lack of supervision of the public health facilities as well as unprofessionalism of health workers are contrary to the various provisions of the constitution already mentioned above.

Thus, the petitioners sought for an order from the court to the effect that the families of Sylvia Nalubowa, who died in Mityana Hospital and Jennifer Anguko, who died in Arua Regional Referral Hospital, as a result of several rights violations mentioned above, be compensated adequately.³⁴⁸ However, it is ironic that Article 21 on equality and freedom from discrimination was not included among the violated rights, yet, as set out in chapter two, it is at the heart of maternal mortality and morbidity. Article 21 sets out that, 'all people are equal before the law' and thus prohibits discrimination based upon sex, social or economic standing among others. The constitution further points out the need for enacting laws that put in place programmes to redress economic, social, and educational and any other imbalance in society.³⁴⁹ As elaborated upon in chapter two, a preventable maternal mortality or morbidity is often a result of some form of discrimination. In this case, Sylvia and Anguko were discriminated against on the basis of sex as well as their social/economic standing.

The UN Technical Guidance on MMM asserted that maternal mortality and morbidity is often a result of discrimination against women. It thus emphasized the obligation of states in eliminating all forms of discrimination while paying special attention to adolescents, women living in underserved areas and other stigmatized or vulnerable groups.³⁵⁰ Similarly in the *Alyne vs. Brazil* case, the CEDAW Committee pointed out that Alyne had been discriminated

³⁴⁸ CEHURD and others v Attorney General (2011) Para 2.

³⁴⁹ Constitution of the Republic of Uganda (1995) Art.21.

³⁵⁰ Technical Guidance on MMM Para 14 and 15.

against on the basis that she was a woman, poor and of African descent.³⁵¹ Thus, she had been subjected to numerous forms of discrimination that women experience while trying to access maternal health services.³⁵² Therefore, it is submitted that the petitioners should have included the provision on equality and freedom from non-discrimination as one of the rights that had been violated.

At the start of the hearing, the Attorney General raised a preliminary objection that the maternal health case posed a 'political question' and that by adjudicating it, the court would be interfering with matters, which are ordinarily preserved for the executive and the legislature. He further argued that the adjudication of this case required the court to examine the health policies to ascertain whether resources were indeed sufficiently allocated towards expectant mothers.³⁵³

In its judgement, handed down on 5th June 2012, the Constitutional Court concurred with the government in its ruling on the preliminary objections and emphasised that indeed the case raised a 'political question'. That, despite the fact the government had not allocated adequate resources to the health sector, issues such as this lay in the jurisdiction of the executive and legislature and they could not overstep their boundaries. In agreeing with the government, the court pointed out that the petition dealt with health centres and hospitals, the entire health sector and also expansively covered all expectant mothers. Therefore, the court had no authority to exercise its jurisdiction on issues necessitating the analysis of the health sector government policies. Doing so would be interfering in issues that were not under its jurisdiction. Subsequently, they dismissed the petition.³⁵⁴

The Constitutional Court's interpretation of the maternal health case was a very restrictive one. The decision was in contrast with Colleen and Aeyal's argument that courts should be emboldened to push systems towards inclusive public health care that ensures access for the most vulnerable groups. In doing so, the aim is not to replace policy decisions but rather to interrogate whether policy measures adhere to human rights standards.³⁵⁵ This is even more important in countries such as Uganda where the minority benefit from quality private health care leaving the majority who are poor to deal with inefficient and uninsured public health systems. Thus, in analysing health human rights challenges, courts should aim at addressing this imbalance/unequal situation.

³⁵¹ Alyne da Silva vs. Brazil, Para 7.7.

³⁵² Kismodi E et al (2012)33.

³⁵³ CEHURD and others v Attorney General (2011) Para 8.

³⁵⁴ CEHURD and others v Attorney General (2011) Para 20-27.

³⁵⁵ Flood CM and Gross A, 'Litigating the Rights to health: What can we learn from a Comparative Law and Health Care Systems Approach' (2014)16 *Health and Human Rights Journal* 62-72.

Also, the court's failure to determine whether the reading together of the articles above, indeed showed the existence of the right to health, posed an accountability gap. The court similarly failed to legitimize the position of the 'directive principles' in the constitution and to validate amendment 8A of the constitution. Even so, despite the outcome of the decision, this case was ground breaking as it was the first case dealing with maternal health in the Ugandan Courts and thus served as a test case. Furthermore, the mobilization around this case, which involved other like-minded organizations and academic institutions, raised public attention about the possibility of litigating maternal health issues in Uganda and beyond.³⁵⁶ In Uganda, it pushed maternal health issues in the limelight thus facilitating the opening up of policy and programmatic discussions/dialogues amongst various stakeholders dealing with maternal health issues. However, Salima emphasises that the social mobilisation process should be part of the entire litigation experience. Thus it should start even before the litigation as opposed to it being operationalised as a result of litigation as happened in the CEHURD Case.³⁵⁷

3.3.2 *CEHURD and others v the Attorney General (Constitutional Court Appeal)*

As a result of the dismissal of the CEHURD case by the Constitutional Court, it was appealed to the Supreme Court, which is the highest and last court of appeal.³⁵⁸ The appeal was brought on the grounds that the Constitutional Court erred in law when it; misapplied the 'political question' doctrine; held that the petition did not raise issues requiring constitutional application under Article 137 of the Constitution and decided that the petition asked them to review and implement health policies.³⁵⁹

On the issue that the petition did not raise issues calling for constitutional interpretation, the Supreme Court pointed out that from their pleadings, the appellants had clearly specified the acts and omissions by the government and the health workers, which they maintained were inconsistent with the constitution. The particular provisions of the constitution that the government and its health workers were alleged to have violated were also spelt out. The appellants also asked for specific declarations as well as redress. Thus the Supreme Court ruled that the matters raised competent questions for the court to hear, interpret and ascertain whether the petitioners' allegations warranted the Constitutional Court to issue the declarations or grant the redress sought as per article 137 of the constitution. Thus, on this

³⁵⁶ 'Real Justice could finally be delivered in Uganda by key ruling on maternal health'. Available at <http://www.theguardian.com/global-development/2015/nov/02/real-justice-could-finally-be-delivered-uganda-key-ruling-maternal-health> (Accessed 28 April 2016).

³⁵⁷ Namusoba S, 'Litigating the Right to Health in Uganda: The Necessity for innovation and activism', in E Durojaye (Ed) *Litigating the Right to Health in Africa: Challenges and Prospects*', (2015) 119-139.

³⁵⁸ ICEHURD and others v The Attorney General (2013).

³⁵⁹ CEHURD and Others v Attorney General (2013) Para 9-13

ground, the Supreme Court noted that the Constitutional Court had erred.³⁶⁰ The other issue that was the main bone of contention was that of the ‘political question’

3.3.2.1 The ‘Political Question’ Doctrine

The two grounds mentioned above upon which the appellants launched an appeal before the Supreme Court essentially boil down to the application of the political question doctrine in the Ugandan Courts of law. In deciding the validity of the ‘political question’, the lead judge defined it as ‘a question that Court will not consider because it involves the exercise of discretionary power by the legislative or executive branch of government---- also termed as non-justiciable question’.³⁶¹ She further stated the doctrine emanates from the principle of separation of powers.

The court pointed out the origin of the doctrine, which was in the United States of America in the *Marbury vs. Madison* (1803) case, where the court essentially ruled that the role of the courts was to decide on the rights of individuals and not to inquire how the executive perform their functions. The judge, however, pointed out that even in the USA, the doctrine has not had similar results in the courts as was seen in the *Baker vs. Carr* (1963) case where the court held that the political question could not stop the courts from deciding on the merits of the Tennessee’s system of allocating its State Legislature. He asserted that even if the case was about politics, it also raised questions of how the courts would go about granting relief if they declared Tennessee’s apportionment scheme unconstitutional, thus in that case the court had dismissed the invocation of the political question doctrine.³⁶²

Bringing it back to the Ugandan level, the judge emphasised Article 137(1) of the Constitution which states that ‘any question as to the interpretation of this Constitution shall be determined by the Court of Appeal sitting as the Constitutional Court’. For emphasis, she cited the *Paul Semwogerere and others vs. the Attorney General (Constitutional Appeal)* (2002) where it was decided that Article 137(1) empowers the courts with unreserved jurisdiction to entertain any question pertaining to the interpretation of any constitutional provision. Thus, with regard to interpretation, the Court’s powers are unlimited and unencumbered. She further added that `Article 137(3)(b) states that any person who claims that any act or omission by any person or authority contravenes a provision of the constitution, may petition the Constitutional Court for redress or a declaration to that effect where applicable.’

³⁶⁰ CEHURD and Others v Attorney General (2013) Para 18-24.

³⁶¹ CEHURD and Others v Attorney General (2013) Para 18-24.

³⁶² CEHURD and Others v Attorney General (2013) Para 49-56

She surmised that taking these constitutional provisions into full consideration would not allow for the upholding of the ruling made by the Constitutional Court. Subsequently, the judge ruled that the political question has very limited application in the context of Uganda as it only shields the executive and the legislature when they are properly executing the mandate given to them by the constitution. However, even in those instances, disputes will often come up challenging their action or inaction in respect to their constitutional mandate and whether it is in contravention of the constitution. The judge cited cases such as *Paul K Semogerere and Anor vs. the Attorney General* where the constitution struck down the referendum and other provisions on the basis that they had been passed without the appropriate quorum set out in the constitution.

Oloka Onyango and others vs. AG was also cited where the Anti-Homosexuality Act was struck down on the basis that it had been passed without parliament having the requisite quorum.³⁶³ The lead judge also set out that, if the Supreme Court upheld this decision, all the acts and omissions of the executive branch would be beyond judicial scrutiny leaving the constitution to only deal with violations by private actors. This would go against the constitution, which spelt out the need for all the arms of the state and everyone whether acting in their private or official capacity to respect and adhere to the constitution. Furthermore, that this would run contrary to the letter and spirit of the constitution, which recognizes the principle of separation of powers while at the same time putting in place a system of checks and balances between the executive, judiciary and legislative branches.

Therefore, based on these grounds, the Supreme Court unanimously ruled on the 30th October 2015 that the Constitutional Court hear the Petition No.16 of 2011 based on its merits.³⁶⁴ In agreement with the Supreme Court, Mulhern asserted that the judiciary is the only institution which is empowered with the role of interpreting a constitution and any act which limits the control of the judiciary on the interpretation of the constitution threatens rule of law.³⁶⁵ Thus, it remains to be seen how the Constitutional Court will deal with this case. Whether it will interpret women's right to maternal health services progressively - while putting into consideration the interdependent nature of rights - or it will adopt a restrictive and limited reading declaring that the right to health, is not justiciable within the Ugandan bill of rights. However, it would be expected that the Constitutional Court puts into consideration the observations from various committee reports whose treaties it has ratified as well as

³⁶³ CEHURD and Others v Attorney General (2013) Para 57-79.

³⁶⁴ CEHURD and Others v Attorney General (2013) Para 80-92

³⁶⁵ Mulhern JP 'In defence of the political question doctrine' (1988) 137 *University of Pennsylvania Law Review* 99.

other jurisdictions such as India and South Africa that have been progressive in interpreting the right to health.

Furthermore, courts are meant to be in tandem with societal challenges, thus with the unforgivably high maternal and mortality ratios in Uganda from causes that are preventable, it would be expected that the Court would consider responding to women's plight by offering them a clear legal avenue when their fundamental rights have been violated.

3.3.3 CEHURD and others vs. Nakaseke District Local Government (In the High Court of Uganda, Kampala)

Another case was brought by CEHURD to the High Court in Kampala, in 2012, together with Mugerwa on behalf of his deceased wife Nanteza Irene and their three children against Nakaseke District Local Government.³⁶⁶ The first Plaintiff (CEHURD) and the second plaintiff (Mugerwa David and his children) alleged that Nakaseke District Local Government had violated the right to life, right to health, freedom from inhuman and degrading treatment and equality of Nanteza Irene, including those of her children, when they failed to provide adequate medical treatment to the deceased. This was attributed to the delay in immediately attending to the deceased, as a result of the absence of the doctor who was meant to be on duty for the day, leading to her death as a result of an obstructed labour. The action was brought against the District Local Government that the plaintiffs said had oversight responsibility over the hospital.³⁶⁷

The case concerned Nanteza Irene a mother of three children who went to Nakaseke hospital in her advanced stages of labour. She was admitted, monitored and given intravenous drugs in preparation for her birth. However, about four hours into her admission, one of the nurses found her to be in obstructed labour and in urgent need of an operation to save both her life and the baby's. The nurses then started to look for a doctor to carry out the operation, but were informed by both the hospital administrator and the security guard that the on-duty doctor was not in the hospital. The doctor arrived over 4 hours after the nurses had confirmed that the mother was in need of urgent care. After about 8 hours from the time the expectant mother had arrived at the hospital, she died before the surgery could be carried out.³⁶⁸

In his judgement that was delivered on the 30th of April 2015, the judge found that the negligence of the hospital in dealing with the patient had led to her death. The judge noted

³⁶⁶ CEHURD and Others v Nakaseke District Local Government (2015).

³⁶⁷ CEHURD and Others v Nakaseke District Local Government (2015) Para 2-8.

³⁶⁸ CEHURD and Others v Nakaseke District Local Government (2015) Para 11-31.

that from the testimony given by the various nurses on duty, the doctor had not been at the hospital premises when he was urgently needed, having left in the morning and returned late evening when it was too late to save the patient. The judge expressed his grave disappointment with the doctor's subsequent fraudulent and deceitful actions aimed at placing himself near to the hospital, which included adjusting the time he had arrived, failure to record the exact time of death of the mother as well as the exact cause, saying he had been in the HIV wing which was a mere ten minute walk away from the maternity ward.³⁶⁹

The judge also registered his suspicion regarding the circumstances under which one of the nurses that had testified in the case, had been transferred to another hospital and thus asked that the matter be immediately investigated. He further noted his disappointment with the fact that despite his behaviour, the doctor in question had been recently promoted to Medical Superintendent. He thus stated that the hospital administration was directly liable as they had oversight responsibility over the management of the hospital and staff. The judge also noted that the hospital administrator had been informed of the absence of the doctor as well as the urgent state of the expectant mother, but had not devised any means to expeditiously address the issue including immediate transfer of the patient to another hospital.³⁷⁰

The Nakaseke District Local Government was subsequently found in violation of the right to life, access to efficient medical care, dignity and equality for both the mother and her family. Their failure to effectively supervise health personnel to ensure that they were present when needed had led to the death of the plaintiff. The Local Government was thus asked to pay 35 million Uganda Shillings. The judge also questioned why the plaintiffs had not joined the doctor in question as well as the hospital administrator to the application for the immediate damage caused by their actions or lack of thereof.

He advised that even though they had not been joined to this application there was nothing to stop the plaintiffs from causing criminal proceedings against both of them under the Penal Code Act for neglect of duty that had led to the death of both mother and child³⁷¹ This case was ground breaking as it was the first case in which the court determined the violation of maternal health rights as well as the right to basic medical care. Thus, health activists hoped that they would use this precedent to bring to the Courts more health rights violations.³⁷²

³⁶⁹ CEHURD and Others v Nakaseke District Local Government (2015) Para 34-84

³⁷⁰ CEHURD and Others v Nakaseke District Local Government (2015) Para 34-84

³⁷¹ CEHURD and Others v Nakaseke District Local Government (2015) Para 85-103

³⁷² Green A 'A victory in the Path to Maternal Health Care in Uganda', Women across Frontiers 25 August 2015. Available at <http://wafmag.org/2015/08/a-victory-in-the-path-to-maternal-health-care-in-uganda/> (Accessed 06 July 2016).

Three months after the judgement, the Chief Administrative Officer of Nakaseke District Local Government handed out the first cheque worth 9.4 million Uganda Shillings to Mugerwa David (the husband of the deceased). CEHURD (one of the plaintiffs), commended the local government for promptly taking steps towards implementing the order delivered by the High Court. The status of Nakaseke District hospital was noted to also have been enhanced to include a new out patients' department, three isolation wards, two theatres and the supervision was also said to have improved considerably.³⁷³ This goes to show that the attention brought to women's maternal health conditions through litigation can help to shed light on maternal mortality and morbidity thus contributing to its improvement. Thus, the need to sustain strategic litigation especially on behalf of the vulnerable and often uneducated people is emphasised. The courts should also be continuously tested to give normative content to this right.

3.4 AN ANALYSIS OF THE MATERNAL HEALTH CASES.

The cases above reveal that litigation on maternal mortality and morbidity is gradually and tentatively being introduced to the Ugandan Courts but is still in its infancy stage. To that end, the Courts have not yet developed the contours of the right or given it normative content. By dismissing the petition, the Constitutional Court in the *CEHURD and Others vs. Attorney General* did not make use of the opportunity to put in place guidelines to be followed in interpreting cases pertaining to maternal mortality and morbidity. Thus, it missed out on the opportunity to indigenise jurisprudence on socio-economic rights in a way that could guide lower courts when faced with cases of a similar nature.

The *CEHURD and others vs. Nakaseke District Local Government* was the first case in which the courts found a violation of the right to maternal health care. The Nakaseke judgment was a mixture of a cause of action in negligence and an action based on the violation of constitutionally guaranteed rights.³⁷⁴ Therefore, the court could have ruled on the matter by solely relying on the cause of action in negligence. Indeed, the court found that the doctor caused the death of the petitioner by neglecting his duty to care for the deceased. Yet, the judge also ruled that the failure to promptly provide medical care to the deceased was a violation of her maternal health rights as well as the right to basic medical care.

³⁷³ Jaramogi P 'District Compensates family of Dead Patient', *The New Vision*, 16 August 2015. Available at http://www.newvision.co.ug/new_vision/news/1332742/district-compensates-family-dead-patient (Accessed 06 July 2016)

³⁷⁴ 'Ugandan High Court finds human rights violations where a pregnant woman died of a ruptured uterus and blood loss while in labour 'Legal Grounds III, Case 20. Available at http://www.law.utoronto.ca/utfl_file/count/documents/reprohealth/lg-20_cehurd_nakaseke_uganda.pdf (Accessed 10 December 2016).

However, the reference to the constitutional rights is scanty as the content of the violated rights is not fleshed out or elaborated upon.³⁷⁵

Though, it should be stressed that unlike the *CEHURD and Others vs. Attorney General*, which was brought under Article 137 dealing with the interpretation of rights, the *CEHURD and others vs. Nakaseke District Local Government* was brought under Article 50 of the Constitution, which strictly deals with enforcement of rights. Therefore, the matter before the High Court did not concern the interpretation of a right but rather sought to find a violation of the right to maternal health care. The court that is charged with the interpretation of rights is the Constitutional Court. Thus, having found that the doctor caused the death of the petitioner by neglecting his duty to care for the deceased and having ruled that the petitioner should be suitably compensated, it was not within the High Court's powers to interpret or give normative content to the right to maternal health care.

Article 50 sets out any 'competent court' as any forum for enforcement of human rights and that parliament shall make laws for the enforcement of rights. To this end, the 1992 rules state that the application shall be filed in the High Court.³⁷⁶ Thus, in the *Ismael Serugo vs. KCC & Attorney General (Supreme Court)* it is emphasized that the Constitutional Court may address matters related to Article 50 and Article 137, but ultimately, unless the action requires constitutional interpretation, the High Court is the court of first instance.³⁷⁷

In analysing Article 50 of the constitution, Twinomugisha, poses the question - if a person wants to challenge discriminatory laws that violate women's right to health care, what would be the competent court to decide on the matter?³⁷⁸ In responding to this question, he asserts that Article 137 of the Constitution provides that the Court of Appeal sitting as the Constitutional Court shall determine any questions pertaining to the interpretation of the Constitution.³⁷⁹ However, he takes the position (dissenting) taken by Justice Kanyeihamba in the *Simon Kyamanywa vs. Uganda* case that any Court /tribunal that is suitably constituted has jurisdiction to hear and rule on any dispute arising from the application and enforcement of any constitutional provision.

Adding, if it were decided that any matter relating to any constitutional provision had to go to the Constitutional Court for interpretation or construction, the constitution would be rendered

³⁷⁵ http://www.law.utoronto.ca/utfl_file/count/documents/reprohealth/lg-20_cehurd_nakaseke_uganda.pdf

³⁷⁶ Turyamubona E 'The law applicable for enforcement of Fundamental Rights and Freedoms in Uganda'. Available at www.academia.edu. (Accessed 03 January 2017).

³⁷⁷ Turyamubona E 'The law applicable for enforcement of Fundamental Rights and Freedoms in Uganda'. Available at www.academia.edu. (Accessed 03 January 2017).

³⁷⁸ Twinomugisha BK 'Exploring judicial strategies to protect the right of access to emergency obstetric care in Uganda' (2007) 7 *African Human Rights Journal* 293-296.

³⁷⁹ Twinomugisha BK (2007) 293-296.

stale and unpredictable.³⁸⁰ Thus, it is submitted, that having been progressive in declaring the violation of the right to maternal health care as well as other rights such as women's rights set out in Article 33 of the Ugandan Constitution and children's rights as set out under Article 34 of the Constitution, the High Court should have elaborated upon the content of the right to maternal health care using principles set out in case law from Uganda, other jurisdictions as well as the human rights documents in a way that it can set precedent. In fact, on the whole, the judgement steers clear of human rights norms and principles. These principles include the 'reasonableness' approach set out in General Comment 3 of the Committee on Economic Social and Cultural Rights³⁸¹ and further developed by the South African Courts in cases such as the Grootbroom Case³⁸² or the 'Minimum Core Content' set out in human rights documents such as the General Comment 14.

Since the role of interpreting constitutional provisions primarily falls with the Constitutional Court, as per Article 137, it is expected that in deciding on the *CEHURD and Others vs. Attorney General*, which was reverted back to it by the Supreme Court, the Constitutional Court will be more elaborate in fleshing out human rights principles pertaining to MMM. One of the relevant documents would be General Comment 2 of the Maputo Protocol. As elaborated above, the petitioners alleged that the failure by the government to provide basic maternal health services, leading to the unavoidable deaths as well as morbidities of hundreds of women, coupled with unethical conduct of health workers is in contravention of various provisions of the constitution already mentioned above.

Their allegations are in line with General Comment 2 provisions which emphasize state responsibility in ensuring availability, accessibility of quality sexual and reproductive health care services. Government is obliged to provide comprehensive, rights-based and integrated services. To this end, General Comment 2 emphasises that the national public health plan should be inclusive of comprehensive sexual and reproductive health services protocols and guidelines that are in line with current evidence based established by WHO as well as the other relevant United Nations documents.³⁸³

The petitioners also sought that the families of those who had died from preventable maternal health causes be adequately compensated. This is also stressed by General Comment 2, which sets out that administrative appeal and complaints mechanisms be put into place to allow women to fully exercise their rights and access the remedies provided

³⁸⁰ Twinomugisha BK (2007) 293-296.

³⁸¹ Committee on Economic Social and Cultural Rights, General Comment No 3, The Nature of state obligations (Art,2,Para 1 of the CESCR) 1990.Doc. No.E/1991/23.

³⁸² *Government of the Republic of South Africa and Others v Grootbroom and Others Para 42.*

³⁸³ General Comment 2 of the Maputo Protocol Para 29-30.

within the timelines.³⁸⁴ It is stressed that by making use of human rights documents such as the General Comment 2, the court will be in position to give the much needed interpretive guidance to the right to adequate maternal health care in a bid to combat preventable MMM.

Additionally, in the Supreme Court ruling, in overturning the Constitutional Court ruling, it would have been expected that in countering the political question (separation of powers), the judge would make reference to the human rights principle of the ‘interdependence of rights’. In fact, the petitioners themselves relied on this principle by reading a series of rights as having been violated as a result of the death of the two mothers from preventable maternal health issues. These included; right to life (Article 22), rights of women (Article 33), rights of children (34) and freedom from degrading and inhuman treatment (Article 24 and 44(a)).³⁸⁵ Nonetheless, there was no reference to it as the judge restricted the arguments to case law both from Uganda and from the US where the political question is said to have originated.

It is also surprising that in both judgements, there is no reference to any international or regional human rights documents, that Uganda has ratified, that provide for the right to maternal health care. The minimal or lack of utilisation of human rights norms and principles in arriving at judgements may be attributed to non-familiarity by judges on developments in the human rights field pertaining to reproductive health rights. This observation ties in with the CEDAW Committee observation on Uganda pertaining to the lack of knowledge on critical human rights treaties and principles by various Government branches including the judiciary.³⁸⁶ Therefore, awareness raising on human rights norms and principles should not exclude the judicial officials. Consequently, it is hoped that if the Constitutional Court arrives at a decision for the case, it shall be comprehensive enough, setting out the contours of the right to maternal health care which can act as a precedent.

Nevertheless, a few notable issues arose from the *CEHURD and others vs. Nakaseke District Local Government*. In delivering the judgement, the judge takes into consideration the impact of the judgement on the continued operation of the hospital. In other words, he is careful in ensuring that by setting out the costs to be met by the hospital for the petitioner (Nanteza Irene), he doesn't cripple the running of the hospital to enable it to continue delivering the much needed services. Thus, he aims at achieving a balance between the individual rights that have been violated and the rights of other service users. This is vital to take into consideration in the context of achieving equity as exorbitant individual claims may

³⁸⁴ General Comment 2 of the Maputo Protocol Para 29

³⁸⁵ CEHURD and others v Attorney General (2011) Para 1, 2, 4, 5.

³⁸⁶ Concluding observations of the Committee on the Elimination of Discrimination against Women, Uganda (2010) Para 14.

cripple the access to services for other groups, especially the marginalized groups who cannot access legal services.

Gloppen asserts that the bringing of many litigation cases to the courts around health rights claims, especially those seeking individual remedies, might lead to a situation that has been referred to as a 'litigation pandemic'. This has been pointed out in countries like Brazil, Columbia, Costa Rica and Argentina. Most of the cases brought to the courts in line with health, concern individuals who have been denied access to treatment, who subsequently sign an urgent writ of protection claiming a breach of fundamental rights. In deliberating on such cases, courts often use statements from the doctors of the patients to confirm that the treatment that has been denied is vital for the effective treatment of the patient's medical condition.³⁸⁷

The Courts then often decide in favour of the patients and owing to the civil law tradition, these judgements are often not precedential, thus there maybe numerous cases asking for the same type of treatment. This form of litigation has been criticized by the policy makers and the health administrators who maintain that it compromises their ability to put the limited resources to maximal use in a way that will benefit all members of the population especially the vulnerable ones.

It is also argued that this 'litigation pandemic' further worsens the inequalities as it is mostly those who are advantaged who are in position to bring cases to the courts, thus enabling them to jump the queue and divert scarce resources their direction.³⁸⁸ This is counter to principles set out in the Technical Guidance on Maternal Mortality which emphasises that human rights must pay particular attention to vulnerable, marginalized and often excluded populations.³⁸⁹ Ultimately, it is vital for litigants to put into consideration the complexity of the health sector, comprising numerous power and information centres such as health administrators, policy makers, service providers (pharmaceutical and insurance companies) and the service users.³⁹⁰ Therefore, trade-offs have to continuously be made at all levels of the health centres to equitably utilize the limited scarce resources towards the realization of the right to health for all.

Another issue to point out in the *CEHURD vs. Nakaseke District Local Government Case* is how the power dynamics that operate at health centres influence access to justice for the vulnerable members of the population. The judge reveals the attempts by the doctor on duty

³⁸⁷ Gloppen S *Right to health in contexts of resource Capacity: towards judicial enforcement of the right to a fair share* Centre on Law and Social Transformation Working Paper, CMI, University of Bergen (May 2015) 5-6.

³⁸⁸ Gloppen S (2015) 5-6.

³⁸⁹ Technical guidance on Preventable Maternal Morbidity and Mortality (2012) Para 15.

³⁹⁰ Yamin AE, 'Promoting Equity in Health. What role for Courts?' (2014)16 *Health and Human Rights* Editorial.

by virtue of his position, to use various means to cover up his absence from the hospital including manipulating the facts and the times surrounding the maternal death. Furthermore, the nurses on duty seem reluctant to give information for fear of repercussions from their boss who happens to be the doctor. The hospital administrator, in writing his report, also omits the absence of the on-duty doctor from the hospital at the time when the emergency occurs. Even more surprising is that at the time of hearing the case, it is revealed that one of the nurses that testified in the case has been transferred to another hospital while the doctor whose absence is said to have contributed to the preventable maternal death has been promoted to a higher post of medical superintendent. These events clearly depict the role of power dynamics within the health systems and how they affect accountability and yet these are often overlooked.

Freedman points out that most accountability approaches avoid dealing with the dynamics of power operating within a health system. For instance, unprofessional behaviour by health workers may persist and become accepted or even expected, despite laws and professional standards discouraging it.³⁹¹ To this end, more often norms and values rather than policies and laws greatly influence individual as well as organizational behaviour. Yet, in devising interventions, the fixation is often on putting in place new laws, policies as well as adopting best practices from elsewhere. This often leads to a situation of well-drafted legal and policy documents with well-spelt out indicators, yet the dysfunction on ground persists. This explains the well-worn lamentation of policies that never translate into practise. Therefore, it is vital to bring a critical lens to the complex workings of power and how they affect access to health services.³⁹²

It is also submitted that the *CEHURD and others vs. Nakaseke District Local Government* case could have been easier to deliberate upon because it applied to an individual and thus relief could be sought more easily. On the other hand, in the *CEHURD and Others vs. Attorney General*, while relief was being sought for the two women whose rights had been violated, the petitioners also sought relief that went beyond the individual to systemic choices touching in policy decisions. Thus, it is forwarded that one of the reasons for turning down the case, could have been because the judges felt that they were not equipped to deal with deciding on policy issues thus deeming them as belonging to the executive. Dennison also intimates that the court could have been hesitant to define the right to health because of the enormous work that it would entail. The court could also have been wary of opening the

³⁹¹ Freedman LP and Shaaf M (2013) 103-112.

³⁹² Freedman LP and Shaaf M (2013) 103-112.

flood gates for all individuals who felt that their right to health had been infringed upon thus they chose to side step the huge responsibility by declaring it a political question.³⁹³

In agreeing with this position, Yamin postulates that sometimes judges' reluctance to recognize the justiciability of social demands may be that they feel that their capacity is limited. She recommends that in adjudicating such cases judges may consider the mixing of 'weak/soft' remedies together with 'harder' ones. An example of 'soft' remedies are those whereby courts do not define the policies themselves but force the executive or legislative branches of government to devise policies and programmes to address the challenge before them.³⁹⁴ She gives an example of the *Treatment Action Campaign* case where the government was asked to come up with a Plan of Action for ensuring the prevention of mother to child transmission of HIV, while putting into consideration the scourge of HIV/AIDs in South Africa.³⁹⁵ On the other hand, 'harder' remedies may include imposing strict deadlines for compliance.³⁹⁶

That in such cases, courts set timelines for the putting in place of such programmes and remain seized with the case for supervisory purposes. Examples are given of Argentina, Columbia and India where the courts have continued to be involved in tracking the implementation of decisions including those involving the rights to health.³⁹⁷ However, the success of these structural orders is highly dependent on willingness by the political arms of Government to comply with the court orders towards the implementation of the orders. Conversely, such orders are sometimes met with hostility or indifference from the political branches of government.³⁹⁸ In Uganda, some instances have been recorded of blatant disregard for the courts of law, which are elaborated upon in the answerability section of this chapter. In such a context it would be an uphill task for the implementation of such orders but nonetheless, should not dissuade judges from playing their role in ensuring access to justice for violations leading to maternal deaths and morbidities.

Ultimately, the adjudication of cases pertaining to maternal deaths and morbidities is an uphill task especially in the context of Uganda where the justiciability of the right to health is still in question. As highlighted by Ngwena, in the absence of succinct constitutional mandate, courts are in murky waters when it comes to adjudication of the right to health.

³⁹³ BD Dennison BD 'The Political Question Doctrine in Uganda: A reassessment in the wake of CEHURD' (2014)18 *Law, Democracy and Development*.

³⁹⁴ Yamin AE (2014) Editorial.

³⁹⁵ *Minister of Health and Others v Treatment Action Campaign and Others (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002).*

³⁹⁶ Yamin AE (2014) Editorial.

³⁹⁷ Yamin AE (2014) Editorial.

³⁹⁸ Yamin AE (2014) Editorial.

Even where there is a constitutional mandate, courts may be restrained in order not to seem to be overstepping into the realm of the executive.³⁹⁹

Deciding on health rights issues is not just a matter of deciding between two opposing factions, but more often involves reconciling mutually interacting variables. Thus, it entails making difficult decisions pertaining to resource allocation and contentious policy decisions. Ultimately for judicial accountability to be realized, courts should develop both the constitutional but more importantly the institutional capability to adjudicate maternal health issues.⁴⁰⁰ It should also be emphasised that enforcement of maternal health rights goes beyond litigation. Therefore, it is forwarded that a series of mechanisms should be adopted alongside litigation which include social mobilisation, capacity building of various concerned stakeholders, coalition building and the use of administrative regulatory bodies such as the commissions or the professional associations to enforce rights. These are discussed in greater detail in the subsequent chapters.

3.4 ANSWERABILITY FROM THE LEGAL PERSPECTIVE (Court System)

Answerability is twofold; first it is the process by which duty bearers share all the relevant information on available legal remedies.⁴⁰¹ It should not be assumed that information sharing/awareness creation will automatically lead to improved participation. Thus, information sharing should be deliberately packaged so as to encourage and ultimately increase participation of communities in judicial processes. Increased participation can be seen through the number of people accessing the judicial structures.

The second aspect of answerability is establishing supervisory/ monitoring/tracking mechanisms to continuously oversee these institutions and inform themselves about whether they are performing as expected. Processes must be inbuilt within these monitoring systems whereby judicial officials can justify decisions taken or not taken.⁴⁰² It is vital to point out, once more, answerability does not equate to participation or monitoring. However, it combines elements of information sharing, participation, monitoring/tracking as well as continuous justification of decisions taken. Therefore, in the human rights context, answerability aims at ensuring access to justice especially for the marginalised groups that are often overlooked in the judicial system.

³⁹⁹ Ngwena C, 'Scope and Limits of judicialization of the Constitutional Right to Health in South Africa: An appraisal of key cases with particular reference to justiciability' (2013)14 *Journal of Health Law* 43-64.

⁴⁰⁰ Ngwena C (2013) 43-64.

⁴⁰¹ DW Brinkerhoff DW 'Accountability and health systems :toward conceptual clarity and policy relevance' (2004) 19 *Health policy and planning* 372

⁴⁰² DW Brinkerhoff (2004) 19 372

3.5.1 Access to Justice

Access to justice can be achieved through ensuring that all members of the population regardless of their socio-economic status are in position to access courts when their rights have been violated. Legal systems are plagued by a striking contradiction. While the law is aimed at achieving justice, the parties involved are usually unequal. Therefore, in actuality, the powerful and the wealthy often have more chances of benefiting from the legal systems.⁴⁰³ Therefore, the law is a double-edged sword as it is a tool exploited by those who possess or hold power to control and subjugate those over whom control is being exercised. On the other hand, activists can use the law to reverse unjust practises and bring about fundamental change.⁴⁰⁴

Formal courts are often perceived by rural/ local communities as removed from their daily lived experiences. Access to justice for women generally, and in line with maternal health related rights, leaves a lot to be desired. A series of combined factors, hinder women from accessing the legal structures. First off, are the high illiteracy levels already pointed out in chapter two. In a bid to access justice, high illiteracy levels amongst women hinder them from understanding the language (English) used in the formal courts of law thus keeping them away from the formal court systems.⁴⁰⁵ The high illiteracy levels compound the lack of awareness regarding how the courts operate and which courts to reach out to in case their reproductive health rights have been violated.⁴⁰⁶

Ignorance about judicial operations is not only restricted to vulnerable or rural illiterate communities. There is a wide spread level of ignorance on the role of the judiciary, as well as people's rights, and the responsibility as spelt out in the constitution. This may be attributed to among other factors, a non-inclusive curricular, at the lower levels (primary and secondary schools) that does not involve creating awareness about the Constitution and how the various arms of Government perform as well as interact with each other.⁴⁰⁷ As a result of the high illiteracy levels, coupled with ignorance, in instances of violation of their reproductive health rights, many women and their families especially those in rural areas do not view preventable maternal mortality and morbidity as a human rights violation but mostly as an unfortunate incident.

⁴⁰³ Maru V, 'Social Accountability and Legal empowerment' (2010)12 *Health and Human Rights* 83-93.

⁴⁰⁴ Tamale S (2014) 150-171.

⁴⁰⁵ Rural Women and access to justice: FAO's contribution to a Committee on all forms of Discrimination against Women (CEDAW) half-day general discussion on access to justice (Geneva 18 February 2013), 5.

⁴⁰⁶ Action Aid 'Strategies for success access to justice for women, 2011, 8. Available at

<http://www.actionaid.org/publications/strategies-success-access-justice-women?width=960&inline=true>

(Accessed 11 July 2016).

⁴⁰⁷ CA Baldwin CA *Combating Judicial Corruption in Uganda* The Brookings Institution, Washington DC, September 2009, 4.

Another factor is that of the cost of accessing courts. Many women, especially those leaving in rural areas, are often not in position to afford the high legal fees needed to acquire legal services. Over 7 million people are estimated to be living below the poverty line in Uganda with majority of these living in rural areas, yet legal aid services are concentrated in urban areas.⁴⁰⁸ Also, the accessibility of the courts in terms of how they are spread out in the various regions of Uganda, their distance and which parts of the population can access them.⁴⁰⁹ It is estimated that over 85 percent of the lawyers are concentrated in Kampala living about 84 percent of the population without adequate access to legal representation. The majority have to rely on other forms, such as the Local Council Courts.⁴¹⁰ Currently, the justice centres have only four offices serving an ever growing population of over 30 million people in over 120 districts. These offices are located in; Lira, Tororo, Hoima and Kampala (Mengo)⁴¹¹

One's ability to seek a legal remedy is greatly determined by the content of the laws. The inability of laws to expressly provide for women's health rights affects the extent to which they can access justice. Similarly, as has been elaborated upon in chapter two, gender neutral laws disproportionately impact on women as they ignore existing inequalities.⁴¹² For instance, the failure to adequately provide for socio-economic rights such as the right to health, in the bill of rights, as is the case with Uganda where they are reserved for directive principles, adversely affects women. The undermining of women's rights can be seen when one looks at the pervasively high maternal mortality rates on the one hand, and on the other hand, the reluctance of courts to adjudicate maternal health issues.

These factors make the courts of law removed from the daily circumstances of the average Ugandan woman. It is for this reason that for many women whose rights have been violated, their first point of contact is not the formal courts of law but the local council structures as well as religious and cultural institutions that are often more accessible to them. Local Council Courts (LCCs) were previously called Resistant Committee Courts that were introduced in 1986 by the National Resistance Movement (NRM). The LCCs were formed in order to bring justice closer to the grassroots level, be more responsive to

⁴⁰⁸ Uganda, Draft National Legal Aid Policy (2012) Para 24

⁴⁰⁹ Uganda, Draft National Legal Aid Policy, 2012) Para 2.

⁴¹⁰ Uganda, Draft National Legal Aid Policy, 2012) Para 25.

⁴¹¹ 'Justice Centres Uganda'. Available at <http://www.justicecentres.go.ug/index.php/2014-11-27-11-30-03/about-us> (Accessed 07 July 2016).

⁴¹² Rural Women and access to justice: FAO's contribution to a Committee on all forms of Discrimination against Women (CEDAW) half-day general discussion on access to justice (Geneva 18 February 2013), 3.

customs/traditions and to simplify the administration of justice.⁴¹³ However, while LCCs are often more accessible to them, they are often perceived by women as being biased about them.

The LCCs subscribe to the patriarchal societal systems that often regard women's rights as inferior to those of men. For instance, on land related issues, if a woman lives with her husband, if she takes a land related dispute to the male dominated LCs, chances are that she will find her husband's social companions and relatives within the executive committee, especially at the lower levels such as the village and the parish.⁴¹⁴ If this is the case with land, one would imagine the challenge related to trying to access justice for reproductive health rights at the local level where as elaborated upon in chapter two, the overriding perception is that women belong to their husbands. Thus, their primary role is to bear children, mostly sons to advance the family name.

Amongst the avenues that have been pursued to ensure access to justice for vulnerable women is legal aid. The Lilongwe Declaration on Accessing Legal Aid in Criminal Justice Systems in Africa (2004) set out that legal aid goes beyond mere legal representation to include education, advice and assistance as well as alternative dispute resolution mechanisms on both criminal and civil matters. It emphasised the government's responsibility in undertaking measures and allocating resources towards transparent and effective legal aid for the poor and vulnerable especially the women and the children thus enabling their access to justice.⁴¹⁵ Legal aid for vulnerable people especially in accessing maternal health rights can be captured in the spirit of Article 21(4) of the Ugandan Constitution which states that nothing in this article shall preclude parliament from enacting laws aimed at redressing social, educational, economic and other imbalance in society.

To that end, a sector wide approach to the judicial sector was adopted by the government. The Justice Law and Order Sector (JLOS) was established to bring together institutions with similar mandates in the administration of justice, rule of law, and upholding human rights. The sector comprises of numerous institutions including but not limited to; Ministry of Justice and Constitutional Affairs, The Judiciary, The Department of Public Prosecutions (DPP), Judicial Service Commission, The Ministry of Local Government (Local Council Courts), The

⁴¹³ Oloka-Onyango J and Tejan-Cole A 'Reassessing Customary Law Systems as a vehicle for providing equitable access to justice for the poor', working paper produced for the World Bank Conference 'New Frontiers of Social Policy: Development in a Globalizing Word', December 12-15 2005,6.

⁴¹⁴ Khadiagala LS The failure of popular justice in Uganda: Local councils and women's property Rights. (2001) 32 *Development and Change* 57.

⁴¹⁵ 'The Lilongwe Declaration on Accessing Legal Aid in Criminal Justice Systems in Africa: Conference on Legal Aid in Criminal Justice: the Role of Lawyers, Non-Lawyers and other Service Providers in Africa', Lilongwe, Malawi, November 22-24, 2004.

Ministry of Gender Labour and Social Development (Probation and Juvenile Justice), The Uganda Law Reform Commission, The Uganda Human Rights Commission and the Uganda Law Society among others.

Amongst the intended outcomes of JLOS is to reduce the amount of time taken to access JLOS institutions by ensuring access within a 15 km radius.⁴¹⁶ To this end, in 2012, JLOS drafted the Legal Aid Policy aimed at ensuring the provision of legal aid services to the poor in Uganda. The policy also aimed at; consolidating the legal framework pertaining to legal aid, and applying a ‘means and merits’ test to ensure that those vulnerable people who qualified indeed got the service. However, to-date, the bill has not yet been finalized and enacted into law.⁴¹⁷ Also, the adoption of this policy, is not guaranteed to improve access to justice as a series of laws and policies already exist aimed at improving access to justice, yet the political, financial, technical and legal will to implement them is still lacking.

Currently both public entities and private entities provide legal aid services. These include; State Briefs scheme (operated by the judiciary), Justice Centres (with pilot sites in Lira and Tororo districts that operate as a one-stop centre. They provide legal aid services both for criminal and civil cases for the vulnerable persons while at the same time empowering individuals to claim their rights and demand for change), Uganda Human Rights Commission, community based legal aid (provided by local council courts in areas where other JLOS institutions lack presence), Uganda Law Council, the regulatory body for advocates and legal aid service providers, operates a pro-bono scheme, Legal Aid Project (operated by the Uganda Law Society), Law Clinics (Law Development clinic has a law school clinic model providing legal aid services), Para-legal Advisory Services (provide legal services including education, counselling ,referral) and Independent Legal Aid Service Providers (LASPNET) (a network of civil society organizations providing legal aid services).⁴¹⁸

However, the provision of legal aid services is done in a haphazard, non-consolidated manner which has been referred to as ‘patch work’. This is due to the fact that it is often limited in scope, extremely understaffed, concentrated in urban areas, at the discretion of the service providers, dependent on external funding, thus only ends up reaching and benefiting a small part of the population.⁴¹⁹ It is for this reason that JLOS proposed the formulation of

⁴¹⁶ Judicial Service Commission ‘The justice, Law and Order Sector: An Overview’. Available at http://www.jsc.go.ug/index.php?option=com_content&view=article&id=73&Itemid=90 (Accessed 03 July 2016).

⁴¹⁷ ‘Uganda: Quickly approve policy on Legal Aid’, *The Monitor*, 8 April 2016. Available at <http://allafrica.com/stories/201604080068.html> (Accessed 03 July 2016).

⁴¹⁸ Uganda, Draft National Legal Aid Policy (2012) Para 56- 78

⁴¹⁹ Uganda, Draft National Legal Aid Policy (2012)

the legal aid policy to consolidate, upscale legal aid and to ensure that the state takes primary responsibility for its operationalisation. However, the fact that to date the bill has not yet been adopted or enacted into law leaves a lacuna in the system.

Another challenge with the formal court system approach is that it is dependent upon the litigants' ability to prepare and argue a winning case. This is counter-productive for vulnerable women who often lack resources to acquire and pay seasoned lawyers that are better positioned to win cases. Therefore, possibly one of the most innovative approaches that have been introduced within the court system to improve their 'answerability' nature is the principle of 'meaningful engagement' introduced within the South African judicial system. Meaningful engagement creates a platform where the voices of the poor, uneducated are heard and taken into consideration while arriving at a judgement.

It has mostly been used in housing litigation and was elaborated upon in the *Olivia Road Case*. The case concerned over 400 occupiers of two buildings in the inner city of Johannesburg who were challenging their eviction by the City of Johannesburg on grounds that the buildings they inhabited were unhealthy and unsafe.⁴²⁰ In the interim, the court ordered both the city and the occupiers to engage meaningfully with each other and then report back to the court at a specified time with the results of the engagement, which would be considered while arriving at a decision.⁴²¹ The court stressed that it was not right to grant an eviction order, in the circumstances of the case, unless some form of 'meaningful engagement had been conducted.⁴²²

In justifying the need for meaningful engagement, the court set out that section 26 of the South African constitution provides for the right to housing and also requires the state to take 'reasonable' measures towards realizing this right. The court specifically included meaningful engagement in Article 26(3) as one of the 'relevant circumstances' to be put into consideration prior to conducting evictions.⁴²³ Furthermore, it emphasised that the managerial role of the court may need to be undertaken innovatively. To this end, the procedural and substantive aspects of justice and equity must always go hand in hand. Therefore, one effective way of realising sustainable reconciliation between warring parties is to require them to proactively and honestly engage with each other towards reaching mutually acceptable solutions. Furthermore, that it had become evident, that the city had not engaged with the occupiers, with the view of identifying pragmatic and dignified solutions to

⁴²⁰ *Occupiers of 51 Olivia Road, Berea Township and 197 Main Street of Johannesburg v City of Johannesburg and Others* (24/07) (2008) ZACC 1;2008 (3) SA 208 (CC); 2008 (5) BCLR 475 (CC) (19 February 2008 Para 1).

⁴²¹ *Occupiers of 51 Olivia Road v City of Johannesburg and Others* Para 5.

⁴²² *Occupiers of 51 Olivia Road v City of Johannesburg and Others* Para 22.

⁴²³ *Occupiers of 51 Olivia Road v City of Johannesburg and Others* Para 18.

their dilemma, prior to deciding to undertake the evictions despite knowing that the people would become homeless as a result of the eviction.

It was further pointed out that engagement would only work if both sides acted in a reasonable and honest manner. Thus the people who risked being rendered homeless were urged not to act with an uncompromising attitude or make the engagement process non-negotiable. The city was also asked not to view the occupiers as a disempowered group but rather encourage them to be pro-active rather than defensive. Civil Society organizations (who were amicus curiae) were also called upon to support people's claims and facilitate the engagement process. Thus secrecy was greatly discouraged as it was considered counterproductive to the entire process.⁴²⁴

Both parties meaningfully engaged with each other and came up with a comprehensive agreement which included, amongst others, detailed provisions on relocating the occupiers to alternative accommodation, steps to be taken to ensure that the buildings were safer and more habitable. It also emphasised that alternative accommodation was to be availed pending the provision of suitable permanent housing to be provided by the city in consultation with the occupiers.⁴²⁵ Therefore, the court endorsed the agreement and proceeded to deal with residual issues arising from the parties' reports.⁴²⁶ Apart from the Olivia Road case, the court has also ordered the parties to meaningfully engage with each other in other housing cases such as *Abahlali*,⁴²⁷ and *Joe Slovo*⁴²⁸ case.

Liebenberg points out that the principle of meaningful engagement, if well utilised, has the potential to encourage contextual, localised solutions to human rights challenges. Thus, it can bring about political, systemic and administrative reforms aimed at enabling community participation in resolving conflicting rights as well as implementing programmes and policies that are constitutionally-grounded.⁴²⁹ Therefore, this principle could be very necessary in the adjudication of maternal health related challenges in Uganda especially because, as already indicated, these cases usually touch on systemic, programmatic and policy issues. Meaningful engagement also has similarities with traditional dispute resolution mechanisms that use mediation between parties to resolve issues, thus ultimately solving challenges or problems that arise in communities.

⁴²⁴ Occupiers of 51 Olivia Road v City of Johannesburg and Others Para 9-21

⁴²⁵ Liebenberg S 'Engaging the paradoxes of the universal and particular in human rights adjudication: The possibilities and pitfalls of 'meaningful engagement'', (2012)12 *African Human Rights Law Journal*15.

⁴²⁶ Occupiers of 51 Olivia Road v City of Johannesburg and Others Para 27-51.

⁴²⁷ *Abahlali BaseMjondolo Movement SA and Another v Premier of the Province of KwaZulu-Natal and Others* (CCT12/09) (2009) ZACC 31; 2010 (2) BCLR 99(CC) (14 October 2009) Para 114.

⁴²⁸ *Residents of Joe Slovo Community, Western Cape v Thubelisha Homes and Other* (CCT 22/98) (2009) ZACC 16; 2009 (9) BCLR 847 (CC); 2010(3) SA 454 (CC) (10 June 2009) Paras 117,238,247,261,378,380

⁴²⁹ Liebenberg S (2012) 26.

3.5.2 Tracking/ Monitoring/Supervision

Tracking/Monitoring of judicial officials is another vital element of answerability which asks the question ‘who judges the judge?’ or rather ‘who is the judge accountable to?’ Due to the fact, that judicial officials, dispense justice, they are not above the law, infact the onus is on them to uphold the law. In order to ensure that they perform as expected, there should be controls in form of cheques and balances aimed at ensuring that they are performing as expected. Thus, accountability operates cyclically in that it ensures that no one is unaccountable. One body that is vital for the strengthening of the answerability aspect of the Ugandan judicial sector is the Judicial Service Commission (JSC). This body is established by Article 146 of the Constitution which provides for a 9-member commission and gives it a wide mandate.

Amongst the functions set out in article 147 are; to appoint persons to hold any office, exercise disciplinary action over such persons and where needed to remove them from office; to formulate and implement programmes on the education and availing information to the judicial officials as well as the public on the law as well as the administration of justice; to act as a channel between the people and the judiciary by receiving and implementing recommendations and complaints from the public pertaining to the judiciary.⁴³⁰ This role is very vital in that if well implemented it has the potential of ensuring access to information for the people, improving participation of the people in judicial processes, implementing the monitoring aspect of accountability thus ultimately ensuring answerability.

The JSC has improved over the years by appointing more judicial officials to fill the vacant positions throughout the various judicial courts in the country in an attempt to address the huge backlog that has been reported in the judicial sector over the years. The Commission is charged with advising and recommending to the President, the Chief Justice, Deputy Chief Justice, the Principal Judge, Justice of the Supreme Court, Justice of Appeal and Judge of the High Court. Then from the recommendations, the president appoints the most suitable person with parliament’s approval.⁴³¹ In addition, the JSC is charged with appointing deputy registrars, chief magistrates and other judicial officials. In the 2013/2014 period, the Commission reported that it had appointed 13 Registrars, 50 Magistrates and 33 Judicial Officials.⁴³² In the 2014/15 period the JSC appointed 28 judicial officials and 14 grade one Magistrates.⁴³³

⁴³⁰ Constitution of Uganda Article 147(a) (c) (d)

⁴³¹ Constitution of Uganda Article 142.

⁴³² Judicial Service Commission ‘Annual Report Financial Year 2013/14’, 17.

⁴³³ Judicial Service Commission, ‘Annual Report Financial Year 2014/15’, 14.

In undertaking such appointments, the JSC should be independent and not subject to the control or direction from any person or authority.⁴³⁴ However, in certain instances the President has ignored the JSC recommendations and appointed judicial officials without the required recommendation from the Commission.⁴³⁵ A case in point was when the President reappointed Justice Benjamin Odoki, who had served as a Chief Justice for the Supreme Court for 12 years, as a Chief Justice for an extra 2 years despite having clocked his retirement age. In doing this, He ignored the JSC recommendation of another judge with repute.⁴³⁶

As a result, a case, *Karuhanga vs. Attorney General*, was brought to the Constitutional Court challenging the re-appointment of the retired judge. The Constitutional Court declared the Act unconstitutional and emphasized that the constitution gives a tripartite role regarding appointment of judicial officers. The JSC has to forward their recommendation to the President and he must select from the list given to him by the Commission after which, he forwards the list to Parliament which approves his nomination. The skipping of any of these stages would be undermining both the constitution as well as role of JSC and the parliament.⁴³⁷

Regarding civic education, the Commission conducts radio talk shows, distributes education, information and communication materials aimed at promoting public awareness and encouraging the utilization of judicial services.⁴³⁸ It also holds civic education meetings with local leaders and the communities on various aspects of the law such as succession, sexual offences. Regarding complaints the JSC reported that in 2014/15, it investigated 7 complaints, the disciplinary committee held 26 meetings aimed at considering complaints raised against judicial officials, held sensitization meetings aimed at popularizing the JSC public complaints system and carried out inspections in 16 Courts spread out in 16 magisterial areas.⁴³⁹ However, despite attempts to raise awareness about the judicial system and to track/monitor courts with the aim of improving judicial operations as well as increasing access to justice, the JSC faces several challenges that get in the way of its effective implementation of its mandate.

⁴³⁴ Constitution of Uganda Article 147(2).

⁴³⁵ Ssekika E 'How judges cut Museveni's wings', *The Observer* 8 August 2014. Available at.

<http://www.observer.ug/component/content/article?id=33206:-how-judges-cut-museveni-wings> (Accessed 11 July 2016).

⁴³⁶ Karuhanga v Attorney General (Constitutional Petition No 39 of 2013) (2014) UGCC 13 (4 August 2014).

⁴³⁷ Karuhanga v Attorney General (2014).

⁴³⁸ Judicial Service Commission, 'Annual Report (2014/15)16-19.

⁴³⁹ Judicial Service Commission, 'Annual Report (2014/15) 19-22.

The functions and roles laid out above, give the JSC an exceptionally wide mandate, probably more so than any other service commission as they require it to traverse the country in order to implement its duties and responsibilities. These functions are as vital for the strength of the judicial sector and improving its overall accountability role as they are for dealing with corruption in the judicial sector, ensuring access to justice for the vulnerable sections of the population and also bringing the courts closer to the people. Yet, the JSC has complained time and again about the challenge of underfunding, which impedes their ability to; travel to the field and conduct training and civic education activities , collect complaints and also affects their ability to conduct research aimed at improving the sector.⁴⁴⁰

Thus, JSC reported that they were only able to reach 40 out of 16,000 sub-counties in the 2014/15 financial year and this number was likely to reduce to a meagre 16 sub-counties in the next financial year. The other challenge is the very skeleton staff to implement all their activities due to the fact that there are no resources to take on more staff. For instance of the 9-member Commission, only the chairperson works full-time, which affects the number of complaints they can take on and investigate and as a result, there is still huge case backlog since the cases keep coming in daily.⁴⁴¹ For reasons such as these, despite the work done by bodies such as the JSC, corruption is still pervasive in the judicial sector. Corruption is so pervasive in every sector in Uganda and the judicial sector is not immune to it. Uganda was ranked 137th out of 167 countries in the Corruption Perception Index.

Also, the judiciary was identified amongst the most corrupt sectors with corruption noted to have increased from 38 percent in 2012 to 45 percent in 2015.⁴⁴² Judicial corruption is manifested through; arbitrary issuance of summons, delays in the execution of court orders, unauthorized granting or denial of bail, refusal to produce suspects before court, misappropriation of bail money, absenteeism and lateness in court, sexual harassment of staff, disappearance of files, inability to access public records on court proceedings, unsubstantiated delays in delivering judgements, appointments arising from undue influence by the executive, post retirement placements.⁴⁴³

Several corruption incidences have been reported within the judiciary. For instance, in 2010/11, the Supreme Court was noted to have budgeted for 64 criminal appeals but only conducted 14 despite the funds having been released. The judiciary also failed to account for millions of shillings that had been released for training judicial officials and for the

⁴⁴⁰ Judicial Service Commission, 'Annual Report (2014/15) 33 -35

⁴⁴¹ JSC 'Annual Report (2014/15) 33 -35.

⁴⁴² Afro Barometer *Fighting Corruption in Uganda: Despite small gains, citizens pessimistic about their role* Dispatch No 77.

⁴⁴³ 'Corruption Plague in the Judiciary' *Black Monday Newsletter*, Issue 21, September 2014 1-2.

purchase of 15 vehicles for the new judges.⁴⁴⁴ Ultimately, corruption in the judiciary endangers the right to judicial protection thus affecting the right to fair trial. Corruption in the judicial system is also detrimental as it affects one of the fundamental accountability agents and gets in the way of their holding other organs of state accountable for corrupt acts.⁴⁴⁵ Last but not least, in order to be answerable, the judiciary itself must be independent from coercion and intrusion from any other arms of government or persons of authority.

This is emphasized in Article 128 of the Constitution, which sets out that the courts shall be independent from the influence of any person or authority in the application of their judicial power. It calls upon all the state organs to assist the courts towards ensuring they operate effectively. It also emphasizes that judicial officials should not be liable to any suit or action for any act or omission in the process of exercising their judicial power. Yet, the Ugandan judiciary faces a series of challenges that often undermine its independence. These include; poor facilitation, delays in appointing judicial officials, open attacks on the judiciary and the refusal to comply with and enforce decisions of the court.⁴⁴⁶

One of the most notable cases of disregard of judicial decisions was the *High Court Criminal Case No.955/05* in which Dr. Col. Kizza Besigye was arrested together with 22 others and charged before the Buganda Road Court with treason and misprision of treason.⁴⁴⁷ On November 16 2005, the accused persons were granted bail by the High Court, but were unable to process their bail release forms as members of the armed forces surrounded the courthouse and re-arrested them for production before the General Court Martial (GCM). As a result, the accused persons were taken to Luzira prison instead of being released and two concurrent trials continued both in the High Court and GCM on the same set of facts.⁴⁴⁸ Following these events, the Uganda Law Society (ULS) filed a Constitutional Petition challenging the constitutionality of these events.⁴⁴⁹ By majority decisions, the Constitutional Court issued an order for the release of the accused. The government petitioned the ruling by appealing before the Supreme Court. The Supreme Court dismissed the appeal by the

⁴⁴⁴ Corruption plague in the Judiciary (2014)1-2.

⁴⁴⁵ Peters A 'Corruption and Human Rights', Working Paper Series 20 (September 2015) Basil Institute of Governance 7.

⁴⁴⁶ 'Judiciary not free, says Odoki' *The Monitor* 11 September, 2011. Available at

<http://www.monitor.co.ug/News/National/-/688334/1233650/-/bjam4yz/-/index.html> (Accessed 03 July 2016).

⁴⁴⁷ International Bar Association Human Rights Institute *Judicial independence undermined. A report on Uganda*. September 2007 .

⁴⁴⁸ International Bar Association Human Rights Institute(2007).

⁴⁴⁹ Uganda Law Society v Attorney General of the Republic of Uganda (Constitutional Petition No. 18 of 2005) (2006) UGCC 10 (30 January 2006).

Attorney General and ordered for an immediate end to the trial of civilians under the General Court Martial.⁴⁵⁰ However the government disregarded both Courts orders. ⁴⁵¹

Hence, courts are a principal accountability agent. Therefore, they should implement the suggested measures in order to improve their responsibility, answerability and most importantly their enforcement role. Furthermore, in order for them to effectively undertake their role, supervisory bodies such as the Judicial Service Commission should be strengthened in order for them to effectively track judicial operations and ultimately ensure access to justice for women whose reproductive health rights have been violated.

3.6 UGANDA HUMAN RIGHTS COMMISSION (UHRC)

3.6.1 Responsibility Aspect

The UHRC is another entity that is vital for the implementation of human rights accountability in the elimination of preventable maternal mortality and morbidity. Therefore, this section sets out the mandate of the Uganda Human Rights Commission and within the subsequent sections its answerability and enforcement role is elaborated upon. Human Rights Commissions (HRCs) are usually state entities empowered with a constitutional or legislative mandate to promote and protect human rights and usually principally funded by the state.⁴⁵² Thus HRCs have increasingly been instrumental in implementing international human rights standards and norms at the national level.⁴⁵³

The role of the Uganda Human Rights Commission is much broader than that of many of the HRCs at the African level and beyond. When the Constitution was being drafted, one of the issues that was brought up was the establishment of a HRC and providing for its operation within the constitution. This was mainly due to Uganda's past where the judicial structures (courts) and the parliament had not been sufficient in preventing gross human rights abuses of the various military regimes that had been in place during the post-independence period.⁴⁵⁴ To this end, the Constitution gave the UHRC expansive powers including judicial powers which were unprecedented in other countries.⁴⁵⁵ The UHRC was thus formed to

⁴⁵⁰ Attorney General v Uganda Law Society Constitutional Appeal No.1 of 2006

⁴⁵¹ Human Rights Watch '*Righting Military Injustice. Addressing Uganda's unlawful prosecutions of civilians in military courts* (2011).

⁴⁵² Office of the High Commissioner for Human Rights *National Human Rights Institutions: History, principles, Roles and Responsibilities* (2010) 13.

⁴⁵³ Carver R 'A new Answer to an old Question: National Human Rights Institutions and the Domestication of International Law' 10(2010) *Human Rights Law Review* 4-6.

⁴⁵⁴ Maina CP 'Human Rights Commissions in Africa-Lessons and challenges', in Bosl A and Diescho J(Ed) *Human Rights in Africa* (2009) 351.

⁴⁵⁵ Hatchard J 'A new breed of institution: the development of Human Rights Commissions in commonwealth Africa with particular reference to the Uganda Human Rights Commission' (1999)32 *The Comparative and International Law Journal of South Africa* 38

ensure that there was a body primarily charged with promoting and protecting the human rights of all Ugandans.⁴⁵⁶

The Uganda Constitution provided for the Uganda Human Rights Commission (UHRC) which extensively sets out its duties and responsibilities provided for by article 48 and then from article 51 to 58. The provisions in the constitution are to be read together with the Uganda Human Rights Commission Act as well as the UHRC rules of procedure. The functions of the Commission are; investigating complaints by any person or group of persons, continually conduct research, education and widely disseminate human rights related information, to create awareness within the public on their rights and inform them of ways to continuously advocate for the respect of their rights, to recommend to Parliament ways of implementing and improving human rights, to monitor government compliance with international human rights, treaties, conventions and norms and to perform such other functions as permitted by the law.⁴⁵⁷ Additionally, the Commission was given expansive powers, similar to those of a court; to issue summons or orders requiring the attendance of any person before the Commission, to question any person in line with any subject matter before the Commission, to require any person to disclose information regarding any investigation and to commit persons for contempt of its orders.

To this extent, upon the determination that there has been an infringement of any human right the Commission may; order the release of an imprisoned/detained person, compensation, any legal redress or remedy. A person dissatisfied with the order of the Commission may appeal before the High Court and thus the Commission may not investigate any matter pending before a court or judicial tribunal.⁴⁵⁸ The Commission is an independent entity which is not to be under the direction and control of any authority or person. It is self-accounting in terms of finances and the Parliament as a legislative body may make laws regarding the Commission.⁴⁵⁹ Thus the UHRC is required to publish periodic reports on its findings and forward annual reports to Parliament on the state of freedoms and human rights in the country.⁴⁶⁰ Therefore, despite the Commission being an independent accountability body, some checks and balances are put in place to ensure that it does not completely go unchecked. In these annual reports, the Commission often sets out elaborate recommendations that the various government departments ought to put in place to improve human rights.

⁴⁵⁶ Maina CP (2009) 351.

⁴⁵⁷ The Uganda Constitution, 1995, Article 52.

⁴⁵⁸ Uganda Constitution ,1995 Article 53

⁴⁵⁹ Uganda Constitution, 1995 Article 54-55.

⁴⁶⁰ Uganda Constitution, 1995 Article 52(2).

Though, as will be elaborated upon in the enforcement section, some of these recommendations are not often addressed by these entities and thus find themselves in the subsequent reports. Therefore, there is need for an established procedure specifically aimed at holding specific government officials accountable for specific recommendations that are continuously not implemented. As regards appointment, the chairperson (who should be a High Court judge or any person qualified to hold that position) and members of the Commission are appointed by the president with the approval of parliament.⁴⁶¹ The provisions pertaining to the removal of a High Court judge in the constitution, are the same provisions pertaining to the removal of a member of the Commission.⁴⁶² On the other hand, the appointment of the officers and other employees of the Commission is made by the Commission in close consultation with the public service Commission.⁴⁶³

The UHRC has established structures overtime in order to implement its mandate. The various departments include; monitoring and inspections department, complaints, investigations and legal services department, finance and administration department, research education and monitoring department and the regional services department.⁴⁶⁴ The Paris Principles stated that human rights commissions must reflect their national circumstances.⁴⁶⁵ Thus, they must be put in place putting into consideration the country's history, norms, and its relationship with other existing structures.⁴⁶⁶

In order to improve its operations, the UHRC has also embraced the notion of shared practices with other human rights commissions through information dissemination and sharing programs.⁴⁶⁷ This is aimed at improving day-to-day operations of a human rights commission. The Commission also frequently undertakes inquiries in its various offices throughout the country and gives penalties to those found in violation of specific rights. The Commission is not without its challenges amongst which; are the limited resources availed to it by the government in order to conduct its country wide operations, insufficient human rights personnel (commissioners) to hear cases, the very slow or sometimes non-payment of compensation to victims of human rights violations.⁴⁶⁸

⁴⁶¹ Uganda Constitution, 1995 Article 51(2-3)

⁴⁶² Uganda Constitution, 1995 Article 56.

⁴⁶³ Uganda Constitution, 1995 Article 57.

⁴⁶⁴ Maina CP (2009) 358-359.

⁴⁶⁵ Paris Principles 'National Institutions for the promotion and protection of Human Rights' A/RES/48/134 , 85th Plenary Meeting, 20 December 1993 Section 2 &.12

⁴⁶⁶ Hatchard J (1999)28-53.

⁴⁶⁷ 'The Role of National Human Rights Institutions in the Universal Periodic Review' A Paper presented by Med. S. Kaggwa ,Chairperson Uganda Human Rights Commission, at the UPR Seminar for Parliamentarians-Geneva,12-13 November 2012 7-8.

⁴⁶⁸ Maina CP (2009) 361-362.

One of the main reasons for the formation of human rights commissions was to nationalise international human rights treaties and norms.⁴⁶⁹ And so, the UHRC has been remarkable in ensuring the ratification of international human rights treaties as well as ensuring that these are effectively implemented at the national level.⁴⁷⁰ It has done this by working closely with the parliamentary human rights committees and encouraging them to include human rights provisions in their various policies and programmes.⁴⁷¹ The UHRC has also worked with various legislation drafting committees with the aim of ensuring that internationally recognised human rights norms are included in such legislation. It has thus put pressure on the government to ensure that it abides by the reporting time frames to the various treaty monitoring mechanisms.⁴⁷² Therefore, the UHRC plays the role of providing the government with the appropriate information on various human rights areas, clarifying certain human rights issues and also submitting independent reports to the treaty bodies on areas where it feels adequate attention ought to be given.⁴⁷³

After the recommendations have been handed down to Uganda by the various bodies, the Uganda Human Rights Commission widely disseminates these to the parliament and various government bodies. The recommendations may also be broken down in simple language, easily understood by everyone. It also sensitises the general population in order to encourage the communities to advocate for the implementation of these recommendations.⁴⁷⁴ Therefore, as a result of lobbying and technical assistance by the UHRC, the government developed a National Action Plan on Human Rights (NAPHR) and the process is in its final validation stages. Furthermore, as a result of its lobbying for a HRBA in government programming, the second NDP (2016-2021) set out a directive that all sectors, Ministries Departments and local Governments should adopt HRBA in their programmes, legislation, policies and plans.⁴⁷⁵ Due to its wide coverage, the UHRC deals with rights that might not necessarily be justiciable in the Ugandan Constitution such as socio-economic rights. It is for this reason that the UHRC established a 'right to health unit' in 2008 charged with sensitising citizens on the right to health, monitoring violations in the

⁴⁶⁹ Jeong-Woo K and OR Francisco OR (2009)1342

⁴⁷⁰ The Institute of International law and Human Rights *A comparative look at implementing Human Rights Commission Laws* (March,2009) 10

⁴⁷¹ Hatchard J (1999) 50-51.

⁴⁷² The Institute of International law and Human Rights (2009)10

⁴⁷³ Kaggwa MS (12-13 November 2012).

⁴⁷⁴ Kaggwa MS (12-13 November 2012).

⁴⁷⁵ Second National Development Plan, Uganda, 2015/16-2019/20.

health sector and ensuring that those whose rights have been violated have access to adequate remedies.⁴⁷⁶

In undertaking its role, it uses legislation and policies that are already in place such as the constitutional provisions on the right to health, National Health Policy (2009), National Development Plan(2010/11-2014/15, Health Sector Strategic Plan III(HSSP 2010/11-2014/15), the Reproductive Health Policy, the Reproductive Health Maternal, New Born and Child Health (RHMNCH), known as the Sharpened Plan 2013, National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights. The UHRC uses the guidelines set out in these various laws and policies as the standard which the government ought to achieve since it's the one that drafts them.

To this end, the UHRC has taken to inform stakeholders on the right to health through workshops and conferences. For instance, towards the end of 2015, it organized a multi-stakeholder meeting aimed at discussing the status of implementation of the UPR recommendations pertaining to the right to health.⁴⁷⁷ The recommendations were given to Uganda in 2011 and those relating to accountability and maternal mortality included; strengthen women's participation in the design and implementation of development programmes at the local level, adopt measures to harmonize legal recognition of economic, social and cultural rights, urgently respond to the reduction of the high MMM rates and improve health information systems by ensuring the collection of more disaggregated data from surveys, administrative structures and health facilities in a bid to improve effective monitoring.⁴⁷⁸

As a result of that and other related fora, in preparation for the upcoming UPR review of Uganda in 2016, the UHRC prepared a report on the implementation of UPR recommendations as well as the remaining issues/gaps that need to be addressed. In line with maternal health, the Commission pointed out inadequate funding of the health sector budget which affects number of skilled birth attendants especially in the hard to reach areas,

⁴⁷⁶ 'Health Unit Launched' *The New Vision* Available at <http://www.newvision.co.ug/PA/8/13/652335> (Accessed 1 July 2015).

⁴⁷⁷ Uganda Human Rights Commission 'UNHRC holds a multi stake holder meeting on the Status of implementation of the Universal Periodic Review Recommendations on the Right to Health', November 27 2015. Available at <http://uhrc.ug/uhrc-holds-national-multi-stakeholder-meeting-status-implementation-universal-periodic-review> (Accessed 11 July 2016).

⁴⁷⁸ Human Rights Council *Report of the Working Group on the Universal Periodic Review Uganda*, A/HRC/19/16, 22 December 2011.

unavailability of EMoC services in health facilities and the non-reporting of maternal deaths especially in private facilities.⁴⁷⁹

3.6.2 The Answerability Role of the Uganda Human Rights Commission

The Uganda Human Rights Commission's answerability role therefore involves information sharing, justification of decisions taken, ensuring community participation in its programmes and monitoring/supervising health facilities. When the HRC was formed, one of the guidelines pointed out was that it had to report periodically to parliament on its activities.⁴⁸⁰ Apart from that, the UHRC is expected to involve the general public in its operations by conducting sensitisation campaigns on the work that it does as well as on the key human rights issues. The UHRC also has to inform the public about how they can get involved in its activities.⁴⁸¹ One such activity is its complaints procedure.

In order to effectively reach the general population, the UHRC opened up branches in all the four regions where it operates. These include; the central regional office, Gulu, Fort portal, Hoima, Jinja, Arua, Masaka, Mbarara, Moroto and Soroti Office.⁴⁸² Upon receiving a complaint, the Commission gathers information either from individuals or organizations working at grassroots levels in a bid to verify the information and then works to resolve the issues. One of the means that the Uganda Human Rights Commission has devised to be closer to the people is the establishment of toll free lines in all its regions of operation, which the people can use to report any type of complaint.⁴⁸³ It thus operates as a channel between the people and the government. The UHRC then provides feedback to those who have forwarded complaints either by holding legal proceedings and mediation or contacting the purported violator.

Furthermore, as part of its sensitisation campaign, the Uganda Human Rights Commission has translated various documents into several local languages for them to be understood in the different regions. Some of the documents that have been translated include the Ugandan Constitution, CEDAW, ICESCR, CRC, ICRPD and ICCPR. At the domestic level, the UHRC uses the health provisions in the Ugandan Constitution and the various sexual and reproductive related policies to create awareness amongst the population on the existing standards as well as structures and how the population can have access to each of these. In

⁴⁷⁹ Uganda Human Rights Commission *NHRI submission for Uganda's second Universal Periodic Review* October 2016, Para 15.

⁴⁸⁰ Hatchard J (1999) 50-51.

⁴⁸¹ Hatchard J (1999) 46-48.

⁴⁸² UHRC Report (2014) vi

⁴⁸³ UHRC Report (2014)'15.

addition to this, it monitors and reports on the implementation of the health related policies and points out the existing gap.⁴⁸⁴

Likewise, the UHRC regularly monitors health centres at all levels. The health centre structure in the country is decentralised; there should be at least one Health Centre II for every parish, one Health Centre III at the sub-county level, one Health Centre IV at county level or at parliamentary constituency level, and ideally each district should then have a hospital. Thus in 2014, the UHRC inspected 538 health facilities; 178 Health Centre IIs out of 1618, 249 Health Centre IIIs out of 936, 77 HCIVs out of 206 and 34 hospitals out of 58. Its wide presence enables it to inspect a wider area than any other accountability or monitoring entity in Uganda, which gives the UHRC a unique advantage. Furthermore, with the increase in funding and coverage of the UHRC, the number of health facilities inspected has increased over the last three years starting from 2011 to 2014.⁴⁸⁵

Yet, according to the 2014 annual report, no complaints were handled or even reported to the UHRC directly regarding maternal deaths,⁴⁸⁶ despite Uganda's high MMR rate of 436 per 100,000 live births. This can be attributed to a series of factors, one of the most outstanding being that Ugandan women do not consider preventable maternal mortality and morbidity a human rights violation, but rather, an unfortunate but acceptable condition of life. Thus they don't perceive government's obligation to ensure availability, accessibility, acceptability and quality maternal health services towards the reduction of MMR as an entitlement, but rather, as a benefit and sometimes a political favour.

This lack of awareness opens the ground for a lot of manipulation by government officials as well as politicians who frame maternal health services as political favours (gifts) that they will give the communities if elected into power. Thus, the UHRC has a lot of work to do in raising people's awareness for them to clearly understand that it is the government's duty and obligation to ensure that health facilities are well-stocked, in good hygienic conditions, and that skilled health attendants are available. To this end, the UHRC should urge the population to be vigilant in reporting human rights violations that occur in the maternal health sector.

⁴⁸⁴ UHRC Report (2014) 158

⁴⁸⁵ UHRC Report (2014) 158.

⁴⁸⁶ UHRC received 12 complaints of alleged human rights violations on the right to health, 5 were on denial of access to medical treatment, six were on medical negligence, one on discrimination on grounds of HIV/AIDS. These complaints were mainly against places of detention such as the prisons service and in the police force (page 159 of the UHRC Annual 2014 Report).

3.6.3 The Enforcement Aspect of the Uganda Human Rights Commission

A vital question in the setting up of any HRCs, is how much enforcement power it should have. The amount of power often varies from country to country thus some countries do not see the value of a commission due to the belief that the existing structures such as the courts of law, vibrant civil society together with the parliament should be sufficient in promoting and protecting human rights.⁴⁸⁷ However, most countries especially in Africa recognize the unique role of having a HRC especially due to the fact that its make-up provides for more innovative ways of upholding human rights. For instance, some have considered courts of law as too formal, following strict bureaucratic guidelines, costly, time consuming all of which can become impediments to accessing justice. On the other hand, HRCs employ numerous methods such as mediation, the formal court system procedures, awareness raising and are often more accessible and affordable to a bigger part of the population. Some of these remedial measures used such as mediation have similarities with the African conflict resolution approach.⁴⁸⁸

As well, their specific focus on human rights enables them to comprehensively deal with human rights violations unlike the courts of law or the parliament that might have too many other issues to deal with and thus may side-line human rights. During the process of instituting the UHRC, it was emphasised that it should have “teeth” by having a judicial element. Thus, the UHRC has more power than any other commission elsewhere. The UHRC acts like a court which can receive any type of complaint except those pending before the courts of law or a tribunal. The guidelines establishing the Commission state that its decisions shall have effect as those of the court and shall be enforced in the same manner.⁴⁸⁹ In case of grievances on how the case has been handled with the UHRC, one can appeal before the High Court of Uganda.

The reason for giving the UHRC such powers was to avoid establishing a ‘toothless institution’ which would then have to revert all its cases back to the courts thus bringing about backlogs and prolonging the time for people whose rights have been violated to be redressed. This would in turn exacerbate the issues of huge case backlog which is already one of the challenges faced by the Ugandan courts of law. Therefore, the UHRC has a tribunal which receives, investigates, hears and resolves complaints - a mandate bestowed upon it by Article 52(1) of the Constitution. Thus, in 2014, it resolved 138 complaints in

⁴⁸⁷ Maina CP (2009)351.

⁴⁸⁸ Uganda Human Rights Commission *17th Annual Report to the Parliament of Uganda* (2014) 30-32.

⁴⁸⁹ Hatchard J (1999) 41-46.

favour of the complainants and dismissed 68.⁴⁹⁰ In line with the right to health all the 12 complaints received were based on discrimination on the grounds of HIV/AIDS.

The Commission attributed the increase in complaints, on the right to health, from 5 recorded the previous year to awareness as a result of increased sensitisation on the right to health.⁴⁹¹ However, the Commission did not receive any maternal health related complaints. The Commission also reported that the lack of witness protection law makes witnesses reluctant to record their statements for fear of retaliation from respondents and inadequate human and financial resources for sufficient resolution of complaints.⁴⁹² However, despite, the fact that the UHRC has implemented various mechanisms towards combating maternal mortality and morbidity, the MMR rates are still persistently high. The HSSP target for MMR is 131 per 100,000 live births, however currently it stands at 438 per 100,000 live births which translates to an average of 16 women dying every day.⁴⁹³ One of the reasons for this is that despite establishing tribunals to deal with human rights violations, there are no enforcement mechanisms for the failure by the government officials to implement the recommendations set out in the UHRC annual reports.

Enforcement is a vital aspect in that it is aimed at ensuring that established mechanisms are in place to determine that public officials are adhering to the set standards and if not, sanctions are imposed upon them as well as corrective measures to correct the imbalance caused. Therefore, the non-existence or the failure to ensure the existence of this element in some shape or form, renders accountability a weak concept. The UHRC reported in 2014 that only 1.9 percent of its recommendations had been fully complied with while 55.9 percent were partially complied with and 42.2 percent were not complied with.⁴⁹⁴ It further noted that while the health budget had increased from 2011 to 2014, the proportion of the government's budget allocated to the health sector declined over the past four years from 8.9 percent in FY 2010/11, to 8.3 percent in 2011/12, 7.8 percent in FY 2012/13 and then 8.7 percent in FY 2013/14.⁴⁹⁵

Another observation made by the UHRC was that, even though the proportion of skilled health workers increased from 38 percent in 1995 to 58 percent in 2011, this number merely reflected a national average and thus does not consider the disparities in regions, which in some cases may be much smaller than this number.⁴⁹⁶ Therefore, the UHRC recommended

⁴⁹⁰ UHRC Report (2014) 2.

⁴⁹¹ UHRC Report (2014) 159.

⁴⁹² UHRC Report (2014) 45.

⁴⁹³ UHRC Report (2014) 160

⁴⁹⁴ UHRC Report (2014) 203.

⁴⁹⁵ UHRC Report (2014) 175.

⁴⁹⁶ UHRC Report (2014) 160

to the ministry of public service and the ministry of health to revise the salary structure for health professionals especially in the hard to reach areas as a way of attracting and retaining health professionals. It also recommended to the government to increase budgetary allocations to the health sector and to increase financial, human and infrastructure towards maternal and child health.⁴⁹⁷ Yet, despite these recommendations, in the 2015/16 budget, the allocation to the health sector from the overall budget dropped even further to about 7 percent⁴⁹⁸ and in the most recent 2016/17 budget, it hit an all-time low of 6.7 percent.⁴⁹⁹ Even though the actual amounts improved, these percentages are way below the 15 percent target of the Abuja declaration.

It is submitted that merely giving recommendations to the government is not sufficient. They should be followed up with other enforcement measures such as using the wide mandate bestowed upon it by the constitution⁵⁰⁰ to summon or call for the attendance of any government official before the Commission to explain why a certain recommendation may not have been addressed. These summons maybe be happening on a small scale but should be more structured and comprehensive such that, and if, after thorough investigations, it is established that a government official or department is directly responsible for the non-implementation of a certain recommendation, remedial measures (sanctions) are instituted against this entity to give some binding force to the recommendations. Other measures include; mass sensitisation to mobilise people to advocate for prioritisation as well as resource allocation to the health sector, monitoring and investigating cases of resource misuse by duty-bearers, widely disseminating petitions calling upon a certain government entity to promptly respond to a maternal mortality and morbidity crisis where it has been observed.

Also at the health facility level, the UHRC should employ various measures to ensure that it has comprehensively dispensed its enforcement role. For instance, while undertaking its supervisory/monitoring role, it often has the opportunity to witness various forms of misconduct in the health facility. While human rights discourage scapegoating of health workers - if it has been established after comprehensive investigations that a human rights violation can be attributed to an individual or a group of people - the UHRC should take

⁴⁹⁷ UHRC Report (2014) 176.

⁴⁹⁸ 'Revised budget focuses on Energy and Transport', 25 May 2015. Available at <http://www.intosouthafrica.com/countries/UG/news/revised-budget-2015-2016-focusses-on-energy-and-transport> (Accessed 12 July 2016).

⁴⁹⁹ Olive Nakatudde, 'Parliament approves FY 2016/2017 Budget Framework Paper' URN 7 January 2016. Available at <http://ugandaradiornetwork.com/story/parliament-approves-fy-20162017-budget-frame-work-paper> (Accessed 12 July 2016).

⁵⁰⁰ Article 53(1) of the 1995 Constitution gives the UHRC such powers.

measures to ensure that this action cannot be repeated in future. Therefore, from the human rights perspective, a big part of accountability is about ensuring that causal factors are identified and all possible avenues are taken to remedy/correct these wrongs. Otherwise, government officials will merely pay lip service to these recommendations.

Accountability without effective enforcement mechanisms may be counterproductive and is an incomplete process. Consequently, despite the fact that the Uganda Human Rights Commission has been remarkable in exercising its protection and promotion role, it should comprehensively employ its expansive enforcement powers to ensure that human rights standards in the maternal health sector are not only responsive and answerable but that they are also effectively enforced.

3.7 CONCLUSION

This chapter set out to apply accountability to the Ugandan legal sector. Therefore, it uses the three elements of accountability elaborated upon in chapter two; responsibility, enforcement and answerability. These three elements are measured against Uganda's legal sector to ascertain its implementation of accountability towards elimination of preventable maternal mortality and morbidity. Under responsibility, it is stressed that norms, standards and guidelines must be in place for combating maternal mortality and morbidity and these must be human rights compliant.

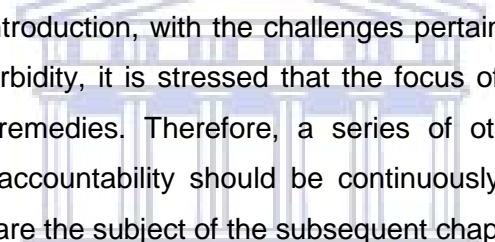
It is pointed out that the non-recognition of the right to health in Uganda's bill of rights presents a lacuna in its judicialisation which has been seen in the courts of law. Nonetheless, activists have found a way of working around this shortcoming to adjudicate women's maternal health rights leading to victory in the High Court of Uganda.

Under answerability, it is emphasised that participation must be continuously improved by using avenues to increase women's access to justice. Furthermore, the judicial service Commission is identified as a vital tracking/monitoring/supervisory body. If well-facilitated, the JSC can substantially improve its role of bringing courts closer to the people. Yet, despite strides taken towards being more responsive to the population, the courts of law are still removed from the daily circumstances of the vulnerable women. These women often find Local Council Courts -which are also not devoid of challenges such as corruption and patriarchal attitudes that aim to suppress women's voices - more accessible to them. Legal aid is increasingly being accessed by vulnerable women even though it is still largely concentrated in urban areas where the minority of the vulnerable women are found. The chapter also emphasises that the failure to address the high maternal mortality rates, is an indicator of how women's rights are viewed and implemented in the legal sector.

Under enforcement, the maternal health related case law that has come before the courts of law is elaborated upon. This section demonstrates that the right to maternal health care is increasingly being recognized by the courts of law. It is acknowledged that Civil Society Organizations such as CEHURD are increasingly using strategic litigation as one avenue for accessing accountability for those whose maternal health rights have been violated even without their explicit recognition in the constitution.

The Uganda Human Rights Commission is fronted as one avenue through which women can ensure their maternal health rights are upheld. This is because, its sole purpose is to promote and protect human rights. Its expansive mandate and wide scope of operation presents an added advantage. However, the Commission is urged to become more vigilant in turning its recommendations into benchmarks upon which government performance ought to be measured. It is suggested that government officials should be put to task for failure to implement recommendations and where necessary sanctions should be undertaken to ensure that the UHRC recommendations are taken seriously.

Finally, as set out in the introduction, with the challenges pertaining to access to justice for maternal mortality and morbidity, it is stressed that the focus of accountability mechanism should go beyond legal remedies. Therefore, a series of other mechanisms including administrative and social accountability should be continuously formulated and improved upon. These mechanisms are the subject of the subsequent chapters.

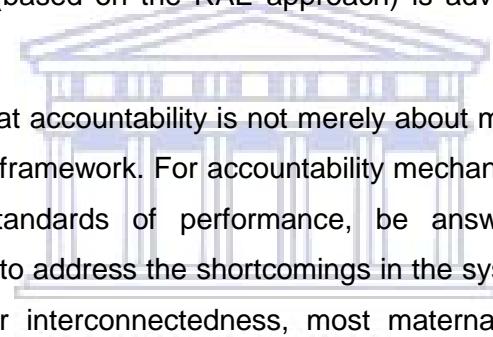


UNIVERSITY of the
WESTERN CAPE

CHAPTER FOUR: ROLE OF ADMINISTRATIVE ACCOUNTABILITY TOWARDS REDUCING MATERNAL MORTALITY AND MORBIDITY.

4.0 INTRODUCTION

The purpose of this chapter is to analyse existing accountability mechanisms in the health administrative structures. It builds on chapter three (legal accountability) by elaborating upon administrative accountability. This is premised on the fact that human rights have paid a lot of attention to judicial remedies such as courts and human rights commissions as accountability mechanisms and little attention to the development of administrative accountability. Yet, the focus on administrative accountability is likely to bring about more change than any other accountability mechanism⁵⁰¹ Administrative accountability directly interacts with the systems such as health facilities and health policymaking bodies where direct transformation is required in order to do away with preventable maternal mortality and morbidity. Therefore, in this chapter, in proposing strategies for combating MMM, the accountability framework (based on the RAE approach) is advanced to the administrative aspect of accountability.



It is further emphasised that accountability is not merely about monitoring and evaluation as set out in Uganda's policy framework. For accountability mechanisms to be fully operational, they should establish standards of performance, be answerable and put in place enforcement mechanisms to address the shortcomings in the system. Furthermore, it is vital to note that, due to their interconnectedness, most maternal health policies are often combined with child health. However, even though this chapter shall mention such policies, attention will specifically be on maternal health as it is the focus of the study. That is not to discount the interrelated nature of maternal and child health but rather to avoid building the expectation that the chapter will also deal with infant/child related issues, which on their own are numerous and diverse.

4.1 UGANDA'S HEALTH POLICY FRAMEWORK

First, it is vital to briefly elaborate upon Uganda's health policy frame work. The Ministry of Health gives leadership to the health sector and since the provision of health services in Uganda is decentralized, the districts and health sub-districts undertake a key role in the provision of health services at district and health sub-district levels respectively.⁵⁰² The health services are then spread out to National Referral hospitals, Regional Referral hospitals, General Hospitals, Health Centres IV (health sub-district level), III (sub-county

⁵⁰¹ 'Who will be accountable? Human Rights and the Post 2015 Development Agenda (2013) 10. 37-38.

⁵⁰² Ministry of Health *The Second National Health Policy Promoting Peoples' Health to enhance Socio-economic Development* (July 2010) 4-5.

level), II (parish level) and I (village/community level). The Health Centre I's often do not have physical health structures but rather have a team of people known as Village Health Teams (VHTS) that function as a link between the health facility and the community.⁵⁰³ The primary mandate of the Ministry of Health is policy formulation, resource mobilization, standard setting, quality assurance, capacity development, strategic planning, budgeting, monitoring and evaluation of overall health sector performance.⁵⁰⁴

Due to the fact that Uganda operates under the decentralization programme, the public general hospitals are managed by the Ministry of local Government under the district local governments.⁵⁰⁵ The constitution and the Local Government Act (LGA) gives powers to the District Local Government (DLG) to budget, plan and implement health policies as well as health sector plans. The DLG is also empowered to undertake monitoring and supervision of all health activities including those in the private sector in its respective area of responsibility. A new level of government was introduced below the district known as the Health Sub-District (HSD) with the aim of devolving the management and delivery of health services to a level lower than that of the district.⁵⁰⁶ However, even with the annual increment in financing to the health sector, the financing of local government health services still leaves a lot to be desired, despite the fact that they have been granted autonomy under the decentralization programme.⁵⁰⁷

Additionally, the private health sector is a vital contributor to health in Uganda. However, private health facilities are mostly concentrated in urban areas. For instance, it is estimated that public health facilities account for only 1.9 percent in the capital city of Uganda, Kampala.⁵⁰⁸ In 2012, the Government adopted a National Policy on Public-Private Partnership in Health. The purpose of the policy was to guide the partnership between the government and the private health care providers in order to ensure that both operate within the legal, policy and programmatic health framework. The policy categorised private providers into three major categories; Private Not for Profit Health Providers (PNFP), Private Health Practitioners (PHP) and Traditional and Complimentary Medical Practitioners

⁵⁰³ The Republic of Uganda, Ministry of Health Sector Strategic Plan III 2010/11-2014/15' 2.

⁵⁰⁴ Republic of Uganda 'Ministry of Health'. Available at <http://www.health.go.ug/about-us/about-ministry-health> (Accessed 20 September 2015).

⁵⁰⁵ Health Sector Strategic Plan III 2010/11-2014/15 4.

⁵⁰⁶ Health Sector Strategic Plan III 2010/11-2014/15 83.

⁵⁰⁷ The Republic of Uganda, Ministry of Health 'Annual Health Sector Performance Report' Financial year 2013-2014 (October 2014) xviii.

⁵⁰⁸ Kampala Capital City Authority *Kampala Capital City Authority submission to the sessional Committee on Health regarding renovation of Mulago National Referral Hospital and Relocation of medical services to Kiruddu and Kawempe Hospitals* (2015) 3.

(TCMP).⁵⁰⁹ The policy is comprehensive, however as will be emphasised in this chapter, mere policy formulation is not enough. Due to the weak supervisory mechanisms in place, the private health facilities are not well-regulated and thus are prone to getting away with violation of human rights.

Government oversight role concerning private health facilities was emphasised in the *Alyne vs. Brazil* case. The CEDAW Committee refuted the state's claim that it could not be held liable for the inadequacy and the poor quality of care at the private health care institution in question. Thus, the Committee emphasised that the state is directly responsible for the actions of private institutions and thus it has the duty to monitor and regulate them. The state was also reminded of Article 2(e) of the CEDAW Convention which emphasises that it has an obligation to take measures towards ensuring that private actor activities, in line with health policies, are appropriate. Subsequently, the Committee recommended that the state ensures that private health facilities comply with international and national standards on reproductive health care.⁵¹⁰

The Ministry of Health (MoH) formulates and executes its policies within the decentralized structures of Uganda, which operate both at national and local level. Therefore, the MoH is guided by a series of policies such as the Second National Development Plan 2015/16-2019/20, National Health Policy II (2010), Health Sector Strategic Plan III 2010/11-2014/15 and the Health Sector Strategic and Investment Plan 2010/11-2014/15 among several others. The policies and plans that have been adopted specifically targeted at MMM include; National Policy Guidelines and Service Standards for Reproductive Health Services (2001), National Adolescent Health Policy for Uganda (2004), Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality in Uganda (2007-2015) and the Reproductive Health Maternal, New Born and Child Health (RHMNCH), known as the Sharpened Plan 2013.

Before delving into the implementation of administrative accountability, it is vital to point out the significance of undertaking a contextual analysis prior to policy implementation.

4.2 RATIONALE FOR CONTEXTUAL ANALYSIS IN COMBATING MMM

Freedman posits that there is often a contrast between the way sexual and reproductive health rights challenges as well as interventions are framed at the global level and the lived realities of communities on ground.⁵¹¹ He asserts that the way policies and plans are formulated at the international/regional level may seem comprehensive, but are most likely

⁵⁰⁹ Government of Uganda, 'National Policy on Public Private Partnership in Health' (March 2012) 4-6.

⁵¹⁰ *Alyne da Silva v Brazil* Para 7.5 and 8(2).

⁵¹¹ Freedman LP and Shaaf M (2013)103-112.

to achieve little or no progress if they do not undertake a robust contextual analysis.⁵¹² Thus, prior to formulating and implementing policies, it is vital to understand the complex interplay of the power dynamics that affect the health systems. These are often characterised by a multiplicity of interests among health policy makers, providers and patients. Due to diverging interests within each of these groups, they also hold different forms of power that must be examined in order to understand the different accountability relationships that exist.⁵¹³ Ultimately, the distribution of power within health systems, communities and households affects the success/failure of an intervention.

Accordingly, both national governments and donors must substantially prioritize more contextualized strategies that are more likely to achieve long lasting and sustainable achievements.⁵¹⁴ Freedman further asserts that while the more commonly used approach of adopting new laws, policies, plans or compliance mechanisms plays a certain role in ensuring accountability, it may prove insufficient, thus exacerbating the common complaint of the divergence between policy and practise. Contextualized studies have revealed that more often, norms rather than policies are influential in shaping individual as well as organizational behaviour.⁵¹⁵ Such unique and specific nuances are often overlooked with this top-bottom approach of policy making emphasised above. Therefore, there is need to build accountability from the ground up while putting into consideration the Technical Guidance on Maternal Mortality, which emphasises that accountability is vital for each stage from planning, resource allocation, feedback from the ground to implementation.⁵¹⁶

From a feminist analysis, Obiora forwards that a contextual analysis is especially important as it enables consideration of the particular typologies of power and means of subjugation through which women are socially constructed and situated. This enables the transformation of feminist ideals into practical strategies.⁵¹⁷ Subsequently, that the legitimacy of the international human rights regime is enhanced by culturally sensitive approaches. Thus, Obiora recommends a process of dialogic democracy which recognizes the ideas of the other and is willing to openly listen to and debate them in a mutually reinforcing process. Otherwise, people will not submit to imposing and external regimes unless the suggested approaches are connected to practices on ground.⁵¹⁸

⁵¹² Freedman LP and Shaaf M (2013)103-112.

⁵¹³ Freedman LP and Shaaf M (2013) 103-112.

⁵¹⁴ Freedman LP et al (2005) 997-1000.

⁵¹⁵ Freedman LP and Shaaf M (2013), 103-112.

⁵¹⁶ Technical Guidance on Preventable Maternal Morbidity and Mortality, Para 67-68.

⁵¹⁷ Obiora LA (1997) 367.

⁵¹⁸ Obiora LA (1997) 377, 405-406.

In agreeing with these assertions, it is submitted that successful policy making should be bottom-up and contextually based. Thus, it must first identify the specific challenges affecting the various communities in Uganda, develop themes of these challenges and come up with a comprehensive policy framework that responds to people's unique challenges. However, a critical look at Uganda's policy formulation process quickly reveals that it is a top-bottom approach. The Ministry of Health and concerned health officials will draft policies mostly based on international and regional developments and pass them on to the lower levels for their implementation. For instance, the formulation of the Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality in Uganda (the Road Map) was primarily influenced by World Health Organization (WHO)-Africa region, supported by UNFPA. In order to address the challenges in the African Region, in 2004, WHO proposed the development of the 'generic 'Maternal and New-born Road Map' to be used by countries in the creation of national plans of action in a bid to accelerate progress of the MDGs 4 and 5.⁵¹⁹ Subsequently, the World Health Organization adopted a resolution on the Road Map for Accelerating the Attainment of the MDGs relating to Maternal and New-born Health in Africa in which it emphasised the development of national road maps by African states.⁵²⁰

On the other hand, the development of the Sharpened Plan came from a high-level forum convened in Washington DC in 2012 by the governments of Ethiopia, India and the United States of America organised in close collaboration with UNICEF.⁵²¹ This forum was specifically focused on child survival under the theme 'Child Survival Call to Action' and launched the 'Commitment to Child Survival: A Promise Renewed'. Under this commitment 178 governments, civil society, faith-based organizations and private sector, signed a pledge undertaking to do everything to stop women and children from dying of preventable causes.⁵²² As a result, countries launched 'sharpened country strategies for child survival' hence the birth of the Uganda Sharpened Plan'.

The five strategic shifts that were agreed upon by countries to accelerate progress are the exact ones, word for word, that appear in Uganda's sharpened plan. These are; focusing geographically, high burden populations, high impact solutions, mutual accountability and

⁵¹⁹ Wolman LBY *African Maternal and New-born Health National Plans (Road Map) Assessment Report* UNFPA Technical Division, Sexual and Reproductive Branch (July 2009) 5.

⁵²⁰ Road Map for Accelerating the Attainment of the Millennium Development Goals relating to Maternal and New Born Health in Africa, AFR/RC54/R9, 3 September 2004, Brazzaville, Republic of Congo.

⁵²¹ 'Every Child deserves a 5th birthday USAID's contribution to a promise renewed'. Available at <http://5thbday.usaid.gov/pages/responsesub/event.aspx>. USAID 'Fact Sheet: Call to action sets course to end preventable child deaths', July 10, 2012. Available at <https://www.usaid.gov/news-information/news/fact-sheet-call-action-sets-course-end-preventable-child-deaths> (Accessed 18 May 2016)

⁵²² UNICEF 'Committing to Child Survival: A promise Renewed Progress Report (2015).

education, empowerment and economy, environment.⁵²³ While it is important to keep abreast of and to be informed by regional and international developments, it is also important to ensure that the designed policies are drafted to directly respond to the unique challenges of the country and not ‘copy-paste’ versions of regional policy frame work. This could partly explain why, even though, on paper, the policies look like they are comprehensive, they do not often specifically respond to and address the diverse historical, political, cultural and socio-economic challenges that are specific to Ugandan communities.

It is further asserted that this gets in the way of identifying home grown solutions to the unique challenges facing the country. It also affects implementation as health officials are often less likely to implement policies that do not directly respond to the unique challenges that the local communities face thus they remain on paper. Therefore, more critical thought should be put into designing policies and plans that are directly tailored to identifying home grown solutions to the unique challenges specific to the Ugandan context. In order to be implementable, the policies must consciously and continuously find local solutions to the unique challenges faced by the health facilities in ensuring access to maternal health services.

This is in line with human rights principles which emphasise that the standards and guidelines for reproductive health services should be based on evidence.⁵²⁴ They should also be culturally appropriate thus directly responding to the specific issues facing that particular community.⁵²⁵ The same applies to accountability mechanisms that are more likely to be implemented if they fit the country’s specific circumstances rather than being imported from elsewhere.

Locally/nationally driven frameworks are more likely to be inclusive of various groups, transparent thus having legitimacy.⁵²⁶ The adoption of contextually based approaches to combat MMM also contributes to the strengthening of the entire health system. This is in line with human rights norms that require integrated and holistic interventions ultimately leading to well-functioning and coordinated health systems.⁵²⁷ Therefore, it is stressed that international partners including funders should help in achieving this outcome by ensuring

⁵²³ Summary Road Map Child Survival: Call to Action: Ending preventable and child deaths, Version 1, June 14 2012 9. The Republic of Uganda, Ministry of Health Committing to Maternal and Child Survival: A promise Renewed, Reproductive Maternal Neonatal and Child Health Sharpened Plan for Uganda (November 2013) 38.

⁵²⁴ General Comment No. 22 Para 47.

⁵²⁵ General Comment No. 14 Para 12.

⁵²⁶ Commission on information and accountability for women and children’s health, ‘Keeping Promises, Measuring Results, Final Report of the Commission (19 May 2011)7.

⁵²⁷ Technical Guidance on Preventable Maternal Morbidity and Mortality Para 37.

that their support does not directly or indirectly bear conditions fostering the government to implement their strategies as a condition for future support.

4.3 ADMINISTRATIVE ACCOUNTABILITY

Accountability basically comes down to mechanisms/processes put in place to ensure that the programmes/policies and strategies agreed to by the government are implemented. This is based on the premise that without strong cheques and balances, duty-bearers may merely pay lip service to proposed programmes/policies but not implement them. This is so especially in the area of women's rights which have been often excluded from the programming without much consequence. When women are involved in policy and programme planning and implementation, they are treated partnerlistically as they are not given autonomy to make decisions about their reproductive health. Instead, they are treated as recipients of government programming.⁵²⁸

Therefore, administrative accountability requires that standard guidelines and norms are established within the health facilities and within the Ministry of Health aimed at making subordinates accountable to the superiors and these should often be monitored by an institution with no conflict of interest.⁵²⁹ In the *Alyne vs. Brazil* case, the CEDAW Committee emphasised that despite the government assertion that it had adopted a series of policies aimed at addressing women's specific needs, the author claimed that there was still a systematic lack of access to quality medical care during delivery, especially concerning the management and supervision of human resources. Therefore, the Committee emphasised that government health policies must be action/result oriented and adequately funded. Furthermore, strong and focused bodies must be in place within the executive to ensure the effective implementation of such policies. That failure to do so, violates maternal health rights set out in article 12(2) of the Convention and was also discriminatory as per article 2 of the Convention.⁵³⁰ Therefore, administrative accountability is aimed at overseeing maternal health policy implementation to ensure that the ideals set out within the policy frame work are operationalized.

4.4 OPERATIONALIZATION OF THE ACCOUNTABILITY FRAMEWORK

As established in the previous chapters, the accountability framework constitutes; responsibility, answerability and enforcement. Therefore, this chapter investigates the application of this framework within health administrative structures towards curbing

⁵²⁸ RJ Cook 'Gender, Health and Human Rights' in M Grondin et al *Health and Human Rights in a changing World*, 2013 344-345.

⁵²⁹ Technical guidance on Preventable Maternal Morbidity and Mortality Para 16.

⁵³⁰ Alyne da Silva v Brazil Para 7.6.

maternal deaths and morbidities. Under responsibility, the chapter points out human rights provisions that provide for tracking of the implementation of maternal health programs with the aim of averting MMM. It identifies and examines accountability aspects within Uganda's policy framework which include; monitoring/supervisory provisions, maternal death audits, and data collection mechanisms.

Under answerability, the need for the establishment of a comprehensive accountability body charged with MMM is emphasised. It is further pointed out that the enforcement aspect of administrative accountability is still very weak, thus the proposal that a series of strategies need to be implemented together to strengthen it. It is also stressed that the streamlining of all MH supervisory mechanisms into one consolidated accountability body will allow for easier enforcement/undertaking remedial measures in case of identified gaps in the system.

4.4.1 RESPONSIBILITY

In advancing the accountability framework, this section focuses on responsibility under administrative accountability. As has been emphasised in chapter three, responsibility is about putting in place standards of performance by which the implementation of policies/programmes can be measured. These standards of performance must be in line with human rights norms and principles such as participation, non-discrimination, and equality that have been emphasised throughout the previous chapters. Therefore, administrative accountability ensures that norms, rules and structures within the Ministry of Health as well as health facilities adhere to certain standards of conduct.

The system also puts in place an organised procedure by which subordinates are accountable to their superiors and the entire system is tracked or monitored by an independent entity.⁵³¹ Human rights documents are increasingly laying emphasis on the need for strong accountability mechanisms at the national level to ensure the implementation of maternal health policies and programmes. The CEDAW General Comment 24 stressed that states should monitor the provision of women's health services by both public and private organizations in order to ensure equal access and good quality of services provided.⁵³² Similarly, the General Comment on health pointed out the need for states to establish monitoring mechanisms (including institutional responsibility) at the national level for the implementation of health plans and strategies as well as appropriate recourse procedures.⁵³³ It further emphasised that the failure by states to regularly monitor the realisation of the right

⁵³¹ Technical guidance on Preventable Maternal Morbidity and Mortality, Para 74.

⁵³²CEDAW General Recommendation No. 24 Para 31(d).

⁵³³ General Comment No. 14 Para 56.

to health by for example, putting in place appropriate indicators and benchmarks, is a violation of its obligation to fulfil the right to health.⁵³⁴

The Technical Guidance on the Prevention of Maternal Mortality that was adopted several years later than the two documents mentioned above was more elaborate in setting out accountability and showing that accountability goes beyond monitoring. It emphasised that accountability should not be perceived as an afterthought but rather as a continuous process which establishes internal norms and rules within the Ministry of Health and the health facilities. The implementation of accountability entails the establishment of standards for performance/conduct that make subordinates accountable to superiors and ensures that an independent monitoring entity or individual is instituted.⁵³⁵ It further points out the need for effective participation which involves women being aware of their entitlements in regard to sexual and reproductive health right and thus being empowered to make claims to these rights. The Technical Guidance also points out the need for the continuous tracking and evaluation of the implementation of maternal health policies using both quantitative and qualitative indicators. Last but not least, it is emphasised that remedies should be put in place to give effect to the rights and these should not only be restricted to judicial mechanisms.⁵³⁶

The various components of accountability mentioned in the Technical Guidance are in line with the responsibility, answerability and enforcement model of accountability which is the approach that is forwarded for this study. Recently, the Committee on Economic Social and Cultural Rights adopted General Comment 22 on Sexual and Reproductive health. Amongst its core obligations, it emphasises the need to periodically monitor and review the implementation of sexual and reproductive health services using participatory and transparent processes. Another core obligation is ensuring access to effective remedies for the violations of sexual and reproductive health rights which may be administrative or judicial.⁵³⁷

Similarly, General Comment 2 of the Maputo Protocol obligates states to ensure that laws are comprehensive in that they are accompanied by administrative appeal procedures as well as complaints mechanisms in order to allow women to fully exercise their rights.⁵³⁸ The operationalisation of accountability in the health administrative system is one of the most direct ways of the inclusion of rights-based approaches in the health system. The

⁵³⁴ CESCR), 'General Comment No. 14 Para 52, 57, 58.

⁵³⁵ Technical guidance on Preventable Maternal Morbidity and Mortality Paras 18, 74.

⁵³⁶ Technical Guidance on preventable Maternal Mortality and Morbidity Paras 17, 67-70.

⁵³⁷ General Comment No. 22 Para 49.

⁵³⁸ General Comment 2 of the Maputo Protocol Para 29.

prioritisation of rights-based approaches in health care cannot be undermined. From 1990 to 2015 (MDG period) Nepal substantially reduced her MMM rates by over 5 percent annually. One of the main factors that was forwarded for the reduction of these rates, was the reframing of its health policies to reflect a rights-based approach. Plans and programmes addressing safe motherhood, gender, and neonatal health were gradually revised to strongly reflect human rights principles.⁵³⁹

In line with these human rights principles, this chapter aims at analysing accountability mechanisms within the health administrative system aimed at combating maternal mortality and morbidity. The aim is to ascertain whether they adequately track the implementation of maternal health as well as sanction violations of maternal health rights. Specific emphasis is laid upon those accountability mechanisms specifically concerned with reproductive health. To this end, instruments that are discussed in this section include; Monitoring/Supervisory bodies, Maternal Death Audits and Data Collection Mechanisms.

4.4.1.1 Monitoring/Supervision

Monitoring is an integral element of accountability, however it does not fully encompass accountability. Accountability should be interpreted and implemented wholistically taking into consideration its vital elements; responsibility, answerability and enforcement. Yet, as is elaborated upon within this section, the limited understanding of accountability is seen within Uganda's policy framework where it is often narrowed down to monitoring and evaluation. Even so, within the reproductive health policies, a clear accountability framework for the implementation of maternal health programmes running from the national to the local level is not clearly elaborated upon. This runs counter to the Technical Guidance on Maternal Mortality, which emphasises that where the health system is decentralized, the government remains accountable for complying with human rights obligations relating to sexual and reproductive health.⁵⁴⁰ One of these obligations is the implementation of accountability, which requires regular bottom-up diagnostic exercises aimed at identifying blockages in the system that hinder women from safely giving birth, and providing the prompt feedback needed to address these blockages.⁵⁴¹

Several policies have been adopted, specifically aimed at combating MMM. These include; National Policy Guidelines and Service Standards for Reproductive Health Services (2001), National Adolescent Health Policy for Uganda (2004), Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality in Uganda (2007-2015) and the Reproductive

⁵³⁹ Trends in Maternal Mortality (1990 to 2013) 27-28.

⁵⁴⁰ Technical Guidance on preventable Maternal Morbidity and Mortality Para 23.

⁵⁴¹ Technical Guidance on Preventable Maternal Morbidity and Mortality Para 53.

Health Maternal, New-born and Child Health (RHMNCH), known as the Sharpened Plan 2013.

The policies that were drafted earlier on, such as the Adolescent Health Policy and Policy Guidelines for Reproductive Health Services barely made mention of accountability. The Policy Guidelines for reproductive health services set out that the Reproductive Health Division under the Community Health Department would be in charge of monitoring and evaluation of the overall reproductive health sector among other tasks.⁵⁴²

The Reproductive Health Division under the Ministry of Health is charged with advancing reproductive health interventions including family planning, safe sex, obstetric and antenatal care and other initiatives aimed at ensuring safe pregnancy as well as delivery. It also chairs the Maternal and Child Health Technical Working Group.⁵⁴³ Apart from setting out the Reproductive Health Division, the policy vaguely states that higher placed health facilities will be charged with supervising and monitoring the lower placed ones. For example, it states that the national/regional referral hospitals will supervise the implementation of reproductive health services at the lower health facilities. Yet, it does not elaborate upon which person or entity within the health facility will be specifically charged with this monitoring/supervision.⁵⁴⁴

On the other hand, the Adolescent Health Policy set out a Technical Committee for Adolescent Health and another Technical Advisory Committee aimed at reinforcing the technical base for the steering committee. It is submitted that the roles of these two committees would have been collapsed into one committee to avoid duplication of initiatives and spreading out the already scarce resources.⁵⁴⁵

Nonetheless, amongst the responsibilities of the technical committee for adolescent health, is monitoring and coordination of the implementation of the adolescent health policy. At the district level, the policy sets out that the District Committee on Adolescent Health shall among other functions undertake monitoring and evaluation of adolescent health programmes.⁵⁴⁶ Except for a few statements such as these, in both documents, monitoring and supervision are given very little priority and accountability is almost never mentioned.

⁵⁴² Ministry of Health 'The National Policy Guidelines and Service Standards for Reproductive Health Services', Reproductive Health Division: Community Health Department, May 2001, 7.

⁵⁴³ Leary E and Akitobi E 'A case study of reproductive health supplies in Uganda', Population Action International (June 2009) 14.

⁵⁴⁴ National Policy Guidelines and Service Standards for Reproductive Health Services (2001) Section 2.5.

⁵⁴⁵ Ministry of Health 'National Adolescent Health Policy for Uganda', Reproductive Health Division, (October 2004) 24-28.

⁵⁴⁶ National Adolescent Health Policy for Uganda (2004) 24-28.

Ironically, several years later (2011) after the adoption of the Adolescent Health Policy (2004), an adolescent Health Strategy was adopted by the Ministry of Health and in its monitoring/implementation section, the same provisions ‘word for word’ as those in the earlier policy, were set out in this strategy.⁵⁴⁷ It would have been expected that with an increased understanding of accountability as a result of international and regional developments, this strategy would be more elaborate in setting out oversight mechanisms but that was not the case.

Two important policies that were adopted more recently and directly in line with maternal mortality are; Road Map on the Reduction of Maternal and Neonatal Mortality in Uganda (2007-2015) and the Reproductive Health Maternal, New Born and Child Health (RHMNCH), known as the Sharpened Plan 2013. The Sharpened Plan is commended for the fact that for the first time accountability, is mentioned as one of the priority areas for ensuring maternal and child survival.

However, it is ironic that while the reproductive health division of the Ministry of Health was put at the centre of monitoring and supervision of maternal health policies in earlier documents, the Sharpened Plan’s monitoring and accountability section, does not mention it. Instead, the plan states that the technical working group on maternal and child Health (presumably under the reproductive health division) as well as its sub-committees shall be in charge of coordinating the technical plan. Yet, it also goes ahead to state that the task force for the reduction of infant and maternal mortality, under the Ministry of Finance shall be strengthened.⁵⁴⁸ Though, the exact role that the task force shall undertake, in relation with the technical working group mentioned above, is not elaborated upon. This creates confusion as to which of these two bodies is charged with overall coordination of maternal and child health polices and how they shall interact with each other.

Other structures that the Sharpened Plan makes mention of at the district level include; the district stakeholders’ forum as well as the assistant district health officer for maternal and child health. Yet, the linkages between these various structures/bodies are also not elaborated upon within the plan.

Unlike the Sharpened Plan, the Road Map that came before the plan, made mention of the reproductive health division. However, it pointed out that the reproductive health division was severely understaffed and could not provide technical assistance to the districts. Thus it

⁵⁴⁷ Ministry of Health, ‘The National Adolescent Health Strategy (2011-2015) 29-33.

⁵⁴⁸ Sharpened Plan –Uganda (2013)50.

called for the provision of technical support to the division to improve its operations.⁵⁴⁹ Therefore, it is vital to note that, the setting up of various bodies with similar functions without establishing clear linkages between them creates potential for the duplication of services and the stretching of the already scarce resources. This is why the next section emphasises the need to streamline the monitoring/tracking of maternal health services by forming one body other than setting out several fragmented, inefficient and duplicating structures. This would also mean that the already scarce resources would be consolidated to this one body rather than being divided between various technical working groups and committees.

4.4.1.2 Maternal Death Audits

Maternal death audits are a vital aspect for tracking the reduction of preventable maternal deaths and the realisation of reproductive health rights. This is in line with human rights, which emphasise the need to put in place a system of conducting maternal death audits for establishing causal factors for maternal deaths.⁵⁵⁰

These should be comprehensive enough, going beyond the health facilities to establish the social, economic and cultural factors that contributed to the death.⁵⁵¹ The World Health Organization with a series of other organizations adopted a Maternal Death Surveillance and Response (MDSR) Technical Guidance in 2013. The Technical Guidance described maternal deaths as qualitative in-depth inquiries into the causes of, circumstances surrounding maternal deaths that take place both in the health facilities and within the communities.⁵⁵² Therefore, maternal death reviews require the following essential elements; a comprehensive record of all the deaths, good attribution of the reason of death and knowledge of the pregnancy status of the women in the reproductive age who die.⁵⁵³

These take into consideration both the deaths that occur at the health facilities through post-mortem pathological examinations and those that occur outside the health facilities reported through verbal autopsies. One of the main attributes of a maternal death audit set out by WHO is the need to set up a committee at the hospital or health facility level. However, studies have shown that about half of the maternal deaths that occur often go unreported even in countries with sufficient civil registration systems.⁵⁵⁴ Also, the Technical Guidance

⁵⁴⁹ Ministry of Health 'Road Map for accelerating the reduction of maternal and neonatal mortality and morbidity in Uganda (2007-2015) 14, 27.

⁵⁵⁰ A/HRC/18/27 (2011) Para 33.

⁵⁵¹ A/HRC/18/27 (2011) Para 33.

⁵⁵² World Health Organization et al 'Maternal Death Surveillance and Response Technical Guidance: Information for action to prevent Maternal Deaths' (2013)3.

⁵⁵³ Mills S (2011) 1.

⁵⁵⁴ Mills S (2011) 1.

on MSDR outlined the major steps to be undertaken in conducting MDRs; presenting a written summary of each death to a multidisciplinary committee, the committee reviews all relevant data and writes a brief report on the medical cause of the death, contributing factors and avoidability, these findings are coded and entered into a data base and then the committee issues recommendations that need to be taken to avert similar deaths in future.⁵⁵⁵

The main danger that lies in conducting maternal death audits is in ‘scape-goating’ of health workers who might end up facing strong sanctions. This might hinder the effective determination of the cause of the maternal death. While, enforcing human rights accountability, it is vital to realise that often a maternal death is a result of several systematic failures / bottle necks in the system rather than individual behaviour. Thus, such audits should be conducted comprehensively without placing blame on an individual.⁵⁵⁶

Though, after conducting comprehensive investigations, if it is indeed established that a health worker directly contributed to a maternal death, appropriate measures should be taken to ensure that the health worker is penalized accordingly. Also, actions should be taken to ensure that the family of the deceased is adequately compensated for the damages caused as a result of the death of their loved one. An example of this was the *CEHURD vs. Nakaseke District Local Government*, which has been elaborated upon in the legal accountability chapter. In this case, the judge found the doctor in violation of the right to maternal health care as a result of his absence from the hospital when he was meant to be on duty. His absence subsequently led to the death of the expectant mother (Nanteza Irene) as a result of an obstructed labour that was not promptly responded to.⁵⁵⁷

Maternal death reviews are principally guided by confidentiality as the information on issues such as the health personnel who handled the delivery and the details on the deceased mother or baby are not expected to be available to anyone except the team that conducted the review.⁵⁵⁸ Furthermore, the maternal and perinatal deaths audits are expected to be conducted by the service provider involved in the care of the deceased mother and baby while the confidential inquiry is conducted by independent assessors. These may include relatives, community members who looked after the deceased before the time of their death

⁵⁵⁵ Technical Guidance on MSDR (2013) 3.

⁵⁵⁶ Mills S (2011) 1.

⁵⁵⁷ *CEHURD and Others v Nakaseke District Local Government*.

⁵⁵⁸ Healthy New born Network ‘Maternal and Perinatal Death Review Guidelines’. Available at <http://www.healthynewbornnetwork.org/resource/maternal-and-perinatal-death-review-guidelines> (Accessed 21 September 2015).

in order to get a complete picture of the conditions surrounding the death of the mother or the child.⁵⁵⁹

Elsewhere, maternal death reviews have been effectively utilised to contribute to the gradual reduction of maternal mortality. Sri Lanka, is one such country where lower maternal deaths have been reported in comparison to other countries in South East Asia. Amongst the contributing factors is its comprehensive and unified maternal death review (MDR) process which includes facility-based reviews (with a strong emphasis on confidentiality) as well as community-based verbal autopsies.⁵⁶⁰ The findings from the MDRs have led to the revision of policies for better service delivery, improving emergency transportation, improvement in the referral systems, community awareness on maternal health issues, pooling of funds to support the disadvantaged people, improved commitment from the public health officials and enhancement in reporting and data collection among numerous other positive outcomes.⁵⁶¹

Amongst the factors that are responsible for the successful implementation of MDR in Sri Lanka are the strong managerial arrangements, senior staff commitment to the process, the inclusion of review teams and committees, engagement and interest from community leaders, better coordination for referrals and staff that are motivated to continuously conduct the reviews. More importantly, the process of monitoring the implementation of maternal death reviews is institutionalised through the appointment of contact persons both at the national and local level to regularly improve the data/information collection process and for quality assurance. Additionally, confidential inquiries are emphasised in order to avoid scape-goating and rather focus on learning lessons from the maternal deaths.⁵⁶²

In Uganda, the road map on the reduction of maternal and neonatal mortality set out guidelines emphasising that the Maternal and New-born Death Audits (MDA) should be institutionalised and made mandatory at the health sub-district level. The MDA reports that are received should be analysed both at the district and national level and there should be adequate community involvement in the conducting of the audits.⁵⁶³ Therefore, in 2000, the MoH put in place guidelines for maternal death audits/reviews and in 2008, it included perinatal death auditing as a result of the realisation of the interconnected nature of both

⁵⁵⁹ Healthy New born Network 'Maternal and Perinatal Death Review Guidelines'. Available at <http://www.healthynewbornnetwork.org/resource/maternal-and-perinatal-death-review-guidelines> (Accessed 21 September 2015).

⁵⁶⁰ Mathur A et al, 'Maternal Death Review in selected countries in South East Asia Region' (2014)121 *International Journal of Obstetrics and Gynaecology* 67-70.

⁵⁶¹ Mathur A et al (2014)67-70.

⁵⁶² Mathur A et al (2014)67-70.

⁵⁶³ Road Map for accelerating the reduction of Maternal and Neonatal Mortality and Morbidity in Uganda (2007-2015) Section (v).

maternal and perinatal deaths.⁵⁶⁴ The guidelines set out a national committee on maternal and perinatal death reviews, which was established in 2008. The committee has the role of making recommendations to improve maternal and child mortality based on the reports that have been received on maternal and perinatal death reviews at the regional and district level.⁵⁶⁵

Some measures have been undertaken to strengthen maternal death review committees in all regional referral hospitals, in 70 percent of the general hospitals, and training the village health teams to encourage women to register and to refer them to health facilities.⁵⁶⁶ The maternal and perinatal death reviews from 2009 to 2013 revealed that the top causes of maternal deaths were haemorrhage (36 percent), abortion related causes (10 percent), hypertension that is pregnancy-related (15 percent), and uterine rupture (11 percent). The underlying causes were the three delays; the woman's decision to seek health care, reaching the health care facility and receiving sufficient care once they arrive.⁵⁶⁷ The audits further revealed that another factor that contributes to maternal deaths are the inadequate health personnel to offer critical maternal health services especially in the hard to reach areas as many HCIVs and hospitals often have none of the essential staff (doctor, anaesthetist and midwife).⁵⁶⁸

In addition, Civil Society Organizations have been instrumental in operationalizing WHO guidelines on maternal death reviews. These have organised a series of national and regional workshops to learn from practices of other countries on how the audits can be improved. For instance, in coming up with maternal death audit forms, the Association of Obstetricians and Gynaecologists of Uganda heavily borrowed from that of South Africa.⁵⁶⁹ Thus, civil society has been instrumental in training health workers on how to undertake maternal death notification, reviews and confidential inquiry. However, most CSOs report that very few districts conduct comprehensive maternal death audits. This is largely due to lack of knowledge on how to conduct these audits and also in areas where they are

⁵⁶⁴ Healthy New born Network 'Maternal and Perinatal Death Review Guidelines'. Available at <http://www.healthynewbornnetwork.org/resource/maternal-and-perinatal-death-review-guidelines> (Accessed 21 September 2015).

⁵⁶⁵ Republic of Uganda, Safe motherhood 'Maternal and Perinatal Death review guidelines' (March 2010) 3rd Edition, Reproductive Health Division, Ministry of Health, 14-15.

⁵⁶⁶ The Republic of Uganda Ministry of Health, 'Annual Health Sector Performance Report for Financial Year 2013/14' 7.

⁵⁶⁷ AHSPR (2013/14) 4.

⁵⁶⁸ AHSPR (2013/14) 4-9.

⁵⁶⁹ Association of Obstetricians and Gynaecologists of Uganda' Maternal Death Reviews'. Available at <http://sogc.org/aogu/index395a.html?contentID=55> (Accessed 27 September 2015).

conducted, there is often no follow-up.⁵⁷⁰ Furthermore, due to organisational capacity and funding, CSOs are only able to reach a limited number of health facilities.

On the other hand, note should be taken, that maternal death audits are counterproductive if they are not used to inform and improve health policies.⁵⁷¹ Human rights accountability requires that appropriate channels are in place at the national, regional, district and facility level for analysing the findings and taking appropriate remedial measures to address the identified shortcomings.⁵⁷² Therefore, in order to address accountability, the audits should go beyond merely informing policy to directly being utilised in prompting the policymakers to put in place some form of remedial measures to combat future preventable maternal mortality.

One vivid example is one of the districts of Uganda known as Katakwi district found in the Eastern part of Uganda. In 2011, when the United Nations Population Fund (UNFPA) conducted its annual review meeting in Katakwi, it found out that by implementing maternal death audits, the district was able to lower MMR in one year from 465 to 375 per 100,000 live births. The data showed that six out of the ten maternal deaths were reported on time, these were assessed and the resulting recommendations were implemented. In one instance, delays were attributed to accessing ambulances on time, which led to the ambulance being housed at the Health Centre IV and the number of the driver was displayed at all public district facilities. As a result, there was improved emergency response to mothers in labour thus reducing the number of women who died before, during and after giving birth.⁵⁷³

While it is acknowledged that the health personnel are limited, the few who are sent to distant/remote areas are often absent from their duty stations, others resort to private practise and only show up in the public health facilities on rare occasions. The frequent absence of the health workers can be attributed to a series of factors among which is poor or no supervision in the health facilities and even when the supervision is done, sufficient sanctions are not put in place for absentee staff.⁵⁷⁴ Another obvious factor is the low remuneration of the health workers that forces them to take on other jobs to supplement their low pay, directly contributing to their absence from the health facilities.

⁵⁷⁰ Association of Obstetricians and Gynaecologists of Uganda' Maternal Death Reviews'. Available at <http://sogc.org/aogu/index395a.html?contentID=55> (Accessed 27 September 2015).

⁵⁷¹ Bandali S et AL 'Maternal death surveillance and Response systems in driving accountability and influencing change' (2016) 135 *International Journal of Gynecology and Obstetrics* 365-371.

⁵⁷² Technical Guidance on preventable Maternal Mortality and Morbidity, Para 54.

⁵⁷³ UNFPA Uganda 'Reducing Maternal Mortality: Katakwi does it', 8 August 2011. Available at http://countryoffice.unfpa.org/uganda/2011/08/08/3658/reducing_maternal_mortality_katakwi_does_it/ (Accessed 21 September 2015)

⁵⁷⁴ The Parliament of Uganda *Report of the Parliamentary committee on health on the ministerial policy statement for the health sector for the financial year 2012/13* (August 2012) 5.

Moreover, despite the adoption of these various guidelines, the conducting of maternal deaths reviews leaves a lot to be desired as numerous deaths still go unaccounted for especially in the rural areas. In certain health facilities, there are several limiting factors; there is often no one equipped to undertake the audit, lack of resources to conduct the audit, poor quality of case notes and rigid hierarchical structures within the medical profession.⁵⁷⁵ It is also submitted that in other instances, women do not go to health facilities to deliver but instead use traditional birth attendants or even relatives. In such cases, when there is a maternal death, there is a very high chance that such cases will not be well recorded.⁵⁷⁶

So, as has already been pointed out above, the adoption of guidelines and policies without institutions to ensure that such measures are implemented, does not guarantee their operationalisation. If the government does not take a further step to strengthen institutions that monitor their implementation, they will remain on the paper on which they have been adopted. This point was emphasised by the former special rapporteur on the right to health, who stressed that health plans are often not implemented as they remain ‘grand designs on paper’.⁵⁷⁷

4.4.1.3 Data Collection Mechanisms

Data collection methods are important for the monitoring/tracking mechanisms and institutions on maternal health as they help to provide them with the required data needed to inform planning and implementation. Data collection is like the engine that powers the supervisory institutions. While these mechanisms also collect information on their own through their monitoring, the information from the various data sources enhances the information collected. The data collection methods in line with Maternal Health include; Health Management Information System (HMIS), Monitoring and evaluation units, Profiles, Score Cards.

HMIS is an information gathering process that aims at capturing data on vital management information indicators to guide/facilitate planning, monitoring and evaluation of the health sector performance.⁵⁷⁸ Human rights emphasise the importance of effective health information systems in the improvement of access to maternal health services. For instance,

⁵⁷⁵ Weeks AD et al ‘A criteria-based audit of the management of severe pre-eclampsia in Kampala, Uganda’ (2005) 91 *International Journal of Gynecology and Obstetrics* 292-297.

⁵⁷⁶ Weeks AD et al (2005).

⁵⁷⁷ Human Rights Council, ‘Promotion and protection of all human rights, Civil, Political, Economic, Social and Cultural Rights’, Report of the Special Rapporteur on the Right of everyone to the enjoyment of the highest attainable standard of Physical and Mental Health, Paul Hunt, A/HRC/7/11 (31 January 2008) Para 88.

⁵⁷⁸ Kiberu VM et al ‘Strengthening district based health reporting through the district health management information software system, the Ugandan experience’, (2014) 14 *BMC Medical Information and Decision Making* 2.

the monitoring of the availability and quality of emergency obstetric care is highly dependent on coordinated and functional health systems. Therefore, sound health information systems allow for the collection of data and information on the availability of emergency obstetric care,⁵⁷⁹ which helps to improve and inform programming on maternal health. Uganda's health information system has undergone gradual improvements in a bid to improve its operationalisation. For instance, in 2007 attempts were made to transform it from a paper-based mechanism to a web-enabled software. This change was fostered by the various weaknesses that were facing the paper-based system pertaining to poor quality of data collected in relation to its unreliability, timeliness, incompleteness and its availability.⁵⁸⁰

In 2012 the web-based system known as the District Health Management Information Soft Ware (DHIS2) was rolled out to the 112 districts. This system has substantially improved data collection in terms of timeliness and completeness. It has also improved on the reporting of maternal health-related indicators as an increase was noted in the reporting of the proportion of women who attended 4 antenatal care visits, as well as an improvement in the reporting on the percentage of women who give birth in health care facilities.⁵⁸¹ Regarding profiles, the Sharpened Plan set out that it would put in place a national and sub-national Reproductive Maternal and New Child Health score card based on the HMIS data. The score card would be based on the five strategic shifts set out in the plan which are; focusing geographically, mutual accountability/cross cutting areas, placing emphasis on high impact interventions and performance of the health system (policy, human resource, finance) and increasing access to the high-burden populations.⁵⁸²

DHIS2 is not without its challenges as it is still mostly spread out at the district level with the lower level facilities still relying on the paper-based system, which compromises the quality of the data collected.⁵⁸³ Besides, at the district level, the focus of data collection has not been on informing planning and decision-making but rather on completing and submitting reports in time to the Ministry of Health. For instance, it was pointed out in the Sharpened Plan that the patient statistics from the Health Management Information System (HMIS) are not used in the quantification, allocation, forecasting, in planning decisions at all levels, and distribution of resources. Moreover, that there is absence of routine reporting on Reproductive Maternal and Child Health (RMNCH) indicators coupled with little demand for

⁵⁷⁹ Technical Guidance on Preventable Maternal Morbidity and Mortality' Human Rights, Para 72.

⁵⁸⁰ Kiberu VM et al (2014)

⁵⁸¹ Kiberu VM et al (2014).

⁵⁸² Sharpened Plan for Uganda (2013) 51.

⁵⁸³ Kiberu VM et al (2014).

information by users from concerned stakeholders, all of which frustrate monitoring/supervision mechanisms.⁵⁸⁴

The other challenges pertain to lack of adequate computers, lack of knowledge in accessing computers, lack of adequate qualified personnel to implement the system especially at the lower levels, challenges of internet connection and frequent power shortages in the rural areas.⁵⁸⁵ Therefore, in order to improve accountability for maternal health, there is need to continuously improve on the various facets of the data collection mechanisms in the health sector.

4.4.2 ANSWERABILITY

It has been firmly established in the previous chapters that answerability involves information sharing with the aim of increasing participation of local communities in the formulation and implementation of maternal health-related policies. Answerability also involves duty-bearers putting in place monitoring/supervisory/tracking mechanisms with the aim of justifying decisions that have been taken as well as continuously identifying gaps within the plans/policies and programmes.⁵⁸⁶ Answerability within administrative accountability is very vital in improving the provision of reproductive health services.

It is emphasised that the formation of an accountability body for maternal and child health will substantially reduce preventable maternal mortality and morbidity. Thus, it is submitted that the substantial reduction of maternal mortality is largely dependent on a strong and effective accountability/oversight body with interlinkages to the various structures both at the local and national level that are charged with monitoring the implementation of MH policies.

As pointed out in the responsibility section, one of the major drawbacks to the implementation of the proposed maternal health plan/programs, are the disjointed supervisory mechanisms that do not feed into each other or are not strong enough to enforce maternal health rights. The Sharpened Plan makes mention of various bodies to be involved in the supervision/tracking of maternal health services yet, it does not ascribe specific responsibilities to each of these bodies or show how they would interlink and work with each other. For instance, it states that the task force for the reduction of infant and maternal mortality reduction, chaired by the Ministry of Finance, shall be revitalised. Still, the roles and responsibilities of the taskforce are not set out within the plan. It further states that the technical working group on Maternal and Child Health and sub-committees shall provide

⁵⁸⁴ Sharpened Plan for Uganda (2013) 29.

⁵⁸⁵ Kiberu VM *et al* (2014).

⁵⁸⁶ Brinkerhoff DW (2004) 372.

technical coordination of the plan yet, it does not show how these two bodies interlink and function together.⁵⁸⁷

The plan also provided that the Health Policy Advisory Committee which is charged with coordinating health policy will ensure that the national policies are responsive to reproductive, maternal and child health policies yet it didn't demonstrate how this committee would work together with the task force mentioned above. Rather, the plan vaguely states that the institutional mechanism charged with tracking and monitoring the progress of the implementation of maternal and child health shall be inbuilt within the annual reviews and the sector compact. Other bodies, in line with maternal health, mentioned by the Plan are; the district RMCH stakeholders' forum, assistant district health Officer-Maternal Child Health, Health Unit Management Committees, Village Health Teams and other sectors.

While the data collection methods in line with Maternal Health include; Health Management Information System (HMIS), Monitoring and Evaluation Units, Maternal and Perinatal Death Review Committees, Profiles, Score Cards.⁵⁸⁸ The formation of several working/technical groups and committees, sometimes charged with similar functions creates potential for duplication, disorganisation and haphazard implementation. Subsequently, due to poor monitoring, the feedback from the systems is not consolidated enough to bring about the required change. Yet, if all these are interlinked with one body at the national level specifically charged with tracking and supervision of maternal and child health-related policies, the streamlining, harmonisation of such activities as well as their gradual improvement would be more possible.

It is advanced that there should be one oversight/accountability body at the national level specifically charged with monitoring/supervision of the implementation of maternal health-related policies. This overall accountability body does not necessarily have to be a new one but rather one of the various ones mentioned. The Technical Working Group on Maternal and Child Health housed under the Reproductive Health Division of the Ministry of Health, would thus be well-suited for the overall coordination of the monitoring/supervision. This implies that the Technical Working Group should be strengthened into a fully-functional body that is more than a group that meets a few times in the year. It should then be interlinked to other national and local bodies as well as data collection mechanisms charged with tracking the implementation of maternal health services.

The body would subsequently consolidate the data and information from these various entities and use it to address the gaps within the system that contribute to the pervasively

⁵⁸⁷ Sharpened Plan for Uganda (2013) 50, 51.

⁵⁸⁸ Sharpened Plan for Uganda (2013) 50.

high maternal and morbidity rates. Ultimately, this body would operationalize the responsibility, answerability and enforcement aspects of administrative accountability. This is in line with one of the priorities set out under the Road Map, which is to transform the technical working group into a multi sectoral technical working group charged with overseeing and reviewing progress of maternal and new-born health policy development.⁵⁸⁹ Yet, as mentioned above, despite making mention of it, the Sharpened Plan, which was formulated after the Road Map, did not elaborate upon the roles of this working group. Additionally, this body would coordinate with all the monitoring mechanisms both at the national and local levels. These include; the Health Unit Management Committees (HUMCs) and the Village Health Teams (VHTs)

In order to ably coordinate with accountability structures at every level, there should be someone specifically charged with overlooking/supervising maternal health issues. At the local level, the Health Unit Management Committees are vital bodies that are charged with monitoring the general administration of the health centre on behalf of the local council as well as the Ministry of Local Government. These are established at the Health Centres IV, III and II. At the Health Centre IV, a functional committee must be in place comprising nine members including; public figures with high integrity, the medical officer in charge, community representatives, head of the nursing division, staff representative as well as the assistant of the Chief Administrative Officer.⁵⁹⁰

The committees often comprise the health in charge, a respectable person from the community who acts as the chairperson, a representative for each parish for the HCIII, and a teacher who resides within the zone in which the health centre is located.⁵⁹¹ The HUMCs are charged with monitoring the expenditure and performance of the approved budget as well as funds from other sources. They also track the storage, procurement, utilisation of the health centre goods and services, and evaluate tenders in line with local government regulations. They are also charged with encouraging community participation in health activities both within and outside the unit.⁵⁹² Therefore, it is submitted that in order to prioritise maternal health, one of the members of the HUMCs should be specifically charged with monitoring the implementation as well as allocation of resources to maternal and infant mortality issues and thus report to the structures at the higher level.

⁵⁸⁹ Road Map for accelerating the reduction of MNMM in Uganda (2007-2015) 26, 29.

⁵⁹⁰ Regional Network for equity in health and East and Southern Africa (EQUINET), 'Health Centre Committees: a vehicle for social participation in health systems in East and Southern Africa', EQUINET Discussion Paper, 101, March 2014, 13.

⁵⁹¹ Ministry of Health '*Guidelines on Health Unit Management Committees for Health Centre III and II*', Department of Quality Assurance (2003) Para 2.

⁵⁹² Guidelines on HUMCs (2003) Para 1.2-1.6.

Also, at the lowest level, the government established the Village Health Teams (VHTS) to act as a linkage between the health facilities and the communities.⁵⁹³ Regarding accountability, due to their proximity, to the communities, VHTs are better placed to act as a source of information for the monitoring/tracking structures at the local level that have been mentioned above. These also undertake maternal health programmes. For instance, they encourage mothers to go for antenatal care services. Some of them were formerly traditional birth attendants so they possess basic skills on how to identify early complications of expectant mothers and working together with communities have come up with ways of getting women in labour to health facilities. Through health promotion, these also conduct training on the use of contraceptives and also supply them.⁵⁹⁴ Thus, it is suggested that amongst the VHTs operating at the village level, there should be one that is specifically charged with maternal and child health issues who reports such issues to the in-charge at the nearest health facility. This focal person would also be charged with tracking and reporting on maternal health-related issues within the community/village.

Uganda can draw some lessons from countries like Ethiopia and Rwanda. Ethiopia adopted and implemented a programme involving 300,000 community workers which focused on maternal, child health, HIV and Malaria.⁵⁹⁵ Likewise, in the build up to the post-development process, Rwanda was among the countries that was considered to be on track regarding the reduction of MMM as its annual percentage decline was over 5.5 percent.⁵⁹⁶ Rwanda has been remarkable in annually reducing its MMRs from among the highest in 2005 at 750⁵⁹⁷ to about 320 per 100,000 in 2013.⁵⁹⁸ One of the contributing factors was the functionalisation of the role of community health workers in quickly addressing urgent health needs.⁵⁹⁹ The community health program was initiated in 1995 with an intention of making it the first level of entry within the health system from the village level.⁶⁰⁰

One of the unique factors about the programme is that one of the community health agents at the village level is a maternal health agent. These agents are in charge of maternal and

⁵⁹³ Ministry of Health *National Village Health Teams (VHT) assessment in Uganda* (March 2015) 31-33.

⁵⁹⁴ National VHT assessment in Uganda (2015) 31-33.

⁵⁹⁵ National VHT assessment in Uganda (2015)11.

⁵⁹⁶ Trends in Maternal Mortality (1990 to 2013) 27-28.

⁵⁹⁷World Health Organization *Innovations Catalyst, 'MOH's Rapid SMS and Mubuzima* (2013).

⁵⁹⁸ Department of Maternal, New-born, Child and Adolescent Health (MCA/WHO) *Maternal and Perinatal Health Profile Rwanda*, 2015.

⁵⁹⁹ Trends in Maternal Mortality (1990 to 2013) 27-28.

⁶⁰⁰ UNICEF *Access to Health Care through Community Health Workers in East and Southern Africa Maternal New-born and Child Health Working Paper* (July 2014) 39-40.

child health and their training often involves record keeping, behaviour change communication, maternal and child health-related issues, nutrition and data collection.⁶⁰¹

Subsequently, through its various structures, this accountability body would be in charge of implementing the monitoring and evaluation strategy set out in the Sharpened Plan which involves; train district and hospital based staff on the use of the score card, HMIS, Maternal and Perinatal Reviews (MPR), undertake supervision aimed at improving maternal and child health, ensure the production, dissemination and review of reproductive, maternal and child health programme specific reports, train, facilitate and improve the supervision mechanisms of the Maternal and Perinatal Death Review Committees and enable professional councils to implement the findings from the review as well as conduct independent audits.⁶⁰²

It is further suggested that in its operations, the body should be able to collaborate with other mechanisms that directly impact maternal health. For instance, it would monitor the availability of the required drugs in health facilities. This would be aimed at addressing one of the challenges that have been continuously highlighted by the districts, which is the delay in supplying drugs in sufficient quantities to the districts.⁶⁰³ Therefore, in collaboration with the National Drug Authority, this body would investigate the underlying reasons for the shortages as well as the delays in the distribution of drugs to the health facilities at the local level. After collecting the findings that are specific to reproductive, maternal and child health, from each of its structures, this body should then be in position to take measures to correct the gaps in the system.

The consolidated findings of this body should also inform frameworks at the national level charged with the overall coordination of health such as the HPAC and the annual sector reviews. Without such a framework, there is a great risk of monitoring being carried out in a haphazard, inefficient and non-consolidated manner which is currently the case. This will not subsequently serve the purpose for which tracking/monitoring takes place.

Correspondingly, the tracking of the implementation of policies affecting women's maternal health cannot be done without the involvement/inclusion of the women who face these challenges. Therefore, the functionalisation of an oversight body specifically charged with maternal health issues would also allow for the streamlining of all community engagement initiatives on the implementation of maternal health-related policies. Some avenues of community engagement are set out in the Sharpened Plan and thus involve; training Village

⁶⁰¹ UNICEF Working Paper (July 2014) 39-40.

⁶⁰² Sharpened Plan-Uganda.

⁶⁰³ A Kirunda 'Residents grill health boss over missing drugs' *The Daily Monitor* 29 July 2016. Available at <http://www.monitor.co.ug/News/National/Residents-grill-health-boss-over-missing-drugs/688334-3320370-r7ty45/index.html> (Accessed 29 July 2016).

Health Teams(VHTS) and strengthening their skills to conduct MPDRs, strengthening community linkages to health centres through the Health Centre Management Committees, introducing community transport schemes and upscaling community initiatives such as community-based health insurance schemes as well as social marketing aimed at improving community's ability to access and afford lifesaving maternal health commodities.

As mentioned in chapter two, the idea of a coordination body for maternal and child issues is one that was also proposed by the Commission on Information and Accountability for women's and children's health. The Commission proposed that one of the ways of improving supervisory or tracking mechanisms at the national level is through the putting in place of a National Commission for women and children's health. This body would be accountable to parliament and inclusive of all related government departments as well as inclusive of CSOs.⁶⁰⁴

The Commission likened this body to the various national AIDS commissions in countries that have mobilised themselves in unparalleled ways to prioritize and address the HIV/AIDS epidemic. It asserted that even though AIDS commissions have their shortcomings and don't have legal authority, they have been able to catalyse and coordinate amongst policymakers, non-governmental organisations and development partners in the implementation of AIDS programmes and strategies.⁶⁰⁵

4.4.3 ENFORCEMENT

Enforcement within administrative accountability is examined from the human rights lens, expounded upon in chapter two, which emphasises that enforcement is not sorely punishment driven or a mechanism for apportioning blame. Rather, that it is a dynamic process that involves the sharing of roles and responsibilities with an aim of addressing the bottlenecks and shortcomings within the health system that are responsible for the non-substantial reduction of the preventable maternal deaths and morbidities.⁶⁰⁶ The bottlenecks that directly hinder the full realisation of maternal health rights include; haemorrhage, sepsis, obstructed labour, hypertensive disorders, clandestine abortions as well as the 'three delays.'⁶⁰⁷

In putting in place enforcement mechanisms, it is vital to first point out which conditions should be in place for the substantial reduction, and eventual extinguishing of preventable

⁶⁰⁴ Keeping Promises, Measuring Results (2011) 15-16.

⁶⁰⁵ Keeping Promises, Measuring Results (2011) 15-16.

⁶⁰⁶ Freedman LP (2003) 111-114. Yamin AE (2010) 7 95-231.

⁶⁰⁷ Joint UN Expert Technical Opinion (2011) 3-4. Concluding observations of the CEDAW Committee, Uganda (4-22 October 2010) Para 35.

maternal mortality and morbidity. These include, skilled birth attendants, acceptable family planning services, emergency obstetric care (EmOC), safe abortion services and functional referral systems.⁶⁰⁸ Enforcement helps to complete responsibility and answerability. Accountability without enforcement/ remedial mechanisms presents an incomplete picture. Even though good standards of performance are put in place followed by answerability strategies, without well-researched remedies to address the shortcomings that have been identified, the exercise of accountability will be counterproductive.

It is submitted that the formation of an accountability body that has been proposed within the answerability section would contribute to the strengthening of the remedial/enforcement aspect. The formation of this body would allow for the establishment of regulations to enforce the implementation of maternal health policies. In order to avoid duplication, the body should work together with the various enforcement structures to strengthen the remedial aspect of accountability. For instance, in case of issues pertaining to diversion of drugs, delays in dispatching drugs to health centres, the technical working group should work with the National Drug Authority to take the required remedial actions.

With cases pertaining to systemic failures such as non-functional referral systems, absence of the required basic or comprehensive EmOC services, lack of available and adequate family planning services, high prevalence of clandestine/unsafe abortions, the proposed body/task force should work together with the health management teams (at the national, district and sub district level) to comprehensively devise remedial/enforcement mechanisms to address these challenges. Similarly, the body should not shy away from bringing cases of rights violations leading to maternal deaths and morbidities to the Courts of Law as well as the Uganda Human Rights Commission. Where it is required, this working group should also work closely with civil society organizations working on right to health issues as well as private entities in devising remedies to correct gaps/shortcomings in the system.

This section looks at these major enforcement aspects; enforcement of financial resource utilisation, the role of regulatory bodies (Health Service Commission, professional health associations and the National Drug Authority) in enforcing maternal health care rights.

4.4.3.1 Financial Resource Utilisation

The role of financial resources towards the substantial reduction of maternal mortality cannot be overemphasised. Amongst the challenges Uganda faces towards the realisation of reproductive health rights are the inadequate financial resources for the provision of services required for combating MMM. Despite economic growth recorded over the years, Uganda is

⁶⁰⁸ Lobis S (2013)31-37.

considered among the lowest income countries, thus requires technical and financial assistance from other countries or international organisations.⁶⁰⁹ Therefore, in order to progressively realize reproductive health rights, there should be a gradual increase in the financial, technical and human resources, geared towards a substantial reduction in the high rates of maternal mortality and morbidity.

Budgetary allocations are usually a strong indicator of a country's priorities. Uganda's budget has often prioritized energy, transport and defence. For instance, the highest percentage of the 2015/16 budget went to national security and defence followed by private sector enterprise development.⁶¹⁰ The highest allocations in the latest 2016/17 budget went to the works ministry (3.7trillion), education (2.7 trillion) and the energy sector (2.4 trillion).⁶¹¹ Also, in his 2016, State of Nation Address, despite laying strong emphasis on the energy, infrastructural developments, trade, agriculture and mining sectors, the President Museveni barely made mention of health.⁶¹² This is so despite the numerous recent outcries and campaigns, calling for the prioritisation of the improvement of the dilapidated health system.⁶¹³ Conversely, even though the actual amounts have steadily increased, the percentages to health from the entire budget, over the last 4 financial years, have been noted to be steadily decreasing and have oscillated between 7-9 percent.

This is the case, despite committing to pledge 15 percent of its national budget to health, in the Abuja Declaration. Financial investment to health by the government averaged 8.6 percent of the overall national budget in 2013/14.⁶¹⁴ In the 2014/15 budget, the percentage to the health sector reduced from 8.6 percent to 8 percent of the overall health budget. Though the percentage reduced, the amount itself increased from 1.129.2 to 1.197.8 trillion.

⁶⁰⁹ 'Uganda Economy' Denmark in Uganda: Ministry of Foreign Affairs of Denmark. Available at <http://uganda.um.dk/en/about-uganda/country-facts> (Accessed 20 October 2016).

⁶¹⁰ Development Cooperation, Sexual and Reproductive Health 'Uganda's budget speech FY 2015/16: Highlights Health Sector Priorities'. Available at <http://blog.dsw.org/2015/06/ugandas-budget-speech-fy-201516-highlights-health-sector-priorities/> (Accessed 28 September 2015)

⁶¹¹ Karuhanga J 'EAC 2016/17 Budgets prioritize infrastructure, energy sectors' *The New Times* 09 June 2016. Available at <http://www.newtimes.co.rw/section/article/2016-06-09/200605/> (Accessed 13 August 2016).

⁶¹² State of the Nation Address, 2016. Available at <https://www.yowerikmuseveni.com/statements/state-nation-address-2016> (Accessed 13 August 2016).

⁶¹³ Kagumire R 'Uganda's radiotherapy machine has broken –but crowdfunding is not the fix' *Guardian African Network* 12 April 2016. Available at <https://www.theguardian.com/world/2016/apr/12/uganda-mulago-radiotherapy-machine-crowdfunding>. 'Rotting Hospitals have been exposed' *The Observer* 23 December 2015. Available at <http://www.observer.ug/viewpoint/editorial/41787-rotting-hospitals-have-been-exposed>. Mugerwa Y 'State house Mulago boss clash over hospital decay' *Daily Monitor* 12 April 2016. Available at <http://www.monitor.co.ug/News/National/State-House--Mulago-boss-clash-over-hospital-decay/688334-3155062-132wpftz/index.html> (Accessed 13 August 2016).

⁶¹⁴ AHSP Report, 2013-2014 xiii

However, the budget to reproductive health remained constant at 8 billion shillings.⁶¹⁵ In the 2015/16 budget, the percentage to health went down to about 7 percent although the actual amounts increased to 1.270.8 trillion shillings.⁶¹⁶ In the recently announced 2016/17 budget, the percentage remained at around 7 percent although the exact amount increased to 1.385 trillion shillings.⁶¹⁷ Still, the most important aspect is the maximum utilisation of the available resources. Even the countries that are considered developed do not have all the necessary resources needed to ensure a complete end to maternal deaths.

It is for that reason that human rights emphasises putting the available resources to maximum use towards the progressive realisation of rights. It also emphasises the need for including provisions within reproductive health programs/plans for ensuring effective accountability, including monitoring as well as processes for ensuring timely redress.⁶¹⁸

It is not enough that resources are allocated to the maternal health sector, these resources have to be put to their best use. For instance, despite the Ministry of Health alleging that the poor performance in the health sector is attributable to insufficient funds, other entities like the Ministry of Finance refuted the claim stating that budget allocations to the sector had been reduced in previous years due to low sectoral performance.⁶¹⁹ This assertion was supported by development partners who cautioned the government that if it did not address the shortcomings in the systems, such as the diversion of drugs from the health facilities and absenteeism of the health workers; any more funds given to this sector would not make any real impact as they would essentially go to waste.⁶²⁰

The lack of effective accountability bodies or systems to oversee maximum resource utilisation increases the potential for resource wastage, diversion, embezzlement. Corruption is a real challenge in Uganda and arguably one of the reasons for the perpetually high MMM.

⁶¹⁵ Development Cooperation, Sexual and Reproductive Health 'Highlights from the budget Speech 2014/15'. Available at <http://blog.dsw.org/2014/06/highlights-from-the-budget-speech-201415/> (Accessed 29 September 2015).

⁶¹⁶ Into SA 'Revised Budget focuses on energy and Transport', 25 May 2015. Available at <http://www.into-sa.com/countries/UG/news/revised-budget-2015-2016-focusses-on-energy-and-transport>. Kizza J 'Reading of the 2015/16 National Budget *The New Vision* 11 June 2015. Available at http://www.newvision.co.ug/new_vision/news/1328084/live-reading-2015-national-budget (Accessed 13 August 2016).

⁶¹⁷ Civil Society Budget Advocacy Coalition Group 'Position Paper on Health Sector BFP FY 2016/17', 1.

⁶¹⁸ Technical guidance on Preventable Maternal Morbidity and Mortality, Para 21, 52.

⁶¹⁹ Action for Global Health *Health Spending in Uganda: The impact of current aid structures and aid effectiveness* Country Briefing (April 2010) 17.

⁶²⁰ Action for Global Health (April 2010) 17.

Corruption is so pervasive that it has become a tool of political management, co-option and patronage.⁶²¹

Both the United Nations Convention against Corruption (UNCAC) and the African Union Convention on Preventing and Combating Corruption (AUCPCC) were adopted in a bid to combat corruption amongst member states. Uganda ratified the UNCAC ON 9th September 2004.⁶²² On the other hand, while Uganda ratified the AUCPCC towards the end of 2013, as of 2016, it had not yet ratified it.⁶²³ More importantly, as has been emphasised throughout this study, the ratification of human rights instruments does not often guarantee the implementation of the provisions therein. On the contrary, as emphasised by Freedman, the common approach of stage managing political leaders to publicly profess their commitment to the realisation of human rights complete with photo-ops has often proved to be futile. The success of accountability is more likely to be realised through a genuinely participatory/contextualised political process in which the vision of an effective system is continuously negotiated and agreed upon.⁶²⁴

Additionally, a series of anti-corruptions mechanisms have been put in place which include; the Office of the Inspectorate of Government, the Auditor General, Anti-Corruption Court, Parliament's Public Accounts Committee, Directorate of Ethics and Integrity.⁶²⁵ Despite the existence of these mechanism, incidences of high level corruption in Uganda, often involving astronomical sums of money, have continued to occur over the years. One of such cases occurred in 2005, involving the Global Fund aimed at fighting tuberculosis, HIV and Malaria. This fund directly affected maternal health as more recent data shows that pre-existing medical conditions which are often worsened by pregnancy such as malaria, HIV, Diabetes, obesity now account for the leading causes (28 percent) of maternal deaths.⁶²⁶ After several investigations, the Public Accounts Committee uncovered gross misuse of funds by government officials for personal enrichment. This led to the suspension of nearly 370 million dollars by donors. The fund was later reinstated after a judicial probe had been launched by

⁶²¹ Human Rights Watch, 'Letting the Big Fish Swim: Failure to prosecute high level Corruption in Uganda' (2013) 15.

⁶²² 'Signature and ratification Status as of 21 September 2016'. Available at <https://www.unodc.org/unodc/en/treaties/CAC/signatories.html> (Accessed 23 October 2016).

⁶²³ African Union Convention on Preventing and Combating corruption. Available at <http://www.au.int/en/treaties/african-union-convention-preventing-and-combating-corruption> (Accessed 04 November 2016).

⁶²⁴ Freedman LP and Shaaf M (2013)106.

⁶²⁵ Human Rights Watch (2013)22-23.

⁶²⁶ Centre for Health Human Rights and Development 'Global trends in Maternal Mortality: How does Uganda Fair?' Available at <http://www.cehurd.org/2014/06/global-trends-in-maternal-mortality-how-does-uganda-fare/> (Accessed 30 September 2015)

the Ugandan Government followed by the putting in place of strategies to combat the recurrence of the graft.⁶²⁷

Yet in 2015, the Global Fund's Office of the Inspector General (OIG) revealed extreme delays in procurement of drugs, with some dragging on for years. This subsequently led to denying patients critical drugs and supplies, distribution of expired HIV testing kits, selling items such as condoms meant to be free, drug theft and a disconnect between the inventory figures on the one hand and the actual stocks or disbursements on the other hand. These systemic defaults amounted to 23.7 million dollars.⁶²⁸ Furthermore, in mid-2016 while appearing before the parliamentary public accounts committee, the Ministry of Health officials failed to respond to audit queries raised by the auditor general in the 2014/15 financial year pertaining to over 28 billion Uganda shillings meant for the payment of intern doctors and the recruitment of more health workers.⁶²⁹

Corruption is in contrast with the rule of law which is a prerequisite for the respect of human rights. For starters, research has shown that countries with high corruption rates also often have poor human rights record.⁶³⁰ According to the Global Corruption Perception index, corruption in Uganda has become worse through the years.

In 2010, it was ranked 127, in 2011 it was 143,140 in 2013 and 142 in 2014 out of 168 countries.⁶³¹ Article 2(1) of the ICESCR obliges states to take steps towards the elimination of obstacles that might hinder the effective realisation of socio-economic and cultural rights. Since corruption is one of the factors that may hinder the effective enjoyment of these rights, there is need to put in place fully functional and independent anti-corruption institutions, a national anti-corruption campaign as well as a preventative plan/policy. Still under this provision, states are required to put the available resources to their maximum use. The diversion and misappropriation of government resources hinders their effective and maximal utilization towards realizing health rights. Subsequently, it can be argued that the failure of the state to take comprehensive measures to combat corruption is a human rights violation.⁶³²

⁶²⁷ 'Global Fund in new scandal' *The Observer* 2 March 2016. Available at <http://observer.ug/news-headlines/42898-global-fund-in-new-scandal% 5C> (Accessed 13 August 2016)

⁶²⁸ *The Observer* (2 March 2016).

⁶²⁹ 'Ministry of Health Officials fail to account for Billions' *The Independent* 12 August 2016. Available at <https://independent.co.ug/?p=9485> (Accessed 13 August 2016)

⁶³⁰ Peters A 'Corruption and Human Rights', Working Paper Series 20 (September 2015) Basil Institute of Governance 7.

⁶³¹ Nassaka F, 'Uganda ranked among most corrupt nations' *The independent* 13 December 2015. Available at <http://allafrica.com/stories/201512142509.html> (Accessed 13 October 2016).

⁶³² Peters A (2015) 11, 16-18.

Corruption in the health sector is often a form of discrimination, in instances where health care professionals treat patients differently based on their financial status as well as their personal relationship with the health workers. The request for fees for medical services that are meant to be free of charge as well as asking for informal payments prior to providing treatment is a violation of the right to non-discrimination as well as the right to health. Asking pregnant women with reproductive health problems for bribes which they can't afford puts their lives at risk, thus infringing on their right to life.⁶³³ Incidences of health workers' mistreatment and negligence of patients have been reported. These also involve health workers demanding for money for services that are meant to be free such as charging for caesarean sections in government-funded hospitals or government-supplied drugs.⁶³⁴

Though, in identifying remedies to corruption, there is often a tendency to focus on low-level corruption and ignore high-level government corruption, which is responsible for the division of vast amounts of funds. Also, solely focusing on sanctioning health workers, without putting into consideration the impossibly difficult circumstances within which they operate, is not in line with human rights principles.⁶³⁵

There are numerous ways in which corruption in Uganda contributes to the persistently high MMMs. In 2013 it was reported that in addition to diverting financial resources during service delivery, the government was offering tax exemptions and incentives to some of the largest companies operating in Uganda. Thus, the amount of tax collected by the Ugandan Government from these companies was considered to be the lowest in East Africa. Consequently, in 2011 it was reported that the country lost up to twice of its entire health budget of 2008/9 as a result of tax giveaways by government.⁶³⁶

Budget indiscipline has also been reported, demonstrated through supplementary budgets from various ministries implying a contrast between budget approvals and implementation. This budget indiscipline is often characterized by questionable expenditures under various ministries and government agencies, supplementary appropriations without parliament's approval, flouting of public expenditure regulations, poor prioritization, delayed implementation, and lack of value for money, all of which constitute acts of corruption/misuse of funds.⁶³⁷ An example of delayed implementation happened under the Ministry of Health in

⁶³³ Transparency International, 'Corruption and Human Rights: Making the connection' (2009) International Council on Human Rights Policy 52.

⁶³⁴ Wojczewski S et al 'Portrayal of the Human Resource Crisis and Accountability in Health Care: A qualitative analysis of Ugandan newspapers' 2015(10) *PLoS ONE* 8.

⁶³⁵ Wojczewski S et al (2015) 10, 13.

⁶³⁶ Editorial 'Tax Injustice' *Black Monday Newsletter* (June 2013) Issue 7.

⁶³⁷ Mukunda J, Civil Society Budget Advocacy Group –Coordinator, 'Budget Indiscipline fuels public resource wastage' *Black Monday Newsletter* (June 2014) Issue 18.

the financial year 2012/13 when 706 million shillings was given to the ministry to develop the National Health Insurance Scheme Act, however by the end of that financial year the MoH reported no progress.⁶³⁸ To-date, the National Health Insurance Scheme has yet to take off.

In 2012, the Auditor General and the Criminal Investigation Department uncovered gross misuse of billions of funds by the Office of the Prime Minister meant for Northern Uganda Peace and Recovery and Development Programme.⁶³⁹ This led to aid cuts amounting to US \$300m due to donor concerns about the massive misappropriation of development funds. Likewise, the Auditor General's 2012 Report discovered over 89 billion Uganda shillings that were unaccounted for. In the same year, the Criminal Investigation Department reports revealed that about 150 billion shillings had been diverted through the creation of ghost pensioners as well as forgery in the Ministry of Public Service. Thus, the misappropriated fund added up to 239 billion Uganda shilling.⁶⁴⁰

An analysis was done of the 239 billion Uganda shilling to ascertain what contribution it would have made if it had been reverted to saving the lives of pregnant women prior to, during and after child birth.⁶⁴¹ The analysis revealed that the money would have enabled for the full implementation of the Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity, which had been costed at 150 billion shillings, leaving a surplus of 89 billion shillings to revert to other areas. 992 million shillings of this money would be able to allow for the recruiting of 2000 midwives and pay their salaries for a year. A meagre 24 million shillings of this money would provide solar lighting, which is critical in the delivery room and theatre for all the 2,443 Health Centres IV, III and II at the time.

In looking at these figures, there is no denying that corruption denies women access to essential maternity services thus exacerbating MMM.⁶⁴² The diverted resources would go a long way in addressing the dire state of the Ugandan health system characterized by shortage of health personnel at all levels including midwives and gynaecologists. This situation is worse off in the rural areas where half of the posts are not filled and in certain instances, whole districts don't have a doctor.⁶⁴³ Other factors include; lack of physical infrastructure, lack of basic material such as drugs, surgical gloves, vaccines, transportation, beds, no water, and no electricity.⁶⁴⁴

⁶³⁸ Mukunda J (2014) Issue 18.

⁶³⁹ Senfuka S 'The impact of Public Sector Corruption on delivery of Health Care services', *Black Monday Newsletter* Issue 4 (March 2013) 2.

⁶⁴⁰ Senfuka S (2013)2.

⁶⁴¹ Senfuka S (2013)2.

⁶⁴² Senfuka S (2013)2.

⁶⁴³ Wojczewski S et al (2015) 7-8.

⁶⁴⁴ Wojczewski S et al (2015) 7-8.

Surprisingly, these incidences of grand theft have not led to any form of serious sanctions for the high ranking officials whose offices are implicated. These often remain in office or undergo temporary suspension, which often leads to their re-appointment in other key positions of government.⁶⁴⁵ For the most part, only the technical officers face prosecution or jail time. For instance, one of the high level officials (the State Minister of Health at the time) implicated in the global fund case mentioned above, recently appealed his conviction. This led to the president offering to pay 100 million Uganda shillings for his legal fees, a payment which was confirmed through the Presidential Press secretary. He was acquitted on appeal.⁶⁴⁶ This demonstrates the government's lack of political will to respond to corruption at the highest levels and send out a clear message that it will not be tolerated.

This lack of political will translates to the government's relationship with anti-corruption institutions characterized by harassment, political interference and threats. Additionally, the lack of a comprehensive system for witness protection as well as safeguarding prosecutors from intimidation and bribery has led to the focus on corruption at low levels involving negligible sums of money leaving the top officials to freely accumulate astronomical wealth.⁶⁴⁷ Consequently, by defying accountability and the rule of law, corruption undermines human rights. The failure to impose stricter sanctions against those found liable both at the high levels and the low levels, legitimizes corruption and encourages its persistence. It further demonstrates that the laws and institutions cannot be trusted to deliver justice. Nonetheless, it is submitted that emphasis should be put on strengthening the enforcement mechanisms charged with holding accountable those who formulate and implement budgets. In line with maternal health, the formation of an accountability body for maternal and neonatal survival, with clearly established structures running from the local to the national level, will allow for the continued tracking of the utilisation of financial resources meant for maternal survival.

Just like the accountability process, the finance tracking process should be a continuous one coming from the proportion of the budget allocated to the sector, the breakdown of this budget, the dispatchment of the money, who receives the money up to the lowest level, how is the money utilised and accounting for this money. Furthermore, civil society should be actively involved in holding state officials accountable while empowering citizens. Similarly,

⁶⁴⁵ Human Rights Watch (2013)2

⁶⁴⁶ Human Rights Watch (2013)17.

⁶⁴⁷ Human Rights Watch (2013)2.

the media should play a robust role in bringing to light corrupt actions of both state officials and private institutions.⁶⁴⁸

4.4.3.2 Health Professional Associations

The absence or insufficiency of skilled birth attendants substantially contributes to the high rates of preventable maternal deaths in Uganda. Results from maternal and perinatal death reviews carried out from 2009 to 2013, revealed that one of the factors that greatly contributes to maternal deaths are the inadequate health personnel to offer critical health services.⁶⁴⁹

This is more prevalent in the hard to reach areas as many HCIVs and hospitals often have none of the essential staff (doctor, anaesthetist and midwife).⁶⁵⁰ Furthermore, as emphasised by the Technical Guidance, health workers are both rights holders as well as duty-bearers. On the one hand, they are required to respect the rights of health system users by desisting from neglecting, abusing and disrespecting them. Thus, they should be educated on how to uphold women's reproductive health rights as well as their right to care, especially by ensuring confidentiality and privacy.⁶⁵¹ On the other hand, as rights holders, favourable working conditions should be put in place for them, including benefits and salary. They should also be given a platform to air their grievances and disciplinary procedures should not be solely aimed at scapegoating or fault-finding but rather comprehensively identifying and addressing gaps in the system.⁶⁵²

Bearing this in mind, the task force on maternal mortality should closely work with the Health Service Commission (HSC) as well as the various professional health associations such as the Uganda Medical and Dental Practitioners Council and the Uganda Nurses and Midwives council to ensure that health workers are adequately fulfilling their duty-bearer role but also that their rights are protected as rights holders. It is vital to note that the HSC as well as the health associations regulate health professionals both in the public and private sector. These are discussed further below.

⁶⁴⁸ Raj Kumar C 'Corruption in India: A violation of Human Rights promoting transparency and the right to Good Governance' (2016)⁴⁹ *University of California Davis Law Review* 741-792.

⁶⁴⁹ AHSPR (2013/14) 4-9.

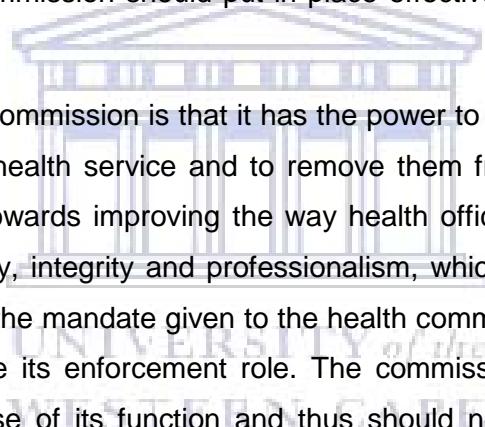
⁶⁵⁰ AHSPR (2013/14) 4-9.

⁶⁵¹ Technical Guidance on Preventable Maternal Mortality and Morbidity, Para 66.

⁶⁵² Technical Guidance on Preventable Maternal Mortality and Morbidity, Para 66.

a) Health Service Commission

The Health Service Commission is one of the vital accountability institutions mandated by the Ugandan Constitution to appoint persons to hold any office in the health service.⁶⁵³ Therefore, in 1998, when the Commission was established it adopted the Health Service Commission Act in 2001. The human resources for health under it include; midwives, nurses, doctors, dentists, nurses, pharmacists, allied health professionals and any other scientific, administrative and support staff that are appointed by the commission.⁶⁵⁴ The Commission is to be composed of 7 commissioners all of whom are to be appointed by the president with approval from the parliament.⁶⁵⁵ The major functions of the commission include; advising the president in relation to the health service, analyse and review the terms and conditions of service including the training and qualifications of members of the health service and make recommendations to government and any other duties and functions that may be set out by the constitution and any other laws.⁶⁵⁶ Therefore, in adhering to its accountability role, the Commission should put in place effective standards of performance to guide its operations.



A vital role played by the Commission is that it has the power to exercise disciplinary control over the members of the health service and to remove them from office.⁶⁵⁷ This remedial power ought to be used towards improving the way health officials operate to ensure that they exercise confidentiality, integrity and professionalism, which are key attributes for the health profession.⁶⁵⁸ Thus the mandate given to the health commission is expansive enough to allow for it to undertake its enforcement role. The commission is also expected to be independent in the exercise of its function and thus should not be under any control or direction from any individual or authority except to be guided by government policy.⁶⁵⁹ Yet, on the other hand, the Commission is also accountable to the parliament in that it is expected to annually submit a report highlighting how it has executed its functions.

So far, the records show that the Health Service Commission has not been consistent in writing these reports as the latest available annual report is for the 2009/2010 period.⁶⁶⁰ Also, the parliament is mandated to regulate the Commission's functions and to give

⁶⁵³ Constitution of Uganda(1995) Article 169-170

⁶⁵⁴ 'Health Service Commission' Available at <http://www.hsc.go.ug/content/background> (Accessed 20 September 2015). Section 3 of the Health Service Commission Act, 2001.

⁶⁵⁵ Constitution of Uganda (1995) Article 169

⁶⁵⁶ Health Service Commission Act, 2001 Section 8(1)

⁶⁵⁷ Constitution of Uganda (1995) Article 170

⁶⁵⁸ Health Service Commission Act, 2001 Section 29-35.

⁶⁵⁹ Constitution of Uganda (1995) Article 170(2)

⁶⁶⁰ This is the latest available report on the Health Service Commission as there is no record of more recent reports. Available at <http://www.hsc.go.ug/publications-and-downloads> (Accessed 21 September 2015)

recommendations on the requirements for public officers to operate in the health service.⁶⁶¹ Though, without consistently submitting these reports, to the parliament, it cannot effectively give recommendations to the Commission.

The Health Service Commission Act also sets out the health workers' conduct. Amongst, the standards that the health workers have to uphold is that they should not accept or ask for bribes, refrain from abandoning patients under their care and shall put first the health, safety and interest of the patient.⁶⁶² However, in many health facilities, the health workers often get away with violating these codes of conduct by; asking for extra fees even in instances where the service is meant to be provided freely, mistreatment of health workers, absenteeism from the health facilities to pursue personal ventures.⁶⁶³

This was the case in *CEHURD and others vs Nakaseke District Local Government*, which has been elaborated upon in the legal accountability chapter. In this case, the doctor on-duty was absent from the hospital while an expectant mother with an obstructed labour condition that needed urgent attention, could not be immediately attended to, leading to her death as well as that of her child.⁶⁶⁴ Therefore, the way health workers treat and attend to an expectant mother determines whether she will be in position to safely deliver or not. Any unprofessional conduct on their part may cost mothers their lives. Yet, one of the main reasons why such behaviour persists, despite regulations discouraging it, is lack of effective supervision and sanctions especially at the public health facilities to ensure that the health professionals abide by such ethical codes. This was also seen in the CEHURD case mentioned above where the hospital administrator who was charged with supervising the medical staff could not account for the whereabouts of the doctor on-duty at a time when he was urgently needed.

Due to the fact that Uganda uses a decentralized system of governance, the HSC works closely with the District Service Commission (DSC) at the district level. The DSC has similar functions to the HSC as it is charged with the powers to appoint any person to hold any office to serve at the district or urban council level. The DSC also undertakes disciplinary measures where there has been misconduct including, the removal of such persons from office.⁶⁶⁵ Thus the HSC may delegate its functions to the DSC and in such cases it should issue guidelines to be used by the DSC in accordance with the Local Government Act. The

⁶⁶¹ Constitution of Uganda (1995) Article 170(4)(5)

⁶⁶² Health Service Commission Act 2001, 'Code of conduct and ethics for Health Workers' Part IV,

⁶⁶³ The Parliament of Uganda *Report of the Parliamentary Committee on Health on the ministerial policy statement for the health sector for the financial year 2012/2013* (August 2012).

⁶⁶⁴ *CEHURD v Nakaseke District Local Government*.

⁶⁶⁵ Local Government Act, CAP 243, Section 55. Available at <http://www.ulii.org/ug/legislation/consolidated-act/243> (Accessed 27 September 2015)

HSC is also required to give advice to the DSC in relation to the management of any personnel in the district health service. Therefore, the district service commissions are mandated to submit reports every four months to the HSCs on the execution of its function in line with the health service. Also, when hearing or undertaking any form of disciplinary action against a person of the health service, the DSC is required to use guidelines provided by the Health Service Commission.⁶⁶⁶

The execution of these functions by the Health Service Commission working together with the District Service Commission is largely dependent on availability of resources to implement their duties and responsibilities. Thus, the parliament is charged with ensuring that sufficient financial resources are given to the Commission to enable it to effectively execute its functions. This also includes their salaries as well as administrative expenses, which should be attained from the consolidated fund.⁶⁶⁷ Though, the Commission has often complained of underfunding, which hinders the effective execution of its roles.⁶⁶⁸ Therefore, the government ought to show its commitment to improving the functioning of the members of the health service by consistently allocating funds to the HSC to enable it to effectively undertake its functions. This is due to the fact that health workers are the most vital element towards the reduction of maternal mortality especially when it comes to addressing the third delay which is the delay in receiving immediate and appropriate medical assistance once mothers have arrived at the health facility.

b) The Health Professional Councils

There are several health professional councils charged with regulating the work of health professionals. Currently there are four; the Uganda Medical and Dental Practitioners Council (UMDPC), the Uganda Nurses and Midwives Council (UNMC), the Allied Health Professional Council (AHPC) and the Pharmacy Council of Uganda.⁶⁶⁹ Focus is now shifted to the Uganda Medical and Dental Practitioners Council and the Uganda Nurses and Midwives council due to the fact that these are the most relevant for this study.

The Uganda Medical Practitioners Council is regulated by the Uganda Medical and Dental Practitioners Act promulgated in 1996.⁶⁷⁰ The act sets out the functions of the UMDPC which include; to monitor, supervise and ensure the adherence to professional medical, educational and dental standards as well as continuing education, to advise and make

⁶⁶⁶ Health Service Commission Act (2001) Section 26

⁶⁶⁷ Health Service Commission Act,2001 Section 13

⁶⁶⁸ Health Sector Strategic Plan III 2010/11-2014/15

⁶⁶⁹ The Uganda Health Professionals' Councils, '*Guidelines and Standards for accreditation*' 2

⁶⁷⁰ The Uganda Medical and Dental Practitioners Act 11 of 1996.

recommendations to government on issues relating to both professions and to have disciplinary control over medical and dental practitioners.⁶⁷¹ The UMDPC is to be principally funded by the government except in cases where fees and moneys are paid to the council for services that it has rendered.⁶⁷² The UMDPC is also expected to report to parliament through its annual report on the duties that have been dispensed together with copies of its audited accounts.⁶⁷³

This is vital as it creates an accountability channel and further entrenches the fact that accountability ought to be cyclical in nature. On the other hand, the Uganda Nurses and Midwives Council is very pertinent for maternal health as nurses and midwives are directly responsible for the lives of expectant mothers. The UNMC is regulated by the Nurses and Midwives Act (UNMCA)⁶⁷⁴ whose provisions are similar to those set out under the Medical and Dental Practitioners Act mentioned above. The UNMA regulates the standards of midwifery and nursing in Uganda, exercises disciplinary action over them, monitors the training, qualifications and continuing education of both professions and comes up with recommendations to the government on issues relating to both professions.⁶⁷⁵ The financing of the council is meant to be principally from parliament as well as from fees obtained as a result of the services rendered by the council.⁶⁷⁶ Just like the UMDPC, the UNMC permits an enrolled nurse or midwife who has been in service for not less than five years to apply for a licence to undertake private practice, which if permitted, a copy of the certificate of registration is given to the nurse or midwife.

It has been reported that giving licenses to health professionals is sometimes not based upon their qualifications but rather their ability to bribe those in charge of providing the certificate of registration.⁶⁷⁷ Both the Medical and Dental Practitioners Act as well as that of the Nurses and Midwives establish inspections as well as disciplinary mechanisms. The Medical and Dental Practitioners Act states that a registrar or any person authorised under the Act shall inspect any health unit together with a law enforcement officer to ensure that it is complying with the provisions of the Act and if any misconduct is uncovered in the process

⁶⁷¹ Medical and Dental Practitioners Act, Section 3.

⁶⁷² Medical and Dental Practitioners Act, Section 11.

⁶⁷³ Medical and Dental Practitioners Act, Section 16.

⁶⁷⁴ Nurses and Midwives Act 1996 Cap 274.

⁶⁷⁵ Nurses and Midwives Act 1996 Cap 274, Section 3

⁶⁷⁶ Nurses and Midwives Act 1996 Section 14

⁶⁷⁷ Road Map for accelerating the reduction of MNMM in Uganda (2007-2015).

of the inspection, a report on the unit will be submitted to the council which will take action as it deems fit.⁶⁷⁸

Regarding enforcement functions in general, the Medical and Dental Practitioners Council acts as a court whose decisions may be appealed to the High Court. Thus, the council may hold an inquiry after receiving allegations of professional misconduct and the person who is the subject of the inquiry is entitled to be represented by an advocate of his or her own choice. The council may also appoint an advocate to help in the conduct of the inquiry and to advise on legal matters and within thirty days after the inquiry, the council shall notify the concerned person in writing its decision.⁶⁷⁹

Concerning the Nurses and Midwives Act, the registrar or any person prescribed by the council may conduct an inspection of any health unit or maternity home to ensure that the provisions of the act are being adhered to. If the inspecting officer finds that the unit is not in compliance with the Act, they will submit a report to the council which may take action as it deems fit. The Act also establishes a disciplinary committee which among others should consist of an advocate who has been in service for not less than five years as well as a member of the Health Service Commission.⁶⁸⁰ The disciplinary committee has the powers to conduct an inquiry if an enrolled midwife or nurse has been convicted of a crime or is alleged to have committed a scandalous act, the person who is concerned should be given adequate notice, is entitled to be present at the proceedings and represented by an advocate. If the person fails to appear before the committee without any reasonable explanation, the committee shall proceed with the hearing and such inquiries shall be taken as judicial proceedings under the penal code act.⁶⁸¹ The council has the powers of the High Court to summon witnesses and examine them under oath.⁶⁸²

Even though both Acts set out that the personnel under question may appeal the decision of the council, they do not set out the steps/measures to be undertaken in case of non-compliance with its decisions. Nonetheless, the provisions for both the Uganda Medical and Dental Practitioners Council as well as the Uganda Nurses and Midwives Council sound intact and comprehensive on paper, however in practice they face numerous challenges that make them almost inoperable. Despite the existence of these professional councils aimed at

⁶⁷⁸ Uganda Medical and Dental Practitioners, Act Section 32

⁶⁷⁹ Uganda Medical and Dental Practitioners, Act Section 33-38

⁶⁸⁰ Nurses and Midwives Act 1996 Section 36

⁶⁸¹ Nurses and Midwives Act 1996, Section 37.

⁶⁸² Nurses and Midwives Act 1996, Section 38.

handling issues of various categories of health workers, these are almost never facilitated financially to enable them to monitor and supervise the quality delivery of services⁶⁸³

Despite the fact that both the Health Service Commission and the Health Professional Councils deal with the regulation of the health workers, there is no clear point of interaction between them. This is with the exception of one or two provisions in the Acts mentioning one of the commissions intermittently. For instance, the HSC involves all the members of the health service including nurses, midwives and doctors all catered for under different associations such as the Nursing and Midwife Association as well as the Medical and Dental Practitioners Association detailed above. Yet all these bodies are empowered to exercise disciplinary action over their members who may belong to more than one category. Within its framework, the HSC does not clearly stipulate how it would interact and work with such like-minded associations. This creates the potential for duplication especially because the target group for these bodies are health workers who may fall in all the various categories. It creates a situation where a health worker may be answerable to more than two bodies and yet there are no clear strategies on how these should work together. This coordinating/working together would be very beneficial as it would ensure that there would be no duplication of the already scarce resources.

Last but not least, in keeping with the accountability principle on answerability, the health service commission as well as the councils set out very limited or no forums for interacting with the communities. The Health Service Commission does not have any forums through which interactions are to be held with the communities to explain decisions that have been taken and to encourage the reporting of any instances of misconduct of persons in the health service. Regarding the Medical and Dental Practitioners council, only one provision is set out on community involvement, which is very limited as it sets out that among its functions the council shall disseminate to the public, ethics on doctor-patient rights and obligations.⁶⁸⁴ The general exclusion of the community in the functioning of the Commission and the councils does not fulfil the answerability principle of accountability and thus contributes to the general ignorance of the communities about the existence of such bodies.

It is thus argued that the work of Health Professional Councils and Associations towards enhancing accountability of health professionals should not be undermined. Uganda can also learn from other countries that have established several bodies to ensure the implementation of accountability in the health sector. For example, to show its commitment to health accountability, South Africa established the Office of the Health Ombudsman, in

⁶⁸³ Road Map for accelerating the reduction of MNMM in Uganda (2007-2015) 11.

⁶⁸⁴ Medical and Dental Practitioners Act, Section 3(h)

addition to the Health Professional Council of South Africa and Professional Boards.⁶⁸⁵ The Health Ombudsman is charged with receiving written and verbal complaints, investigating and disposing of the complaints in an expeditious, economical and fair manner.⁶⁸⁶ The Ombudsperson is established under the Office of Health Standards Compliance (OHSC) which was put in place to ensure the quality of health services as well as the certification of health facilities throughout the country.⁶⁸⁷ In 2015, the Minister of Health announced that the Department of Health would be advertising a position for their first ombudsman.⁶⁸⁸

This was prompted by an exponential increase in medical negligence claims, coupled with, what he referred to as, the deliberate mishandling of claims by litigants causing government to part with huge amounts of money by way of compensation. Consequently, the minister warned that with the appointment of the ombudsperson, they would ensure that, in addition to receiving and investigating complaints, effective sanctions/enforcement measures would be undertaken to gradually ensure improvement in clinical performance.⁶⁸⁹ It is submitted that if fully operationalised, the health ombudsperson will complement and improve the accountability role of the Health Professional Council of South Africa as well as the Professional Boards. Additionally, as pointed out above, it is stressed that health professional associations should be financially and technically facilitated in order for them to effectively execute their accountability role.

c) The National Drug Authority (NDA)

The NDA is established and regulated by the National Drug Policy and Authority Act, Cap 206. The National Drug Policy aims at guaranteeing that essential, effective and affordable drugs are available to all Ugandan citizens in a bid to achieve adequate health care.

To this effect, it relates to all matters pertaining to the importation, production, marketing, distribution, exportation and regulation of pharmaceuticals both in the public and private sector. Subsequently, the NDA is charged with the implementation of the National Drug Policy by among others; approving the National List of Essential Drugs, meeting drug needs, regulation of pharmacies and drugs, oversee the importation and exportation of pharmaceuticals, supervise the quality of both locally and externally produced drugs, encourage research and professional training on drug production and usage, institute

⁶⁸⁵ Health Professions Act 56 of 1974.

⁶⁸⁶ National Health Amendment Act, No 12 of 2013.

⁶⁸⁷ White Paper on National Health Insurance, 11 December 2015, No. 39506 Para 12.

⁶⁸⁸ 'SA to get medical ombudsman' News 24 10 March 2015. Available at <http://www.health24.com/Medical-schemes/News/SA-to-get-medical-ombudsman-20150310> (Accessed 12 November 2016).

⁶⁸⁹ 'SA to get medical ombudsman' News 24 10 March 2015. Available at <http://www.health24.com/Medical-schemes/News/SA-to-get-medical-ombudsman-20150310> (Accessed 12 November 2016).

professional guidelines, share pertinent information to the public and with health professionals and give guidance on the implementation of the NDP to all the bodies concerned with drugs. In line with accountability, the Act also establishes a National Drug Authority Commission charged with the monitoring and supervision of the implementation of the decisions of the drug authority, among other responsibilities.⁶⁹⁰

In as far as regulation is concerned, a drug inspector or his representative is entrusted with powers to enter premises with the aim of inspecting or to ask the owners of the premises to supply information on the activities that are taking place in those premises. He/she is also obligated to take away any drugs if it is suspected that they are unfit for the purpose that they are meant to serve. Furthermore, the auditor general in every financial year is empowered to audit the accounts of the drug authority and within two months after receiving the statement of accounts, deliver a copy of the audited accounts to the drug authority as well as the Minister of Health. Anyone who contravenes the provisions within the Act is liable to; a prescribed fine, removal of their license or permit, impounding/forfeiting/disposing off or destroying their property, imprisonment for a set period. Furthermore, every director, secretary or manager of the body cooperate is criminally responsible for any act or omission by an individual under the body corporate unless, the director/manager can prove that the offense was committed without his/her consent or that He/she exercised due diligence to avert the commission of the offense.⁶⁹¹

Despite the existence of a drug regulatory body, cases of drug misuse are not only rampant but have not been sanctioned. The Medicines and Health Service Delivery Monitoring Unit reported that 60 percent of the facilities visited in 2015 had expired drugs and 26 percent of the health facilities had discrepancies between drugs dispatched by the National Medical Stores and those they received.⁶⁹² Drug shortage is one vivid example of the implications of poor remedial/enforcement mechanisms. Government health hospitals and the health centres sometimes report going for several months without receiving medical supplies, forcing patients to incur out of pocket expenses for private clinics.⁶⁹³ Conversely, the National Medical Stores maintains that after receiving orders from health units they often promptly supply the required drugs and other supplies.⁶⁹⁴ The lack of essential supplies for

⁶⁹⁰ The National Drug Policy and Authority Act, CAP 206, Section 2-6.

⁶⁹¹ The NDPA Act, Section 51-53, 58- 62

⁶⁹² Mugerwa Y 'State House gives MPs hospitals rot evidence' *The Daily Monitor* 16 April 2016. Available at <http://www.monitor.co.ug/News/National/State-House-gives-MPs-hospitals-rot-evidence/688334-3159648-spi0qc/index.html> (Accessed 20 April 2016)

⁶⁹³ Mugerwa Y 'State House gives MPs hospitals rot evidence' *The Daily Monitor*.

⁶⁹⁴ 'Resolve Drug shortage Problem once and for all', *The Daily Monitor*, 29 August 2016. Available at <http://www.monitor.co.ug/OpEd/Editorial/Resolve-drug-shortage-problem-once-and-for-all/689360-3360872-itof9e/index.html>. (Accessed 04 September 2016).

safe delivery such as gloves, needles and plasters also fosters the health workers to ask the expectant mothers to come with their own supplies and failure to do so means they are not attended to.⁶⁹⁵ Consequently, the NDA has an uphill task in implementing the provisions set out in Act in order to remedy the gaps in access to the available drugs. It is asserted that addressing these bottlenecks will contribute to addressing MMM.

4.5 CONCLUSION

Administrative accountability lies at the heart of reducing MMM. The focus on improving administrative accountability procedures is likely to bring about more impact than any other form of accountability. Nonetheless, administrative accountability is often reduced to monitoring and evaluation within Uganda's policy framework. Even so, tracking/supervisory bodies are not interlinked with each other so as to feed information to each other in a way that can influence and improve upon maternal health programmes and policies. Several bodies have been established both at the national and local level without any linkages to each other. This frustrates supervisory efforts and encourages duplication. Furthermore, despite the fact that these bodies are formed, they are usually not well-facilitated to implement their roles and responsibilities.

The chapter emphasises strengthening, streamlining and clearly setting out the responsibilities of the already existing structures. It does not propose the formation of new parallel and duplicate institutions as this would stretch the already scarce resources. It rather stresses the need to prioritize the implementation of the existing maternal health-related policies by putting in place strong accountability institutions. Hence, it emphasises the need to form one body at the national level sorely focused with implementing accountability to combat preventable MMM.

This accountability body should not be established only on paper but should be operationalised by equipping it with the appropriate technical, financial and human resources. It should also run from the national to the local level by way of setting up structures at each level that feed into each other. This will greatly enhance the implementation of accountability in a continuous manner characterised by regular bottom-up diagnostic exercises as emphasised under human rights. Finally, there is need to strengthen the enforcement mechanisms aimed at identifying and curbing corruption at all decision making structures including those charged with formulating and implementing budgets.

⁶⁹⁵ Edema D, 'Jinja Hospital Medics ask patients for Kits', *The Daily Monitor*, 10 June 2016. Available at <http://www.monitor.co.ug/News/National/Jinja-hospital-medics-ask-patients-for-kits/688334-3241970-1410bo4z/index.html>. (Accessed 10 June 2016).

CHAPTER FIVE: THE ROLE OF SOCIAL ACCOUNTABILITY TOWARDS COMBATING MATERNAL MORTALITY AND MORBIDITY IN UGANDA

5.0 INTRODUCTION

This chapter builds on the previous chapters by emphasising the role of community participation in the improvement of accountability. Legal accountability is vital in bringing legal avenues closer to people whose maternal health rights have been violated. On the other hand, administrative accountability directly interacts with administrative structures to improve the implementation of maternal health policies, plans and programmes. The uniqueness of social accountability is that it directly interacts with the rights holders to improve service delivery. Unlike other forms of accountability, where accountability agents represent communities in holding policymakers accountable, social accountability allows for the direct involvement of communities in overseeing and supervising the implementation of maternal health programmes towards the reduction of preventable maternal mortality and morbidity.

Community-led accountability initiatives consist of numerous, diverse and broad actions, all of which cannot be examined within the limited scope of this chapter. Furthermore, many of these initiatives are not recorded and organised enough to allow for their effective analysis. The basis for the focus on CSOs is that to a certain extent they have structures in place that allow for accessing, analysis and comparison of information. Several discussions abound, pertaining to CSOs. Such discussions focus on their history, what constitutes civil society, as well as developments in the role of CSOs as regards representing community interests. Conversely, the focus of this chapter, in relation to civil society organisations as they relate to communities, is placed on those working on maternal health-related issues, either as a sole programme or as a part of their main programmes.

As emphasized in chapter one, the illustrations that are given, are by no means, a comprehensive account of all the interventions undertaken by CSOs to improve social accountability in Uganda. Though, it is hoped that the chapter contributes to the discussion on improving social accountability in a bid to reduce preventable MMM. It should also be stressed that even though, the focus is on CSOs, they are merely ‘vehicles’ that enable communities to better implement accountability. Thus the chapter illustrates interventions undertaken by CSOs to improve the capacity of communities to implement accountability.

5.1 UNDERSTANDING SOCIAL ACCOUNTABILITY

Social accountability is one of the most vital forms of accountability as it aims at the maximum inclusion of the communities in the tracking of maternal health plans/policies and programmes. Malena et al describes social accountability as an approach that directly engages the citizens in extracting accountability⁶⁹⁶

Campbell asserts that citizen-led accountability is at the core of accountability, which is ultimately about services getting closer to the people.⁶⁹⁷ Social accountability includes initiatives by citizens as well as civil society, aimed at holding duty-bearers (government officials, service providers, politicians) responsible for providing services that they have committed to avail to the community.⁶⁹⁸ Thus, Boydell and Keesbury emphasise that there is an implication that those in charge of policy formulation have to be answerable to citizens for action taken or not taken and may be sanctioned in case of failure to respond to these demands (enforcement).⁶⁹⁹ Joshi and PP Houtzager further ascertain that social accountability is an ongoing or sustained engagement of policymakers or state agencies by collective actors for actions taken or not taken, which is influenced by historical as well as current factors.⁷⁰⁰ The underlying objective of social accountability is that increased involvement of citizens will push public actors to implement their commitments.⁷⁰¹

As has been emphasised throughout this study, the main building blocks of accountability are; responsibility, answerability and enforcement. The same applies for social accountability. Social accountability has also become more common as a result of the weaknesses of the other forms of accountability notably political accountability, which emphasises the appointment of representatives to the general masses in ensuring the realisation of accountability. Political accountability, which principally uses voting/elections to hold those responsible accountable, has been criticised on a series of grounds.

Firstly, voting by its nature is limited as it gives citizens only one opportunity to punish or acknowledge numerous government decisions. Secondly, it is difficult for citizens to control the direction of the vote due to its decentralised strategic nature. Finally, the average citizen often lacks adequate information, which is necessary for comprehensively analysing

⁶⁹⁶ Malena C et al, 'Social accountability: An introduction to the concept and emerging practice', World Bank social development paper No.76. (Washington, DC: World Bank, 2004).

⁶⁹⁷ Campbell C, Papp SA and Gogoi A (2013) 2.

⁶⁹⁸ Peruzzotti E & Smulovitz C (Eds) *Enforcing the rule of law: Enforcing Social Accountability in New Latin American Democracies* (2006) 9-11. Jayal NG 'New Directions in Theorizing Social Accountability?' (2008)38 *Institute of Development Studies* 107. UNDP (2013) 3.

⁶⁹⁹ Boydell V and J Keesbury J (2014) 6.

⁷⁰⁰ Joshi A and PP Houtzager (2012) 146 and 150.

⁷⁰¹ Boydell V and Keesbury J (2014) 1-2.

government performance and its decisions.⁷⁰² Social accountability is more effective in the period between elections, as it enables collective actors to use their voices in processes aimed at monitoring public decisions.⁷⁰³

Social accountability is still largely in its infancy stage in Uganda. Only recently, has the term started penetrating civil society work in Uganda. This new focus on social accountability has played a great role in bringing to the fore the importance of accountability in service delivery.⁷⁰⁴ As a result, it is increasingly giving normative content and contributing to the catapulting of legal and administrative accountability, both of which have been expounded upon in the previous chapters.

The increasing recognition of the importance of social accountability has not left it without a series of operational challenges like duplication and non-harmonization of accountability initiatives. This is as a result of various civil society organisations working independently on similar issues and failing to effectively network to amplify their 'voices'.⁷⁰⁵ Also, Edwards and Hulme posited that another challenge faced is the difficulty in measuring the impact of the accountability work of these entities in terms of influencing review of policies and addressing bottlenecks in the system.⁷⁰⁶ Nonetheless, the focus on social accountability has been instrumental in highlighting the importance of implementing accountability towards averting maternal deaths and morbidities.

5.2 APPLICATION OF THE ACCOUNTABILITY FRAMEWORK TO SOCIAL ACCOUNTABILITY

As elaborated upon in chapter two, the accountability framework chiefly comprises; responsibility, answerability and enforcement. Responsibility under social accountability is aimed at examining whether policies that aim at curbing MMM provide for community involvement. In the accountability sense, community involvement implies the ability of local communities to be effectively involved in the monitoring of the provision of maternal health services. Since the focus, is on CSOs, answerability is aimed as ascertaining mechanisms established by CSOs, to track government implementation of policies aimed at curbing MMM. Under enforcement, it is emphasised that the ability to remedy gaps in the system and sanction wrongdoing, is the crux of accountability. Yet, as with administrative

⁷⁰² Peruzzotti E and Smulovitz (2006) 7.

⁷⁰³ Joshi A 'Producing Social Accountability? The impact of service delivery reforms' (2008) 38 *Institute of Development Studies* 13.

⁷⁰⁴ Campbell C, Papp SA and Gogoi A (2013)8 . Boydell Vand Keesbury (October 2014). Maru V (2010)12.. Hulton L et al, (2010)127. Lodenstein E (2013)2.

⁷⁰⁵ Senfuka S 'Mapping Maternal Health Advocacy: A case study of Uganda', Family Care International 2013.

⁷⁰⁶ Edwards M and Hulme D 'Too close for comfort? The Impact of official aid on Non-Governmental Organisations' (1996)24 *World Development* 961-973.

accountability, the enforcement aspect of social accountability is identified to be weak. Thus, mechanisms are proposed for the strengthening of the remedial aspect of social accountability.

5.2.1 Responsibility

Responsibility entails the establishment of guidelines/standards by which performance can be measured. In the social accountability context, responsibility is operationalised by catering for community participation within government plans and policies. However, it is forwarded that participation is not an end in itself. Therefore, accountability focuses on the aspect of community participation that enhances its involvement in the monitoring, tracking and supervision of maternal health-related programmes, plans and policies. As has been elaborated upon in previous chapters, the implementation of accountability towards the reduction of the pervasively high maternal mortality and morbidity rates calls for the upholding of rights such as; maternal health care, sexual and reproductive health rights, women's rights to life, the right to non-discrimination and equality.

In addition to these rights, social accountability requires that rights pertaining to effective participation such as freedom of expression, peaceful assembly, access to information of communities in Government programming are upheld. Article 19 of the ICCPR recognizes the right to hold opinions without interference (freedom of expression and access to information), Article 21 (right to peaceful assembly), Article 22 (right to freedom of association with others) while Article 25 recognises the right of everyone to participate in the running of public affairs, vote and be voted as a political leader, and to have access to public service in their country.⁷⁰⁷ The African Charter has similar provisions; Article 9 (right to receive information), Article 10 (right to free association), Article 11 (right to freely assemble with others) and Article 13 (right to either directly participate in the affairs of their country or through freely chosen representatives.)⁷⁰⁸

In the context of maternal health, General Comment 2 of the Maputo Protocol calls upon states to avail women, especially adolescent girls, access to the appropriate information and education on sexual and reproductive health rights and services such as family planning/contraception and safe abortion services.⁷⁰⁹ Women should also be effectively involved in all decision-making processes pertaining to pregnancy and childbirth. Their effective involvement in such initiatives will allow for the development of more inclusive,

⁷⁰⁷ ICCPR

⁷⁰⁸ ACHPRD

⁷⁰⁹ General Comment 2 of the Maputo Protocol Para 51.

effective, accountable and sustainable health programmes.⁷¹⁰ Additionally, the UN Technical Guidance on Maternal Mortality emphasised that women should actively participate in decisions that have a bearing on their sexual and reproductive health.⁷¹¹

Therefore, they should be enabled to challenge political, social and cultural practices that hinder them from participating in processes and decisions that affect their lives. In order to be able to do this, women should be involved from the problem identification stage, to designing of processes, budgetary allocation, policy implementation as well as the monitoring and evaluation of the programmes.⁷¹² The former special rapporteur on health also asserted that states have an obligation to put in place institutional arrangements to foster continued participation of all concerned stake holders especially the vulnerable sections of the population.⁷¹³

In addition to ratifying several international and regional treaties, Uganda's Constitution sets out several provisions similar to those in the human rights documents mentioned above. Section II (i) of the Directive Principles states that the state shall be governed on the basis of democratic principles which encourage the active participation of citizens at all levels of governance. Section (VI) gives civic organisations power to retain their autonomy in trying to achieve their political objectives. Section III states that all efforts shall be taken aimed at integrating the people of Uganda, taking into consideration their diversity in order to promote a culture of cooperation and tolerance for each other's customs and beliefs. Article 29 states that every person shall have the right to freedom of expression and opinion, freedom to assemble as well as demonstrate peacefully together with others, freedom of association which includes the right to form and belong to associations, unions, political and civic organisations.

Article 38 empowers every Ugandan to participate in government affairs either individually or through his or her representative. It also emphasises that every Ugandan, through civic organisations, should be able to participate in peacefully influencing government policies. In the *Purohit Case*, the African Commission emphasised that the right to participation applies to 'every citizen'. Thus, by reading Article 13 of the African Charter on participation together with Article 25 of the ICCPR, it endorsed the UN Human Rights Committee interpretation of Article 25. To this end, the Commission noted that any conditions to the exercise of the right

⁷¹⁰ A/HRC/ 14/39 (2010) Para 39.

⁷¹¹ Technical Guidance on MMM.

⁷¹² Technical Guidance on MMM.

⁷¹³ Hunt P, '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 E/CN.A/2006/48/Add 2, 19 January 2006, Para 36. Hunt P, '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/HRC/7/11, 31 January 2008, Para 41.

to participation ought to be based on reasonable and objective criteria set out within the law. Consequently, it asserted that there was no reasonable basis within the Gambian legal system for the exclusion of the mentally disabled persons from political participation.⁷¹⁴ Similarly, in *Doctors for life vs the Speaker of the National Assembly and Others*, brought to the South African Constitutional Court, the applicant (Doctors for Life International), argued that in the process of passing certain health bills, the National Council of Provinces had not welcomed public hearings as well as written submissions in a bid to ensure public involvement in its legislative processes.⁷¹⁵

The statutes in question were; the Choice on Termination of Pregnancy Amendment Act 38 of 2004, the Traditional Health Practitioners Act 35 of 2004, the Dental Technicians Amendment Act 24 of 2004 and the Sterilisation Amendment Act 3 of 2005.⁷¹⁶ The judge emphasised that in order to ensure that the national legislative process caters for public involvement as set out in section 72(1) (b), the rules adopted by the National Council of Provinces have to be specific, clear and certain and should make provision for public involvement as set out in section 70(1) (b) of the South African Constitution.⁷¹⁷ Furthermore, as elaborated upon in chapter three (legal accountability), the principle of meaningful engagement, introduced within South African courts of law, especially for housing cases, is one of the innovative legal approaches in line with community participation. Meaningful engagement allows for the proactive and continuous engagement between the duty-bearers and rights holders with the aim of reaching mutually agreeable solutions. The court also emphasised the role of CSO's in the facilitation of the engagements and also enabling the communities to ably express their needs.⁷¹⁸

In addition to the legal framework, the National Policy Guidelines and Service Standards for Reproductive Health (2001) assert that community participation is vital for the effective implementation of reproductive health programs. Thus policy guidelines stressed the need for the various resource persons at the community level such as the traditional birth attendants, community based district agents and community reproductive health workers to;

⁷¹⁴ Purohit and another v The Gambia (2003) AHRLR 96 (ACHPR 2003), Para 73-76.

⁷¹⁵ Doctors for Life International v Speaker of the National Assembly and Others (CCT 12/05) (2006) ZACC 11; 2006 (12) BCLR 1399 (CC); 2006 (6) SA 416 (CC) (17 August 2006) Para 2.

⁷¹⁶ Doctors for Life International v Speaker of the National Assembly and Others Para 4.

⁷¹⁷ Doctors for Life International v Speaker of the National Assembly and Others Para 321-326.

⁷¹⁸ Occupiers of 51 Olivia Road, Berea Township and 197 Main Street of Johannesburg v City of Johannesburg and Others (24/07) (2008) ZACC 1,2008 (3) SA 208 (CC); 2008 (5) BCLR 475 (CC) (19 February 2008).

Abahlali BaseMjondolo Movement SA and Another v Premier of the Province of KwaZulu-Natal and Others (CCT12/09) (2009) ZACC 31; 2010 (2) BCLR 99(CC) (14 October 2009).

Residents of Joe Slovo Community, Western Cape v Thubelisha Homes and Other (CCT 22/98) (2009) ZACC 16; 2009 (9) BCLR 847 (CC); 2010(3) SA 454 (CC) (10 June 2009).

widely disseminate reproductive health information, encourage cultural practises that aim at improving reproductive health.⁷¹⁹

The Road Map (2007-2015) included community involvement and participation within its priority interventions. It included the mobilisation and sensitisation of communities on maternal and new-born health issues such as timely referrals, danger signs, gender issues and the purpose of information systems. This is aimed at creating demand for maternal and new-born health services. It also emphasised the need to build the capacities of the health planning teams at the community level to effectively implement and monitor maternal and new-born health programmes. These include; VHTs, traditional birth attendants, health sub-districts, district health teams and community resource persons.⁷²⁰

More recently, the Sharpened Plan (2013) proposed to prioritise education and empowerment within its five strategic shifts. The plan emphasises that priority will be given to educating girls and women as well as the empowerment of women to make decisions. Furthermore, in its management interventions, the plan sets out that in order to increase community participation and increase demand;, specific emphasis will be put on training VHTs, especially those in low performing districts and health sub-districts; strengthen the capacity of VHTs to conduct community based reporting and feedback on Maternal and Perinatal Death Reviews; encourage male involvement in reproductive maternal, neonatal and child health; and strengthen community linkages by working with the health centre management committees to put in place community transport schemes.⁷²¹

Likewise, Uganda's policy frame work recognized the role of CSO's in overseeing the implementation of maternal health programmes/strategies. In setting out the roles of the NGOs and faith- based organisations, which are part of CSOs, the Road Map set out that these are charged with; contributing to the improvement of policies on maternal and new-born health, implementing maternal and new-born health activities as well as monitoring and evaluation of these services at the district and community level. ⁷²² On the other hand, the Sharpened Plan set out that CSOs would monitor and track the implementation of the targets set out in the plan and to mobilise communities to urge the government to prioritise maternal and child health interventions that are of high impact.⁷²³

Civil Society Organisations are at the centre of the success or failure of social accountability. These are often defined as not-for-profit, non-state voluntary organisations formed by people

⁷¹⁹ The National Policy Guidelines and Service Standards for Reproductive Health Services (2001) 9.

⁷²⁰ Road Map for accelerating the reduction of MNMM in Uganda (2007-2015) 26.

⁷²¹ Sharpened Plan for Uganda (2013) 37, 50.

⁷²² Road Map for accelerating the reduction of MNMM in Uganda (2007-2015) 32.

⁷²³ Sharpened Plan for Uganda (2013) 56.

in the social sphere. These may include networks, associations, movements and groups, which are independent from government that come together through collective action to advance their common interests.⁷²⁴ Non-Governmental Organisations are often considered a central part of CSOs and are usually defined as not-for-profit making entities that aim at influencing government policy as well as complimenting government services.⁷²⁵

Several factors have been forwarded that are vital for the success of social accountability initiatives by civil society. These include; internal organization, advocacy skills, ability to mobilise and utilise media, scope of membership, legitimacy and extent to which they are accountable to their own members.⁷²⁶

Various modes of social accountability are used by civil society organisations which include; community dialogues, budget tracking, advocacy campaigns, public interest law suits, investigative journalism and demonstrations/protests.⁷²⁷ Therefore, they should have a certain level of influence to be in position to influence initiatives, mobilise and attract members to their cause. Likewise, a functional relationship should exist between the CSOs and the government.⁷²⁸ Additionally, it is increasingly becoming vital for CSOs to form strategic alliances as well as networks to make their voice stronger and louder such that it can be heard and responded to by the state and its related entities.

The National Resistance Movement Government has created a relatively stable environment for the flourishing of CSOs. However, as the ruling government further entrenches itself in power, having been the ruling party for 30 years, the voices of dissent have increased with growing grievances on the poor state of public services specifically, the health sector where maternity centres remain in dilapidated conditions.⁷²⁹ In response, the government is increasingly muzzling voices of opposition or criticism. State control and interference over institutions that had been set up or flourished under the NRM Government, including CSOs, is starting to become more apparent. CSOs that engage in political activities are viewed as belonging to the opposition and are threatened with deregistration. This

⁷²⁴ World Health Organization 'Civil Society'. Available at <http://www.who.int/trade/glossary/story006/en/> (Accessed 20 April 2014).

⁷²⁵ World Health Organization 'Civil Society'. Available at <http://www.who.int/trade/glossary/story006/en/> (Accessed 20 April 2014).

⁷²⁶ DSW 'Decentralisation, social accountability and family planning services: The Cases of Uganda, Kenya and Tanzania', 27 November 2011, 21.

⁷²⁷ Women's Democracy Network:-Uganda Chapter 'Best Practices for enhancing Social Accountability in Uganda. Lessons from Uganda', April 2014 6.

⁷²⁸ WDN-Uganda Chapter (2014) 6.

⁷²⁹ Kabagambe AD, 'The Impact of the African Charter and Maputo Protocol in Uganda', in Ayeni VO (Ed) *The Impact of the African Charter and Maputo Protocol in selected African States*, (2016) 263-264.

constraints their work, and leads to self-censorship in order to play it safe and avoid getting on the wrong side of government.⁷³⁰

CSOs can also easily be dismissed or closely regulated by the state, which often uses the excuse that since they are externally funded, they are primarily accountable to their funders. The state maintains that CSOs primarily pursue donor interests thus have no legitimacy to be involved in domestic policy debates.⁷³¹

In 2016, the President assented to the NGO Act 2016 which replaced the Non-Governmental Organisations (Regulations) Act Cap 113 that had been amended in 2006. The Act received a lot of criticism from civil society on the basis of some vague provisions such as Section 44, which prohibits organisations from doing anything that would be deemed as prejudicial to the ‘security’ of Uganda and the ‘interest’ and ‘dignity’ of Ugandans, without attempting to define what ‘prejudicial to the security’ entails. This provision is given the force of law by Section 40(1) (d), which states that any person who does anything prohibited by the Act commits an offence.⁷³² CSOs maintained that provisions such as this could easily be used by the government (as it has done in the past) to intimidate and arbitrarily clamp down on civil society operations.⁷³³ Actions such as these increasingly affect the social accountability initiatives including dialogue, information gathering and community mobilization among others.

Nevertheless, CSOs can be credited for raising the profile of social accountability in Uganda over the recent years. CSOs are essential for policy reform, continuous advocacy for budgetary allocations and reforms, tracking budgets and ensuring that health outcomes are measured and published. Even though, generally speaking, the attention to social accountability and its role towards combating maternal mortality and morbidity is still largely limited and has not effectively permeated institutions charged with upholding maternal health. A number of national and international civil society organisations have been set up that directly deal with maternal health-related issues, among others. These include; White Ribbon Alliance (WRA), Centre for Health, Humans Rights and Development (CEHURD) Uganda Health Marketing Group(UHMG), Reproductive Health Uganda, Uganda National Health Consumers Organization, United Nations Fund for Population Action (UNFPA).

⁷³⁰ Omach P ‘Civil Society Organisations and Local level peace building in Uganda’ (2016)51 *Journal of Asian and African Studies* 82-83.

⁷³¹ Edwards E and Hulme D (1998).

⁷³² The Non-Governmental Organisations Act, Uganda 2016. Available at <http://chapterfouruganda.com/resources/acts-bills/non-governmental-organisations-act-2016>.

⁷³³ All Africa ‘Uganda’s Museveni Assent to NGO Act will cost us all’, 26 February 2016. Available at <http://allafrica.com/stories/201602260831.html> . All Africa ‘Uganda: Repressive NGO Act’, 9 March, 2016. Available at <http://allafrica.com/stories/201603090704.html> (Accessed 09 May 2016).

These have either jointly or on their own devised programmes and policies aimed at improving social accountability.

5.2.2 Answerability

As established in the previous chapters, answerability is principally about duty-bearers justifying their choices through sharing all the relevant information on laws, plans and policies with the communities. This is aimed at enabling them to effectively participate in policy implementation.⁷³⁴ Within the answerability perspective, information sharing is also aimed at empowering communities to ably track and monitor the implementation of maternal health programmes, plans and policies. Since the focus is on CSOs, this section looks at two major aspects; awareness raising initiatives by CSOs as well as mechanisms for tracking or monitoring government programs. For the most part, social accountability is considered to be successful when there has been change in, revision in or formulation of policy or laws to respond to the advocacy and activism.

5.2.2.1 Awareness Raising/ Capacity Building

In line with Article 19 of the ICCPR and Article 9 of the African Charter both of which emphasize the right to search for, access and impart information, Section 41 of the Ugandan Constitution provides for the right to access information for every Ugandan citizen except in instances where the access to information is likely to prejudice the sovereignty or the security of the state. The government went ahead to enact the Access to Information Act whose purpose is to; equip the public with timely and accurate information; protect persons that disclose maladministration, corruption or any other infringement of the law; allow for an effective, transparent and accountable government; and to build the public's capacity to effectively analyse and participate in the decisions of the government which have a bearing on them.⁷³⁵ The Act also sets out that information pertaining to planning as well as management by public bodies is to be placed in the public domain.

Awareness raising is also a vital element of human rights promotion and protection as pointed out by the CEDAW Committee in its concluding observations to Uganda in line with its General Recommendation 24. The committee called for raising the awareness, increasing knowledge and education on; sexual and reproductive health and rights, while including adolescent boys and girls, prevention of early pregnancy and prevention of STIs including HIV, affordable contraceptive methods, access to family planning services and information

⁷³⁴ Campbell C, Papp SA and Gogoi A(2013) (2013) 7

⁷³⁵ The Access to Information, Act (2005) Section 3.

especially for women in rural areas, access to health care facilities as well as trained health personnel.⁷³⁶

Therefore, access to information is necessary for the improvement of the bottlenecks or gaps in the system. Access to information enables the rights holders to become aware of the available services as well as those that are not available. Awareness raising is a prerequisite for tracking and monitoring, because in order for citizens to adequately participate in monitoring, they have to have a clear understanding of government operations and how they factor into them. Subsequently, awareness raising under social accountability is aimed at building women's capacity and confidence to be in position to place their demands and follow-up to ensure that these demands have been addressed. More importantly, is the role of awareness raising in bringing community members to the realisation that they are not merely beneficiaries, but are rights holders who are entitled to demanding for maternal health-related services.⁷³⁷

Civil Society Organisations working on sexual and reproductive health rights have been very instrumental in sensitising various members of the population on issues related to their sexual and reproductive rights. Several initiatives coordinated by CSOs often involve both the communities as well as the service providers. A series of international, regional and national organisations are involved in awareness raising on maternal health. These include; UNFPA, World Health Organization, White Ribbon Alliance, Reproductive Health Uganda, Uganda National Health Consumers Organization, Centre for Health, Human Rights and Development, Marie Stopes-Uganda, Ipas-Uganda, Action Group for Health, Human Rights and HIV/AIDS.

These CSOs conduct awareness raising alongside service delivery. For instance, Reproductive Health-Uganda (RHU) with support from UNFPA provides antenatal and post-natal care, conducts births either naturally or by caesarean, abortion care services (including manual vacuum aspiration) as well as post-abortion care services such as counselling, sepsis management, family planning. RHU also undertakes awareness raising to service providers on abortion care and maternal health related services. In addition, Village Health Teams (VHTS) are sensitised on the use of contraceptives, dangers of unsafe abortions. RHU has also been instrumental in undertaking community sensitisation meetings aimed at empowering communities to hold duty-bearers accountable. It organises dialogues bringing together the communities, health workers, district heath management and Health Unit

⁷³⁶ 'Concluding observations of the CEDAW Committee on the combined 4th, 5th, 6th and 7th Report of Uganda, (2010) Para 36.

⁷³⁷ Campbell C, Papp SA and Gogoi A (2013)7-8.

Management Committees.⁷³⁸ In one sub-county in Mityana district, community members demanded for the finishing of the operating theatre at the Health Centre IV, as well as an ambulance, while in Sheema, district communities noted their grievances about health workers opening health centres late or not opening them at all on some days.⁷³⁹

In an attempt to raise awareness on maternal health and foster the Ugandan Government to fulfil its commitments, the White Ribbon Alliance undertook a massive campaign known as ‘Act Now to Save Mothers’. The campaign involved several meetings with communities from three target districts of Uganda (Kabale, Lira and Mityana) to enlighten them on their rights in line with EmONC, identifying gaps in government’s commitments, informing them of budgetary and planning processes and how to monitor government’s processes.⁷⁴⁰ The campaign also heavily employed the media including; radio programs, blogs, news articles and television programmes, which were estimated to have reached 9 million people. Furthermore, the district health officials were trained on how to prepare annual health plans and budgets. It also engaged with the members of parliament as well as the Ministry of Health working group on maternal and child health to deliver the petitions that had been signed by thousands of people pertaining to maternal health. As a result of this campaign, the district health officials noted that the information acquired had been very important for them as it had enabled them to identify gaps which were included in the revised plans and budgets.

At the national level, the government responded to some of the immediate interventions and pledged to expeditiously take action to respond to the identified barriers.⁷⁴¹ Similarly, one of the priority areas for Uganda Health Marketing Group (UHMG) is the provision of reproductive, maternal and new-born health services. In line with awareness raising, UHMG often undertakes massive media campaigns to ensure access to information.⁷⁴² In 2013/2014, UHMG reported that the initiative aimed at increasing the number of women who access antenatal care, postnatal care, and also to increase the number of women who accompany their spouses for antenatal care involved over 60,000 radio spots, 170 radio talk shows, over 4,000 IEC materials and 22 billboards. Consequently, UHMG reported that of the 35,906 referrals that were sent from the communities to the health facilities 69.8 percent reached the health facilities and 577,776 of these received HIV counselling and testing

⁷³⁸ Reproductive Health Uganda ‘Annual Report 2014’

⁷³⁹ RHU(2014)

⁷⁴⁰ The White Ribbon Alliance-Uganda ‘Preventing Maternal and New born deaths: Prioritizing emergency obstetric and new-born care in Uganda’ (2014-2015).

⁷⁴¹ The WRA-Uganda (2015).

⁷⁴² Uganda Health Marketing Group ‘Annual Report (2013-2014) 26.

services.⁷⁴³ Unfortunately, the shortcoming with mass media is that it is often a challenge to ascertain the direct result of accessing such information. The only estimation that can be made is the number of people that the message is most likely to reach.

Additionally, a series of challenges/bottlenecks hinder access to information on sexual and reproductive health rights and services which is vital for averting MMM. It has been highlighted in chapter two that amongst the challenges that face maternal health, and exacerbate maternal deaths, is women's lack of knowledge about the risk attached to childbirth and how to prevent such risk. The ignorance and lack of awareness in the rural areas can be attributed to a series of factors such as high illiteracy levels, which hinders their ability to understand the language in the documents; lack of an established and organised forum through which the community can be effectively involved in ongoing government programmes as well as the technical nature of the information that is distributed on sexual and reproductive health rights.⁷⁴⁴

Maternal mortality and morbidity is principally an issue of women. As set out in chapter two, health issues that primarily affect women have traditionally been side-lined, with some policy makers viewing maternal mortality as an inevitable consequence of reproduction rather than a social injustice. Therefore, it is vital that women's voices are heard and responded to in policy making and implementation processes.⁷⁴⁵ Yet, in the rural areas of Uganda where maternal mortality rates are still pervasively high, the vulnerable women who are highly affected, as a result of lack of reproductive health care services, lack the necessary information and education that is necessary for their effective participation and demand for services.⁷⁴⁶ Due to their marginalized and subordinated position in society, women are often not open to expressing their opinion.

This is also compounded by the fact that women do not have autonomy in deciding whether or not to use contraceptives, which type of contraceptive they should use and the number and spacing of children they should birth.⁷⁴⁷ At the health facilities too, there is a general disregard for community members who seek to access health services especially at the lower local health facilities. These women often do not have agency as they are maltreated,

⁷⁴³ UHMG (2013-2014)26.

⁷⁴⁴ Campbell C, Papp SA and Gogoi A (2013) (2013) 2-3.

⁷⁴⁵ Cook RJ and Dickens BM (2002) 225-231.

⁷⁴⁶ Guttmacher Institute 'Contraception and unintended pregnancy in Uganda' *Fact Sheet*. Available at <https://www.guttmacher.org/fact-sheet/contraception-and-unintended-pregnancy-uganda> (Accessed 13 December 2016).

⁷⁴⁷ World Health Organization Equity, *Social Determinants and Public Health Programmes* (2010) 178-183.

scolded and made to feel as if access to healthcare services is a favour to them.⁷⁴⁸ They usually spend long hours at the facilities with no explanation or information on when they will be attended to.⁷⁴⁹ Some of the reasons for these delays include; the late opening as well as the early closure of health facilities, large numbers of patients, poor attitudes of health workers, very few health workers, low remuneration of health workers (especially those living in hard to reach areas), health workers staying far from the health facilities as they do not have accommodation near to the health facility.⁷⁵⁰

These factors affect women's self-esteem or confidence, keeping them away from the healthcare facilities and hindering their capacity to freely express themselves in the community meetings or dialogues. The mistreatment of poor, vulnerable, rural women at health facilities is a common occurrence which is not unique to Uganda. This has also been observed in countries such as Peru, which is considered to be deeply unequal, with the maternal mortalities being concentrated in the marginalized and rural areas. The maternal mortality ratio in Peru is considered among the highest in Latin America estimated at 103 per 100,000 in 2008.⁷⁵¹

As usual, such averages often mask deep inequalities of the enormous gaps between the richer and the poorer regions with some going as high as 300. The lack of confidence and reluctance to use health services was noted especially among the female, poor, indigenous and non-Spanish speaking communities. This was partly attributed to mistreatment by the healthcare personnel, illegal charges for not giving birth at the health facility, charging for transport and medicine yet it is catered for under the insurance. All of these demonstrate the unequal power relations between the health care provider and the users.⁷⁵²

Ray, Madzimbamunto and Fonn emphasise that the right to healthcare is not automatically understood by health professionals especially those who perceive healthcare as a commodity to be accessed principally by those who can afford it.⁷⁵³ Thus, the implementation of rights-based approaches requires a critical analysis of the power dynamics that contribute to the persistence of MMM. These power dynamics are deeply embedded in policy making and implementation processes. To this end, rights-based

⁷⁴⁸ Mirugi-Mukundi G, 'A Human Rights-based approach to the realising access to Sexual and Reproductive Health Rights in sub-Saharan Africa' in Durojaye E (Ed) *Litigating the Right to Health in Africa: Challenges and Prospects* (2015) 61-62.

⁷⁴⁹ Campbell C, Papp SA and Gogoi A (2013) (2013) 2-3.

⁷⁵⁰ Uganda National Health Consumer/Users Organization 'Client satisfactions with services in Uganda's public health facilities 'A study by the Medicines Transparency Alliance (MeTA) Uganda, (February 2014)10.

⁷⁵² Frisancho A and Vasquez ML 'Citizen monitoring to promote the right to health and accountability' (2008)371 *The Lancet* 1-4.

⁷⁵³ Ray S, Madzimbamunto F and Fonn S 'Activism: working to reduce maternal mortality through civil society and health professional alliances in sub-Saharan Africa' (2012)20 *Reproductive Health Matters* 41.

approaches should directly engage with these power centres with an aim of transforming them. In line with awareness raising, the first step is to inform policymakers as well as health workers of the public's right to have access to vital information, to enable them track, scrutinise and monitor progress in achieving set targets.⁷⁵⁴

Awareness raising should be both demand and supply driven. While community members are being equipped with information to enable them to be aware of and demand for their rights, the service providers (health practitioners, health administrators, private health providers) should also be capacitated to effectively conduct their duties. In the *LC vs. Peru Case*, the state was urged to conduct education and training programmes for health providers aimed at changing their attitudes especially to adolescent women seeking reproductive health services.⁷⁵⁵

In several instances, the policymakers themselves are not equipped with the skills to infuse a rights-based approach in maternal health-related policies and programmes. Therefore, building their capacity is often the first step towards ensuring that they infuse a rights-based approach in their systems and thus addresses answerability. It also enables them to be more responsive to people's needs.⁷⁵⁶ This includes the policymakers, elected representatives as well as the health officials. Moreover, in order for access to information to be successful, the policymakers and service providers should be willing and open to share all the vital information and not merely general information. This should include; budget statements, policy frameworks, records of inputs, expenditures as well as outcomes and audit reports.⁷⁵⁷

It is further emphasised that capacity building should often be viewed as a means to an end and not an end in itself. Thus, it should not be taken for granted that once the capacities of women to demand for services have been built, these women will automatically demand for services and these services will be provided. Camaro, Jacobs and Fox assert that there is no direct correlation between raising awareness and the increased involvement of communities in demanding for improved services.⁷⁵⁸ In the case of Uganda, some of the factors that hinder communities from demanding for an improvement in service delivery even when they are aware of the gaps in the system include; lack of confidence in the system, fear of reprisal if and when they demand for services, and lack of clearly established channels through which they can make their demands heard.

⁷⁵⁴ Ray S, Madzimbamuto F and Fonn S (2012) 41.

⁷⁵⁵ *L.C v Peru*', Para 12.

⁷⁵⁶ Campbell C Papp SA and Gogoi A (2013) 7-8.

⁷⁵⁷ WDN-Uganda (2014)13.

⁷⁵⁸ Camargo CB and Jacobs E 'Social Accountability and its conceptual challenges: An analytical frame Work, Basel Institute of Governance, Working Paper series No.16 (2013) 10. See also Fox JA, 'Social Accountability: What does the Evidence Really Say?' (2015)72 *World Development* 348,349.

For instance, during the 2016 presidential elections, Kizza Besigye (the leader of the opposition party) visited Abim District Hospital during his campaign trail in Northern Uganda. Upon his visit, he found the hospital in a dilapidated state as it has not had a doctor for two years, did not have running water, and lacked basic medical supplies that had led to patients abandoning the hospital.⁷⁵⁹ However, the three nurses who escorted him around the hospital, pointing out the despicable state of the health facility to Besigye, were suspended shortly afterwards. They were accused of having broken the oath of allegiance/secrecy they had taken by revealing unauthorised information and that they had no authority to speak to the press.⁷⁶⁰ Mr. Besigye was also barred from visiting any other health facility as the police officials maintained that these were not part of the campaign route.⁷⁶¹

Ironically, four days after the visit to Abim Hospital, the district officials held a ground-breaking ceremony aimed at renovating the hospital. This was later followed by major renovations as a result of receiving 700 million Uganda shillings from the Ministry of Finance, a month after his visit. While the district officials maintained that the renovations were in the works, prior to Besigye's visit, the community insisted that the attention of the media to the hospital as a result of his visit led to its prioritisation thus speeding up the renovation process⁷⁶² Nonetheless, the events above depict that, if the cost for the women to step up and demand for services is high, they will tend to shy away from demanding for better services even when they are aware of the huge gaps or inefficiency within the system.

Hence, it is vital that organisations do not solely focus on awareness raising when effecting social accountability but go beyond that to establish other forums through which citizens can feel encouraged to participate in and demand for improved service delivery. It is for this reason that tracking/monitoring/supervision of the provision of maternal health services is an important element of social accountability.

5.2.2.2 Tracking/Supervising/Monitoring Maternal Health Services

It is not enough that the government merely report that progress has been made. This has to be matched with qualitative and quantitative up-to-date information to show the progress

⁷⁵⁹ 'Besigye in Abim Hospital, situation, Alarming', December 5, 2015. Available at <https://www.youtube.com/watch?v=G1wFg8YNquM> (Accessed 08 May 2016).

⁷⁶⁰ Africa Review 'Ugandan hospital nurses suspended over Besigye visit', December 11 2015. Available at <http://www.africareview.com/News/Hospital-nurses-suspended-over-Besigye-visit/-/979180/2992274/-/oxx77xz/-/index.html> (Accessed 08 May 2016).

⁷⁶¹ 'Besigye eludes police to visit health centre', December 21, 2015. Available at <http://www.monitor.co.ug/Elections/Besigye-eludes-police-to-visit-health-centre/-/2787154/3004252/-/6bdxlk/-/index.html> (Accessed 08 May 2016).

⁷⁶² 'Hospital renovated after Besigye visit', February 13 2016. Available at <http://www.monitor.co.ug/News/National/Hospital-renovated-Besigye-visit/-/688334/3074020/-/abfu98/-/index.html>. Accessed 8 May 2016).

made. This is also in line with human rights principles of progressive realisation and maximally utilising available resources. Regarding indicators and benchmarks, as highlighted in chapter two, a series of key interventions have to be in place to ensure the reduction of maternal mortality. These include; accessible, acceptable and good quality family planning services, skilled birth attendance, functional referral systems, emergency obstetric (EMoC) services and safe abortion services.⁷⁶³

Basic EMoC services include; assisted vaginal delivery, neonatal resuscitation, uterotonic drugs, parenteral antibiotics, anticonvulsants, manual placenta removal, and evacuation of retained products of conception.⁷⁶⁴ On the other hand, comprehensive EMoC services involve all the services mentioned under basic EMoC together with blood transfusion and surgery (caesarean section). In order to know whether such services are in place, indicators and benchmarks must be in place. If the benchmarks are not being met, well-articulated indicators should be formulated to point out areas where interventions need to be taken in order to respond to the problems.⁷⁶⁵ Therefore, in order to address the common causes of MMM, a series of indicators have been proposed which provide information on availability of facilities providing EMoC, the distribution of these facilities, whether an adequate number of women are utilizing the facilities, whether the facilities are available to the people who are most in need and whether quality services are being provided. These indicators should be disaggregated in order to cater for issues such as age, social status, and region.⁷⁶⁶

In applying benchmarks to the Ugandan level, a Health Centre III should be in position to provide basic EMoC, while Health Centre IVs and hospitals are required to provide comprehensive EMoC services.⁷⁶⁷ However, results reveal a high unmet need both for basic and comprehensive EMoC services. A study conducted to examine availability of EMoC services revealed that over 86 percent of facilities were not in position to provide basic EMoC to pregnant women.⁷⁶⁸ Subsequently, a considerable number of maternal deaths that occurred in health facilities were a result of lack of one of the services such as insufficient skills to conduct assisted vaginal deliveries, evacuation of retained products of conception and lack of blood transfusion.⁷⁶⁹ Therefore, at the community level, citizens/CSOs can use indicators and benchmarks to enable them to actively participate in monitoring/tracking the availability of EMoC services in health facilities. By collecting information about the services

⁷⁶³ Lobis S (2013) 31-37.

⁷⁶⁴ Lobis S (2013) 31-37.

⁷⁶⁵ Lobis S (2013) 31-37.

⁷⁶⁶ Lobis S (2013) 31-37.

⁷⁶⁷ Mbonye M et al 'Emergency Obstetric care as the priority intervention to reduce maternal mortality in Uganda' (2007)96 International Journal of Gynecology and Obstetrics 220-225.

⁷⁶⁸ Mbonye M et al (2007)220-225.

⁷⁶⁹ Mbonye M et al (2007)220-225.

that are missing, communities are empowered to; demand for better services, know which facilities have the required services and lobby for increased resource allocation.⁷⁷⁰

On the contrary, at the local level, the communities rarely get the opportunity to interact with and engage with their political and administrative leaders. This is due to the fact that there are no clearly established structures aimed at ensuring community involvement in the proposed or implemented policies, plans and programmes. Monitoring and supervision are not prioritised as the monitoring officers that are in place at the local level are not facilitated with funds and other technical resources to conduct the monitoring.⁷⁷¹

The Ministry of Health structures set out that monitoring ought to be executed at every level and the results of that monitoring should be used to influence policies at the various levels. For instance, the M & E plan for the Health Sector Strategic Investment Plan (HSSIP) is aimed at providing overall direction for the health sector by providing a guideline for all concerned parties to review, report progress and undertake joint planning. Yet, in actuality, as elaborated upon in chapter four, monitoring structures at the decentralised level are uncoordinated and infrequent and thus the information captured by the Health Management Information System (HMIS) is not conclusive and sufficient enough to adequately inform policy implementation. Thus, the reports generated with this information do not provide an accurate picture of what is happening on ground.⁷⁷²

Tracking and monitoring by civil society and the community is even more important due to the wide gaps between policy and practice in Uganda. As pointed out above and in chapter four, Uganda's policy on combating maternal mortality and morbidity is elaborate and comprehensive enough to address maternal mortality. Yet, the practise on ground is often far removed from what the policy sets out to achieve. Therefore, monitoring and tracking is vital in highlighting these discrepancies. To give an example, despite the government committing that by 2015 all sub-county and county health centres would be in position to provide basic EmOC, and that comprehensive EMoC would reach at least half of all the centres at the county level,⁷⁷³ the White Ribbon Alliance reported that none of the 43 government-funded health centres visited in three Ugandan districts even met the minimum requirements.⁷⁷⁴

⁷⁷⁰ Mbonye M et al (2007)220-225.

⁷⁷¹ WDN-Uganda (2014) 14.

⁷⁷² Action group for Health ,Human Rights and HIV/AIDs 'Evaluation of the Implementation of Sexual and Reproductive Health and Rights (SRHR) services against global and National targets for Uganda', April 2015,24.

⁷⁷³ Road Map for the Accelerating the Reduction of MNMM, Uganda (2007-2015).

⁷⁷⁴ The WBA-Uganda (2014-2015).

CSOs have been instrumental in filling this gap by bringing community members together with policymakers to identify gaps in the system and jointly devise solutions to these challenges.⁷⁷⁵ Civil society uses various platforms to track or monitor maternal health services. These include; issuing press statements, community dialogues, community watch dogs, citizen report cards, petitions, community score cards and budget tracking.⁷⁷⁶ In most cases, these are implemented as one-off activities or as projects with a limited time line. Joshi and Houtzager asserted that the focus of social accountability on specific methods such as public expenditure tracking systems, report cards, and community dialogues has been criticised based on several factors; the narrowing of the analysis only to the particular intervention, not community driven but determined by external factors (donors), their adversarial nature aimed at pitting communities against public actors and their sole focus on the state in the face of an increase in the public actors as a result of privatisation, offering sub-contracts and decentralisation.⁷⁷⁷

The purpose of these mechanisms is not discounted, but it is emphasised that they should operate as part of a more consolidated process rather than as isolated methods. Community engagement initiatives should be viewed as processes rather than as interventions. Rifkin further maintains that an intervention is a method aimed at pushing communities to accept a change in behaviour aimed at improving their health while a process is a series of actions implemented over time to allow for the acceptance of the intervention. Thus these, processes may include certain interventions but they should be part of continued or sustained actions practised overtime.⁷⁷⁸

Community dialogues are among the most common avenues used for monitoring/tracking government service delivery. These are usually facilitated by the CSOs bringing together service providers and community members to discuss maternal health-related issues. They are often organised in such a way that the policy/service providers will provide information on policies, programmes and plans that have been formulated by the government.⁷⁷⁹ The direct interaction with service providers enables the community to get direct responses to the challenges they face while trying to access maternal health services. The platform is also a good opportunity for jointly devising solutions faced by communities in trying to access

⁷⁷⁵ Simavi 'It all starts in the community: Social Accountability' Fact Sheet. Available at https://simavi.org/wp-content/uploads/2015/03/Factsheets_Simavi_Kenya_Community_Dialogue.pdf (Accessed 20 November 2016).

⁷⁷⁶ Lodenstein E et al (2013).

⁷⁷⁷ Joshi A and Houtzager PP (2012) 14 153-154.

⁷⁷⁸ Rifkin SB 'Examining the links between community participation and health outcomes: a review of the literature' (2014) 29 *Health Policy and planning* 98-106.

⁷⁷⁹ Marston et al 'Community participation for transformative action on women's, children's and adolescent's health' (2016)94 *Policy and practice Bulletin of the World Health Organization* 378.

services. The success of the community dialogues depends on the community's ability to effectively understand government policies and plans in order to participate effectively.⁷⁸⁰

CSOs also often use the opportunity of the community dialogues to present petition letters to the government or politicians on certain pressing issues. In 2015, over 30 CSOs working on maternal health and health-related issues released a press statement criticising the government plan of exporting 300 professional workers to Trinidad and Tobago. They asserted that one of the challenges facing Uganda and contributing to the high maternal mortality rates is the shortage of critical health workers. The loose coalition insisted that the government priorities were upside down as the emphasis should have been on improving health workers' remuneration, improving their working conditions by increasing their pay. They called upon government to reverse the plan and instead recruit more health workers including midwives, increase their pay, provide non-monetary incentives, such as accommodation to encourage their retention and to focus on the hard to reach areas.⁷⁸¹

Additionally, in 2009, the Ugandan Government signed a country compact under the International Health Partnership for the implementation of the HSSIP together with development partners as well as Civil Society Organisations. The compact sets out government and donor obligation to improve health service delivery as well as the CSO's role to independently monitor the health sector performance. Since the signing of the Compact, organisations under Action Group for Health Human Rights and HIV/AIDS (AGHA) have used various methods to monitor health service delivery such as; budget tracking, using community watch dogs, community dialogues. As a result, these periodically produce annual Shadow Reports on the health sector performance.⁷⁸²

In the 2012/2013 report, it was pointed out that health facilities at the lower levels were still plagued by a series of challenges including; lack of sufficient ambulance services, skeleton staff in the lower health facilities, very limited EMoC, stock-out of essential medicines and supplies, limited skilled staff to conduct the procurement of drugs and other medical supplies at the lower level health facilities.⁷⁸³ However, there is no direct way of assessing whether the recommendations pointed out in these reports are adopted by the government towards improving health service delivery.

⁷⁸⁰ Marston et al (2016) 378.

⁷⁸¹ 'Civil Society demands Government of Uganda halt plan to export lifesaving health workers'. Available at http://www.who.int/pmnch/media/news_events/2015/health-workers-uganda-press-statement.pdf (Accessed 28 April 2016).

⁷⁸² 'Civil Society Organisations (CSOs) shadow report on the performance of the Health Sector in 2012/2013', April 2014.

⁷⁸³ 'CSO shadow report-2012/2013 (2014).

One of the functions undertaken by the Civil Society Coalition to end Maternal Mortality in Uganda is tracking budgets on health. Therefore, in reaction to the 2013-14 budget speech, the Civil Society Coalition to end Maternal Mortality in Uganda expressed their grievance with the budget prioritising other issues such as State House spending and defence at the expense of health services.⁷⁸⁴ They asked that revisions be made to the budget in terms of increasing wages for priority health workers particularly at the health Centre III and IV for anaesthetists, midwives and laboratory technicians as this would facilitate the reduction of the high maternal mortality and morbidity rates especially in the rural areas. They estimated that this would come to about 77.9 billion shillings. They also stated that without the appropriate remuneration as well as other forms of motivation such as accessible accommodation, the staff turnover and absenteeism would continue to be high.⁷⁸⁵

In addition to tracking or monitoring, it has already been pointed out in the previous section, that CSOs are involved in service delivery. CSOs that provide maternal health services alongside the government are categorized under private-not-for-profit providers. However, while running such projects alongside government programmes is very necessary due to the numerous shortcomings in government service delivery, it poses some challenges. It may get in the way of civil societies conducting the overseeing/accountability role. It is asserted that service provision by CSOs, which is dependent on donor resources compromises their ability to confront those in power and to be independent from external interests. Besides, their involvement in service provision, to a certain extent turns them into policymakers thus making them also accountable to the communities. This confuses their role as direct representatives of the community to the government. Their project-based nature also puts a timeline on their service provision, which might lead to their abrupt withdrawal, leaving a huge gap as the government may be unable or unwilling to take over responsibility in areas where they have withdrawn support.⁷⁸⁶

Moreover, despite the fact that several organisations are involved in maternal health-related work, these are concentrated in the urban areas with very weak linkages to the districts and the local communities.⁷⁸⁷ Therefore, their scope of operation is usually limited as they

⁷⁸⁴ 'Civil Society Coalition to Stop Maternal Mortality in Uganda: Reaction to the financial year 2013/14 Budget Speech. Available at <http://wougnet.org/download/general/Civil%20Society%20Coalition%20to%20Stop%20Maternal%20Mortality%20in%20Uganda%20Reaction%20to%20FY%202013-14%20Budget%20Speech.pdf> (Accessed 28 April 2016).

⁷⁸⁵ 'Civil Society Coalition to Stop Maternal Mortality in Uganda: Reaction to the financial year 2013/14 Budget Speech. Available at <http://wougnet.org/download/general/Civil%20Society%20Coalition%20to%20Stop%20Maternal%20Mortality%20in%20Uganda%20Reaction%20to%20FY%202013-14%20Budget%20Speech.pdf> (Accessed 28 April 2016).

⁷⁸⁶ Edwards M and Hulme D (1998).

⁷⁸⁷ Senfuka S (2013) 6.

usually work in a few districts and not within the entire district. If an organisation is operating in 2 out of 11 sub-counties of a district and is in 3 districts entirely, it becomes such a challenge to upscale successful initiatives to operate at the national level. This is often due to limited resources which are donor-based, and as mentioned above are project- based. This creates the potential for the duplication of activities in some places while in other cases this much needed service may not reach those in most need of it.

Sometimes civil society priority areas for monitoring have been noted to differ from government goals and objectives. For the most part, CSOs focus on holding the government accountable for global and national commitments while putting very little emphasis towards aligning these initiatives closely to the implementation of the Ministry of Health programmes and policies.⁷⁸⁸ Likewise, CSOs are often involved at a broader level such as, at the stage of presenting the annual health sector performance reports, and the budget reading stage. Also the monitoring they undertake is usually of policies that are already in place like the health sector strategic plan, national budget.⁷⁸⁹ While this monitoring is very important, it would be more effective if they were involved in all the stages; project design, implementation, monitoring and evaluation. Accordingly, it is emphasised that there is need for CSOs to adjust the focus to include regular monitoring and tracking of the implementation of government policies and service provision. Focusing advocacy on the implementation of government policies/programmes will go a long way towards improving the impact of civil society on maternal health service delivery.

Also, while organisations do a lot of work on capacity building, serious thought and resources are rarely put into conducting comprehensive monitoring and evaluation of the impact of their work. The difficulty in measuring the impact of their work is due to the fact that it is largely qualitative.⁷⁹⁰ For instance an organisation whose purpose is to raise community awareness on maternal health-related issues may only be able to measure its success by the number of people that have been involved in the awareness raising sessions. Consequently, what happens as a result of several capacity building sessions such as actions taken as a result of change on attitude and perception is often out of the control of the CSO.

Similarly, despite the fact that many organisations exist, which deal with various aspects of the maternal health sector, their partnerships and networking is still inefficient. Therefore, even though they effectively undertake monitoring activities, their inability to effectively

⁷⁸⁸ Senfuka S (2013) 8.

⁷⁸⁹ Atim OG 'Social Accountability in Uganda' Uganda National Health Consumers Organisation, Internal discussion paper, 2012, 11.

⁷⁹⁰ Edwards M and Hulme D (1998).

partner with each other and amplify their ‘voice’ hinders the widespread coverage of their message. For instance, despite the existence of the Civil Society Coalition to end Maternal Mortality in Uganda, most of the advocacy done at the national level is done by individual organisations. This may be detrimental to the extent that it creates potential for the duplication of advocacy initiatives and also confuses the policymakers who might have to answer to different organisations over the same issues. Attempts at forming coalitions are often frustrated by lack of clear terms of engagement, inability to uniformly mobilise resources, as well as a lack of a shared sense of responsibility.⁷⁹¹ The fear of smaller social organisations being swallowed up by bigger ones in coalitions is real. As NGOs continue pursuing donor interests, there is often the risk that ideas from small grassroots organisations that often lack the capacity to adequately ‘sell’ their ideas, will be taken over by larger, well-resourced organisations.⁷⁹²

Yet, the success of accountability is hinged on the accountability entity possessing some kind of ‘power’. In the case of civil society, this power can be attained through the CSOs working on maternal health issues combining their various strengths to reinforce their influence on the state. If the coalition is strengthened and all organisations working on maternal health issues come together to agree on pressing issues to be raised with the government, their voice will be stronger, and thus will be more likely to be responded to. Consequently, the inability to effectively coalesce often gets in the way of successfully undertaking social accountability.

As pointed out by the Technical Guidance on MMM, accountability should not be perceived as an afterthought but rather as a continuous process aimed at identifying blockages in the system that hinder women from safely giving birth, providing feedback aimed at prompting the taking of action to address these challenges/blockages.⁷⁹³ Finally, with the exception of a few well-resourced organisations that are in position to hire financial analysts, civil society involvement in the various budgetary processes is often weighed down by their technical limitations. Attempts to simplify the budget for CSOs to understand are usually non-existent. Budgetary processes are usually illustrated by the same technocrats who are responsible for the formulation of the budget with very little attempt to simplify the process.⁷⁹⁴ This creates a challenge for individuals and civil society organisations that are seeking to hold government accountable to allocations to the health sector. So, it is not enough that government reads out the overall annual budget and the allocations to each sector and makes it available on its

⁷⁹¹ Senfuka S (2013) 12.

⁷⁹² Edwards M and Hulme D (1998).

⁷⁹³ Technical Guidance on MMM, Para 23, 53.

⁷⁹⁴ Atim OG (2012)18.

website. It should go beyond that to simplify the budget for non-technocrats to be able to understand it.

Challenges notwithstanding, the contribution of increased community involvement in the improvement in health service delivery cannot be overlooked. This can also be seen from Peru's 'Participatory Voices Project', a joint initiative between CARE Peru, (DFID) CARE-UK in partnership with the United Kingdom's Department for International Development (DFID).

The project utilised community dialogues, among other mechanisms, to improve community engagement in health service provision. The project was implemented in these stages; planning of activities by the technical supporting team, public announcement and selection process of the citizens' monitors of the quality of health services, capacity building of the future members of the monitoring teams, planning field visits to health facilities as well as introduction to health authorities, undertaking monitoring visits to health facilities and meeting for a participatory analysis of the findings, community dialogues and negotiations to agree upon commitments for the improvement of health service delivery and monitoring the commitments made as well as planning for the next steps for the monitoring of health service delivery.⁷⁹⁵

Subsequently, despite a few challenges, the implementation of the project from 2009 to 2011, registered a series of successes in the regions where it was implemented. These included; an improvement in the handling/treatment of vulnerable women by health personnel, better enforcement of the working hours by health personnel, promotion of culturally appropriate practices within the health facilities, better understanding of the right to healthcare both by the users as well as the health personnel.⁷⁹⁶ It also created spaces for dialogue and consultation between the health care providers and the rural women, which are often not available. Within these spaces commitments were made for the continuous improvement of healthcare by which the health personnel could be held accountable. As a result of its considerable success, citizen surveillance was institutionalized by Peru's Ministry of Health under its National Policy leading to the launch of the National Policy Guidelines to promote citizen monitoring in 2011.⁷⁹⁷

Finally, Village Health Teams (VHTs) are a vital linkage of the community to the health facilities. Thus, CSOs should collaborate with VHTs to ensure community involvement in health policies and programmes. VHTs constitute the Health Centre 1 with no physical structure whose primary role is to mobilise communities and encourage health promotion.

⁷⁹⁵ Frisancho A and ML Vasquez ML (2008) 1-17.

⁷⁹⁶ Frisancho A and ML Vasquez ML (2008) 1-17.

⁷⁹⁷ Frisancho A and ML Vasquez ML (2008) 1-17.

These were formed with an aim of closing the gap between the health facilities and the communities.⁷⁹⁸ The Village Health Team (VHT) is a non-statutory community (village) structure selected by the people to promote health and wellbeing of the community health members. Therefore, the basic functions of the VHTs are; health promotion and education, mobilizing communities to adequately utilise health services, management of community information, new-born care, management of simple community health issues, distribution of health commodities, management and follow-up of killer diseases among others. The VHTs are vital for answerability as they are charged with empowering communities to take charge of their own health as well as encouraging them to actively participate in the implementation of health programmes. In 2014, it was reported that there were 179,175 village health team members in the 112 districts, therefore an estimated 3 VHTs for each village.⁷⁹⁹

The operationalisation of VHTs is characterised by a series of challenges. While there is a national level coordination office, funds to the VHT programme have been noted to be on a steady decline since the inception of the programme. As a result, there are inadequate funds and staff for the implementation, supervision, monitoring and overall coordination of the programme.⁸⁰⁰ Furthermore, the success of the VHTs is hinged on their constant training and the improvement of their skills. However, the 2014 survey found that nearly 30 percent of these did not have any basic training.⁸⁰¹ Moreover, their effectiveness is dependent on having skilled workers in the health centres. The massive shortage of skilled health workers in almost all rural areas often leads to lack of supervision, thus VHTs often end up taking on tasks that are beyond their skills.⁸⁰²

Accordingly, it is suggested that, in every district, amongst the VHT's, there should be a person or a group of people specifically charged with reporting on the implementation of maternal health indicators. These focal persons would not be charged with implementing maternal health-related indicators but rather in gathering the necessary information to be shared with the assistant district officer – MCH. Therefore, this does not preclude other VHTs from conducting maternal and infant mortality related interventions. However, in terms of compiling the information, there should be a specific person charged with reporting in order to allow for an organized reporting procedure. This person or group of persons should undergo the requisite training to be able to undertake this responsibility.

⁷⁹⁸ Ministry of Health *National Village Health Teams in Uganda* Path Finder International, March 2015, 5.

⁷⁹⁹ National VHTs in Uganda (2015) 9, 10, 17, 22, 22.

⁸⁰⁰ National VHTs in Uganda (2015) 7, 22.

⁸⁰¹ National VHTs in Uganda (2015) 7, 22.

⁸⁰² Road Map for accelerating the reduction of MNMM in Uganda (2007-2015) 13.

It is also suggested that there is need for continuous training of VHTs on maternal and child health issues as well as facilitating them to carry out maternal death reviews. Due to the VHT's proximity to the communities, they are better placed to record maternal deaths that do not occur at the health facilities. These can also capture the specific challenges facing each community that hinder them from accessing health facilities in time. The VHTs should share this information with the contact persons at the health facility specifically charged with maternal and child health issues. As recommended under administrative accountability, every health facility, should have someone specifically charged with monitoring/tracking the implementation of maternal health issues who should in turn report to the higher administrative structures (Health Centres II to III to IV) up to the district level until the national coordinating structure.

5.2.3 Instituting Remedial Mechanisms

As has been emphasised throughout this study, accountability is not complete until issues raised are addressed and in case of failure, remedial/enforcement measures are undertaken to correct these shortcomings. Camargo and Jacobs state that enforcement is aimed at pushing service providers to act in a more responsive manner to the communities that they represent. That this can only be actualised if there exists certain consequences that are implemented in response to the non-implementation of required actions.⁸⁰³

The emphasis on enforcement is what differentiates accountability from any other concepts. These measures should not be aimed solely at identifying who to lay the entire blame on but rather at correcting shortcomings in the system. Remedies or enforcement measures are initiatives undertaken to address the challenges raised by the community in an attempt to access maternal health services. In the human rights contexts, enforcement allows for the remedying of human rights violations. This aspect completes accountability thus it is an important one. As has been emphasised throughout this study, in seeking remedies, accountability should go beyond legal accountability which has been the main focus for most human rights practitioners.

It is submitted that the remedial aspect of social accountability is one that needs critical thinking in order for it to be improved upon. This section further demonstrates the difficulty in separating the elements into neat categories as enforcement may directly flow from responsibility or answerability. The main challenge with social accountability in the Ugandan context is that the main focus is always put on the responsibility and answerability aspect of it. Mechanisms such as budget tracking, community dialogues, citizen monitoring and

⁸⁰³ Camargo CB and Jacobs E (2013) 10.

evaluation of public service delivery often identify shortcomings with the system and come up with recommendations on how to overcome these challenges. However, serious thought has not yet been put into developing comprehensive remedial mechanisms to hold policy makers and other stakeholders accountable for the non-implementation of agreed upon actions.

The remedial/enforcement aspect of social accountability in Uganda is very weak as it is characterised by merely reporting findings and recommendations to policy makers but rarely is it followed by remedial measures aimed at ensuring that policymakers correct the identified shortcomings. Therefore, the implementation of the identified shortcomings is often at the discretion of the policymakers and there are no repercussions for their failure to address them.

Hence, it is forwarded that Civil Society Organisations have a role to play as far as accountability is concerned, which is to go beyond identifying challenges for policymakers, to taking specific action to ensure that the identified challenges are addressed. In order to improve the remedial aspect of social accountability, in agreement with Ray, it is proposed that civil society may undertake the following measures; using a series of strategies together to ensure that policymakers are responsive to challenges raised (social mobilization, media, and legal remedies),⁸⁰⁴ secondly, developing the complaints process into an enforcement mechanism, and thirdly, using the tracking/monitoring/supervisory mechanisms mentioned above to access remedies for the local communities where they operate.

It is proposed that the use of several strategies together (social mobilisation, media, legal remedies) is aimed at mounting a certain amount of pressure on the policy makers to address the challenges raised from the various monitoring mechanisms. This is based on the premise that the continued public attention through public ‘naming and shaming’, litigation and the court of public opinion will push the policy makers towards remedying the identified bottlenecks in the system. Social mobilization is the bringing together of other like-minded organisations, faith-based entities, private entities as well as the community by using a series of methods/strategies to address a certain issue that requires immediate attention. The use of various strategies together rather than merely relying on legal remedies is also important in the Ugandan context where it has been pointed out within the legal accountability section, that access to courts faces a series of challenges ranging from the non-provision for socio-economic rights as fully justiciable rights, compliance with court

⁸⁰⁴ Ray S, Madzimbamuto F and Fonn S (2012) 40-49.

judgements, poverty, ignorance and high legal fees that keep the marginalized sections of the population away from the courts. Even in countries such as South Africa that have made socio-economic rights fully justiciable, litigation on its own, without social mobilization, may not bring about the required change.⁸⁰⁵

For example, in the groundbreaking case, *Government of the RSA vs. Grootboom and Others*, the applicant (Irene Grootboom) died 7 years after the handing out of the judgement, without a home but still in a shack in Wallacedene.⁸⁰⁶ Maru points out that social mobilization practices are often divorced from legal remedies while legal avenues also often don't make use of social mobilization techniques. That, for instance in Uganda, most interventions often focus on the direct interaction between the service provider/policy maker and the community without considering what happens when the service provider fails to respond to persuasion.⁸⁰⁷

It is asserted that in several instances, the failure of social accountability interventions has been attributed to the lack of legal remedies. For instance, in India, monitoring strategies aimed at monitoring nurse attendance did not lead to a reduction in nurse absenteeism. Similarly, that in the absence of a remedy for corrupt officials in India, an increase in exposing fraud did not directly lead to an increase in the amounts recovered. To this end, they await claims of violations. Thus, Maru recommends the combining of elements of social accountability such as data collection, enabling access to information and advocacy with legal strategies to achieve 'legal empowerment'.⁸⁰⁸

At the Ugandan level, there are already actions being undertaken involving media, social mobilisation and legal remedies to ensure that the policy makers fulfil actions set out in the policy framework. However, these need to be scaled up and harmonised to address some of the huge challenges facing the Ugandan maternal health sector. One of the most notable examples was the *CEHURD and others vs. Attorney General Case*, which has been elaborated upon in chapter three on legal accountability. In this case, the petitioners argued that the denial of the essential maternal health services to two mothers leading to their untimely death was a violation of several rights elaborated in the Constitution.⁸⁰⁹ Therefore, in addition to seeking legal remedies, CEHURD utilized massive social mobilisation including various members of Civil Society such as the Coalition to end Maternal Mortality in Uganda, the media, members of the academia, as well as the general public, to seek justice for

⁸⁰⁵ Heywood M 'South Africa's Treatment Action Campaign Case: Combining Law and Social Mobilization to realize the Right to Health', (2009) 1 *Journal of Human Rights Practise* 14-36.

⁸⁰⁶ Langford M et al *Socio-Economic Rights in South Africa: Symbols or Substance?* (2014) 187-188.

⁸⁰⁷ Maru V (2010) 83-93.

⁸⁰⁸ Maru V(2010) 83-93.

⁸⁰⁹ *CEHURD and others vs. Attorney General*.

thousands of vulnerable women who die from preventable causes while trying to give birth.⁸¹⁰

This raised the profile of the case both nationally and internationally and even though success in the courts has not yet been fully achieved, the attention brought to the case has led to the recognition that maternal and child mortality is an issue that deserves adequate attention. However, it is pointed out that the coalition building process in the CEHURD case mostly came about as a consequence of the case and not as an organized strategy implemented prior to the litigation process. Therefore, it is suggested that the coalition /social mobilization process should start before undertaking the litigation process. ⁸¹¹

Uganda can also borrow a leaf from the *Ministry of Health and Others vs. Treatment Action Campaign and Others*, which is another example of how the combination of social mobilization (including marches, legal education), media and legal avenues can facilitate in the enforcement of health rights. In this case, the Treatment Action Campaign demanded for the availing of nevirapine to all expectant mothers in order to reduce mother-to child transmission of the HIV virus. Subsequently, the court made an order in which it emphasised that the government should not restrict the availability of this drug to a few research centres but to ensure that all expectant mothers living with HIV have access to this essential drug.⁸¹²

Beyond the case, the TAC Campaign mobilised a social movement inclusive of poor and black people living with HIV. Heywood noted that the campaign attracted massive media coverage, enabling the amplification of the issues to a national as well as an international case.⁸¹³ The campaign also worked with researchers in the development of alternative policies and plans that would meet the ‘reasonableness’ criteria that has been emphasised in the South African Courts. These factors have been lauded for having contributed to the compliance with the judgement as well as the success of the campaign.⁸¹⁴ Perhaps another factor that made the TAC Campaign a success was the emphasis on awareness raising through the ‘treatment literacy’ model where people were necessitated to understand the science of HIV, the medicines that could work, its effect on the body and any other related research. Therefore, educational materials together with extensive training programmes were continuously conducted with the aims of linking the science of education to human

⁸¹⁰ ‘Real Justice could finally be delivered in Uganda by key ruling on maternal health’. Available at <http://www.theguardian.com/global-development/2015/nov/02/real-justice-could-finally-be-delivered-uganda-key-ruling-maternal-health> (Accessed 28 April 2016).

⁸¹¹ Namusobya S(2015) 119-139.

⁸¹² *Minister of Health and Others v Treatment Action Campaign and Others*.

⁸¹³ Heywood M (2009) 14-36.

⁸¹⁴ Heywood M (2009) 14-36.

rights, equality, and political science. Subsequently, the poor people became personally and socially empowered and thus were in position to advocate for their rights.⁸¹⁵

As a result of litigation coupled with social mobilisation strategies mentioned above, South Africa adopted an ARV treatment programme that was said to be the fastest growing in the World. By 2008, about 420,000 people were said to be receiving treatment from the public health system. Furthermore, the South African Government reported that by 2007 it had up scaled PMTCT services to 80 percent government clinics enabling approximately 580,880 pregnant women to access the services. Similarly, the number of babies born without HIV substantially increased. It was reported that of the 19,758 babies born to mothers living with HIV, 16,288 babies tested negative.⁸¹⁶

Another approach that is proposed for strengthening the enforcement aspect of social accountability, is to develop the various complaints mechanisms at the health facilities into remedial mechanisms. Working through the various structures of the accountability body on maternal and child health issues that has been proposed under administrative accountability, comprehensive steps should be taken to devise remedies for complaints raised at the health facility level. Government has established complaints mechanisms at various health facilities such as suggestions boxes, toll-free lines, email addresses through which complaints should be addressed but these are almost non-operational. A survey conducted in Uganda on client satisfaction with services in Uganda's public health facilities in 27 districts revealed that in most districts, there is absence of a coordinated or institutional approach of dealing with complaints by the health facilities.⁸¹⁷

In instances, where these mechanisms existed, they were not utilised on account that people either did not know of their existence or had used them in the past without much success. People may be aware of challenges they experience in the process of accessing health care, but they are usually complacent with the situation. This is often attributed to low expectations, lack of confidence in the remedial mechanisms as well as the unavailability of alternatives. The survey further revealed that only 27 percent of the respondents had at one time made a complaint using the formal channels for conveying grievances.⁸¹⁸

While there are several channels, mentioned above, through which citizens including those in rural areas can lodge their complaints, there are numerous instances where the complaints are not addressed by the health system which greatly discourages the

⁸¹⁵ Heywood M (2009) 16-19.

⁸¹⁶ Heywood M (2009) 25-26.

⁸¹⁷ Uganda National Health Consumer/Users Organization (2014) VII.

⁸¹⁸ Uganda National Health Consumer/Users Organization (2014) VII, 7.

communities from expressing their grievances.⁸¹⁹ Therefore, CSOs may take several avenues to improve the complaints mechanism process including; raising community awareness on existing complaints processes, using accountability bodies such as the UHRC to monitor the handing as well as the responses to the complaints that are raised at the health facilities and forwarding some of the complaints to concerned regulatory bodies such as Uganda Medicines and Health Services Delivery Monitoring Unit (charged with investigating and prosecuting corruption scandals in the health sector), Health Service Commission as well as the Health Professional Councils.

Thirdly, among the roles that CSOs can undertake to improve remedial mechanisms is to utilise the tracking/monitoring/supervisory mechanisms mentioned in the previous section to access remedies for the local communities. There are several frameworks that have been set up to conduct monitoring and evaluation of health facilities such as; Health Policy Advisory Committee (gives oversight for the implementation of the country compact), Uganda Medicines and Health Services Delivery Monitoring Unit, Joint Review Mission, National Health Assembly among several others.⁸²⁰

However, usually the recommendations pointed out by these mechanisms are not implemented and there are no repercussions for the failure to abide by these recommendations. It has been observed in Uganda that in certain instances, political leaders will go to great lengths to hide discrepancies in the system. For instance, despite the pervasively high levels of corruption, the perpetrators have not been apprehended to date. Civil Society Organisations under the Black Monday Movement revealed that 255 million was lost in the Ministry of Health, 1.6 billion of GAVI (aimed at child immunisation) and 600 billion of the Global Fund (aimed at combating HIV, Tuberculosis and Malaria).⁸²¹ At the local level, illegalities such as, asking for user/illegal fees even where it is against the system⁸²² and the diversion of drugs and other health services from public health care facilities to their private clinics, are very rampant.

Through mechanisms such as community dialogues, Civil Society Organisations have created platforms where communities can raise the complaints and challenges they face while trying to access maternal health services. These platforms that bring together both the policy makers, health practitioners and the community members together allow for the policy

⁸¹⁹ Uganda National Health Consumer/Users Organization (2014) 7.

⁸²⁰ Action group for Health ,Human Rights and HIV/AIDs 'Evaluation of the Implementation of Sexual and Reproductive Health and Rights (SRHR) services against global and National targets for Uganda', April 2015,24.

⁸²¹ Action group for Health ,Human Rights and HIV/AIDs-Uganda (2015) 25

⁸²² 'Uganda's Health Care system explained'. Available at

<http://www.theguardian.com/katine/2009/apr/01/uganda-healthcare-system-explained> (Accessed 18 May 2016).

makers to give immediate response to the challenges raised. For instance, in a social accountability project coordinated by Women's Democracy Network – Uganda Chapter, the communities reported that the health facilities were extremely under-equipped as most did not even have the essential maternity health equipment. The district leaders responded by asserting that they were underfunded as the grants they received at the local government level were conditional and already marked to address certain issues. These could not be re-allocated to address pressing issues that might have been unforeseen at the time of planning. After being informed about the shortage in government funding for the health sector in Yumbe district, the community members and the district leaders from Kochi-sub County fundraised for the improvement of the living conditions of the midwife for Health Centre III by constructing a bathroom and toilet for him/her.⁸²³

Furthermore, citizens from one of the sub-counties in Koboko District demanded for someone to occupy the position of 'in-charge' for Health Centre III in Ludara Sub-County. In the subsequent dialogue, they were informed that the in-charge had been hired. However, WDN-U noted that, beyond the platforms provided by civil society, the community members often do not get the opportunity to engage with political and administrative leaders. This can be attributed to non-prioritisation of accountability, which leads to the failure to put aside funds and facilities to enable the interactions to occur.⁸²⁴

It was further stressed that mechanisms set up by the government such as barazas (community meetings) are infrequent or do not take place at all. Other supervisory mechanisms like the Health Management Committees are not trained to conduct monitoring services nor are funds allocated to them to enable them to implement their responsibilities.⁸²⁵ Therefore, it is not surprising that, the issues that are not addressed during the dialogues might not receive any form of feedback. Hence, CSOs have to continuously work closely with the community to strengthen the enforcement mechanisms in a bid to ensure that the challenges raised by the communities are implemented and if not enforcement measures ought to be undertaken.

Also, the devising of remedial mechanisms requires creativity and innovation on the part of CSOS, yet this is their main challenge, due to the fact that they work within a rigid project-based structure supported by donors. Donors often insist on complex and rigid reporting, appraisal, accounting and evaluation such as logical frameworks which frustrates innovation and flexibility in the way grassroots organisations conduct their programming. The insistence

⁸²³ WDN-Uganda (2014).

⁸²⁴ WDN-Uganda (2014).

⁸²⁵ WDN-Uganda (2014).

on short term quantitative indicators also ignores qualitative changes such as gender relations.⁸²⁶ The project-based initiative by donors run counter to accountability which relies on sustained, on-going processes rather than time-bound interventions for its success. Donors on the other hand, are often not in position or unwilling to support long term, ongoing, or slow initiatives, which in some instances are also unquantifiable. Also, the over insistence on short-term results might foster local organisations to only report good news and leave out challenges or bad outcomes faced which are very vital for the accountability process.⁸²⁷

5.3 CONCLUSION

This chapter has demonstrated the role of social accountability towards combating preventable maternal mortality and morbidity. It specifically focused on the role of CSOs working on maternal health issues in undertaking social accountability strategies. In building on previous chapters, the responsibility-answerability-enforcement framework is used in examining various accountability initiatives.

Emphasis is put on capacity building of communities with the aim of enabling them to participate in tracking or supervising the implementation of maternal health programmes. When it comes, to tracking/monitoring maternal health services, some of the mechanisms such as community dialogues, budget tracking, and use of Village Health teams are highlighted. Though, it is emphasised that the focus should not be on specific social accountability initiatives but rather on using several strategies together overtime towards subsequently reversing the pervasively high maternal mortality rates. It is further pointed out that social accountability is still in its infancy stage in Uganda therefore CSOs face a series of challenges including; their limited scope of operation, weak partnerships/networking amongst the organisations aimed at amplifying their voice, limited involvement in government policy formulation processes which would substantially enhance their accountability initiatives.

When it comes to enforcement, it is stressed that critical thought needs to be put into strengthening the remedial aspect of social accountability as it is currently still weak. First of all, the formation of an accountability body specifically for maternal and child health issues which has been emphasised in the previous chapter, will allow for the continued crystallization of enforcement/remedial measures. Furthermore, some of the suggested avenues include the utilisation of various approaches together such as litigation, social

⁸²⁶ Edwards E and Hulme D (1998).

⁸²⁷ Edwards M and Hulme D (1998).

mobilization and the Media. Cases such as the *CEHURD Case* of Uganda and the *Treatment Action Campaign Case* of South Africa are provided as illustrations.

It is also suggested that the complaints mechanism at the health facilities should be improved upon by establishing channels through which remedies are devised for the complaints raised. Last, but not least, answerability mechanisms such as community dialogues can be used for holding duty bearers accountable for remedying the human rights violation or the bottlenecks in the system raised by the community. In these fora, timelines for remedying violations can be established and independent mechanisms established to hold the policymakers accountable for meeting the timeliness.



CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

The preventable deaths of thousands of women, while trying to bring life in the world, is a crisis that needs urgent attention. In Uganda, despite persistent economic growth, these deaths have consistently remained in the 400s for every 100,000 live births, a figure that is unforgivably high. Also, the various programmatic, policy and regulatory frameworks that have been adopted over the years have achieved little towards reversing the trend. Therefore, increased attention should be placed on implementation of effective accountability/oversight mechanisms. The aim is to ensure that the interventions being undertaken are effective in addressing MMM. Effective accountability mechanisms are also vital for addressing technical, human and financial resource wastage/diversion. This is premised on the basis that if all the available resources are maximised, a substantial number of maternal deaths and morbidities shall be averted. Therefore, the main purpose of this study is to analyse accountability mechanisms towards combating Maternal Morbidity and Mortality (MMM) in Uganda.

Therein lies three major aspects; Human Rights Accountability, MMM and the domestic context (Uganda). The study principally reviewed primary and secondary literature. In responding to the main research questions, the study elaborated upon an accountability framework for Maternal Morbidity and Mortality. The framework relies on three major interrelated aspects; responsibility, answerability, and enforcement (RAE). Subsequently, an attempt is made throughout the study to advance the proposed accountability framework to the administrative, legal and social structures operating within Uganda in a bid to find comprehensive accountability strategies for curbing preventable maternal deaths and morbidities. Similarly, in looking at MMM, a women's rights approach is emphasised. This attributes the continued prevalence of high MMM rates, to the continued side-lining of women's rights, while formulating laws and policies. Thus, the focus on Uganda allows for the undertaking of a contextualised analysis of the challenges that are specific to the domestic setting.

6.1 SUMMARY OF FINDINGS

6.1.1 Accountability framework for Maternal Morbidity and Mortality (MMM).

This study establishes that accountability is an elusive and fuzzy term, which is often thrown around in policy, legal and planning documents. However, little attempt is made at elaborating upon this term to allow for its operationalisation. Consequently, it establishes an accountability framework for MMM.

This framework is expounded upon using the responsibility, answerability, and enforcement (RAE) framework. Responsibility entails the putting in place of human rights compliant standards of performance/guidelines by those in power, in order to allow for their conduct to be assessed in an open and transparent manner. Answerability is the requirement that power is exercised in a transparent manner by demanding that those in power justify their acts. To this end, duty-bearers are required to share all the relevant information. They are also required to establish independent supervisory/monitoring mechanisms to oversee their performance. Enforcement is the process of instituting sanctions aimed at correcting human rights violations as well as undertaking remedial measures to correct the shortcomings/gaps that have been identified within the system. The continuous application of these elements, together rather than separately, allows for the operationalisation of accountability.

Essentially, accountability is about constraining/controlling power as it cannot be assumed that those in power will often act in the interests of the citizens, especially the minorities. The RAE approach is then applied to the implementation of legal, administrative and social accountability structures towards combating MMM.

The study also highlights the monitoring-review-redress approach set out by the Commission for Women and Children. It emphasises that the accountability framework (responsibility-answerability-enforcement) proposed by the study is not in contradiction with it but is rather inclusive of it. Furthermore, it stresses that the monitoring-review-redress approach has the potential of solely focusing on outcomes, yet accountability should be a continuous process starting right before the legal/policy formulation stage hence the importance of the responsibility aspect of accountability.

In drawing linkages between maternal mortality and women's rights, it is established that the persistence of high MMM is an illustration of the continued side-lining of women's rights. Reproduction is principally a function of women thus the right to access reproductive health services is a women's rights issue. There is no single cause of death or disability that affects men that is close to the large-scale of maternal mortality and morbidity.⁸²⁸ Therefore, feminist scholars maintain that the traditional way of viewing the law is patriarchal as it often overlooks the injustices perpetrated against women. They also argue that laws and policies enacted by governments do not prioritise women's reproductive health rights. Where such laws exist, they are never sufficiently implemented.

Furthermore, that the risks attached to childbirth leading to death are often justified as destiny or the will of the higher powers. In other instances, laws are used to control women's

⁸²⁸ A/HRC/ 14/39 (2010) Para 17.

reproductive function and thus subsequently unfairly discriminate against women. The oppression of women becomes even more pervasive on the African continent where numerous forms of oppression are experienced both from international global forces as well as communitarian and extended family multifaceted relations. For instance, the formulation of the law in Africa is still characterized by the colonial elements from which it was derived, whose aim was to control and easily manage the colonial subjects. Several aspects of this law were retained to-date, such as restrictive penal code provisions and customary law, both of which serve to continue oppressing women.

An example of this are the abortion laws in several African countries. Therefore, feminists propose the asking of the ‘woman question’ aimed at analysing the ways in which the laws fall short of putting into consideration the unique, contextualised day-to-day lived experiences of women. In an attempt to prioritise women’s issues, the study focuses on maternal mortality and morbidity, an issue that specifically affects women and hinders their enjoyment of other rights. The focus of the study is national level accountability.

There are numerous forms and levels of accountability however, the emphasis of the study is legal accountability, administrative accountability and social accountability.

6.1.2 Implementation of Legal accountability towards combating MMM in Uganda

Chapter three analyses the implementation of legal accountability towards combating MMM with a specific focus on the courts of law and Uganda Human Rights Commission (UHRC). It advances the proposed accountability framework for MMM to the Ugandan judicial sector. To this end, the chapter demonstrates how the RAE approach can be implemented to achieve legal accountability with the aim of averting preventable maternal deaths and morbidities. One of the vital attributes of human rights accountability is the remedying of human rights violations through formal justice systems, principally the courts of law and the Human Rights Commissions. The increasing judicialisation of economic social and cultural rights has allowed for the adjudication of maternal health cases in countries such as South Africa, India and Uganda.

It is pointed out that access to justice especially in the developing world is rife with numerous challenges including; the non-recognition of the right to health as a fully justiciable right, cost of accessing courts, physical access to courts especially in the rural areas, and non-compliance with court decisions. These challenges point to the fact that while legal remedies play a significant role, practitioners should look beyond the court system to other forms of accountability, notably administrative and social accountability.

This chapter also examines the contribution of accountability towards ensuring access to justice for those whose maternal health rights have been violated. The three elements of accountability are applied to legal accountability. Under responsibility, it is emphasised that the standards of performance are derived from international, regional and national laws on maternal health. At the international and regional level those in line with combating MMM, all of which have been ratified by Uganda, include; CEDAW and ICESCR, African Charter, Maputo Protocol, General Commentary and other Soft Law instruments. At the domestic level, these include; the constitution, and the various health-related regulatory instruments. The right to health is not explicitly provided for in the bill of rights but is rather alluded to in the 'National Objectives and Directive Principles of State Policy'. Thus, it is asserted that the non-provision for the right to health in Uganda's bill of rights affects access to justice for those whose health rights have been violated.

Nonetheless, CSOs have been proactive by bringing maternal mortality cases to the courts. One such case was the *CEHURD and Others vs. Attorney General* brought before the Constitutional Court. The case was overturned on the basis of the political question doctrine. It was appealed to the Supreme Court which overturned the Constitutional Court ruling and reverted the case back to the Constitutional Court to be reconsidered based on the facts. Thus, it remains to be seen how the Constitutional Court will deal with this case. Also, in the High Court of Uganda, the *CEHURD and others vs. Nakaseke District Local Government* case, the petitioners were successful as the court ruled for the first time that indeed there had been a violation of maternal health care rights by the local government.

Accordingly, it is emphasised that the Ugandan courts should progressively interpret the right to health taking into consideration the interdependent nature of rights, like it has been done in other jurisdictions such as India and South Africa. Furthermore, the courts are meant to be in tandem with societal challenges, thus with the high maternal and mortality ratios in Uganda from causes that are preventable, it would be expected that the courts would consider responding to women's plight by offering them a clear legal avenue when their fundamental rights have been violated. To this end, it is revealed that litigation on maternal mortality and morbidity is gradually and tentatively being introduced to the Ugandan courts but is still in its infancy stage.

The courts have not yet developed the contours of the right to maternal health care or given it normative content. Likewise, from the cases that have come to the courts, the judges often shy away from making use of human rights norms and principles such as the interdependent nature of rights, reasonableness approach, minimum core content, and others developed by human rights bodies as well as courts elsewhere. Infact, the judgments barely make

reference to human rights language. This is attributed to, among others, the non-familiarity by judges on how to infuse human rights developments in enhancing their judgments. This observation ties in with the CEDAW Committee observation on Uganda pertaining to the lack of knowledge on critical human rights treaties and principles by various government branches including the judiciary. Therefore, awareness raising on human rights norms and principles should not exclude the judicial officials.

The chapter also points out a series of issues pertaining to the cases brought before the courts. These include; the need to balance individual claims with community needs, the influence of power dynamics within health centres on the successful litigation of cases, as well as the reluctance of judges to decide on cases dealing with policy decisions due to their perceived lack of capacity to effectively adjudicate such cases. It is stressed that deciding on health rights issues is not just a matter of deciding between two opposing factions, but more often involves reconciling mutually interacting variables. Thus, it may require making contentious decisions. Therefore, the judicial officials also often require capacity building to develop the competence to make reasoned judgements.

Another issue that is emphasised is the regulation of abortion in view of the contribution of unsafe abortions to the high MMM rates. It is pointed out that Uganda's position on abortion is somewhat ambiguous. Several provisions of the penal code outlaw abortion except when the mother's life is in danger. Uganda has also gone ahead to place 'reservations' on the Maputo Protocol provisions on abortion. Yet, the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights has been very progressive in providing avenues for conducting safe abortions. Therefore, this confusing legal and policy framework creates confusion with health workers being reluctant to conduct abortions for fear of being sanctioned. Yet clandestine abortions are so rampant that they constitute a considerable proportion of maternal death causes. The real figures are distorted by the fact that abortions may be covered up under other factors such as haemorrhage and sepsis due to stigma. To this end, it is asserted that Uganda needs to make its abortion laws clear and in conformity with human rights principles. One of the required steps is to remove reservations to the Maputo Protocol clauses pertaining to termination of pregnancy.

In line with answerability, two issues are highlighted; enhancing people's capacity to be aware of and access justice, as well as putting in place monitoring structures to account for judicial operations. The section highlights lack of accessibility to courts especially for people in rural areas, cost of legal services as well as ignorance about court operations among the factors that hinder the effective access to justice. The widespread ignorance about judicial operations applies to both the elite as well as the rural impoverished communities.

It is proposed that, the constitution should be taught as part of the school curriculum all the way up from the lower primary. Furthermore, legal aid services should be spread out further to reach a sizeable part of the population. Currently, legal aid work is patchy as the various organs that provide legal aid services operate haphazardly. In order to consolidate legal aid work, a legal aid policy was drafted, however to-date it has not yet been finalized. Also, in order to improve people's participation in judicial processes, the concept of meaningful engagement introduced in the South African Courts is suggested. Meaningful engagement, mostly used for housing cases, has allowed for the participation of communities in court processes.

In regards to tracking and monitoring court operations, the Judicial Service Commission (JSC) is advanced as the body charged with undertaking this task. Among other tasks, the JSC is charged with appointing judicial officials in the various judicial positions as well as acting as a linkage between the people and the judiciary as it receives complaints pertaining to the judiciary and addresses them. It also formulates programmes aimed at educating the masses about judicial operations. Yet, despite its exceptionally wide mandate, the JSC is extremely underfunded such that it can't employ adequate staff to implement its activities and reaches less than 20 percent of the country in conducting sensitisation activities on judicial operations. Also some of its decisions regarding appointment of judicial officials can easily be disregarded by the executive branch.

Another judicial organ that is examined is the Ugandan Human Rights Commission (UHRC). The Commission provides another unique avenue for upholding human rights including mediation, which is similar to traditional conflict resolution mechanisms. It is asserted that the UHRC has an expansive mandate compared to other HRCs as it acts as a court in addition to its human rights promotion role. Thus, it can receive any complaint except those pending before the courts or tribunal and its decisions have the same effect as those of the court. The UHRC also established a 'right to health unit' in 2008 charged with sensitising citizens on the right to health, monitoring violations in the health sector and ensuring that those whose rights have been violated have access to adequate remedies. As such, the UHRC regularly monitors health centres and receives complaints pertaining to violations of the right to health, yet in its most recent reports, the Commission did not receive any maternal deaths or morbidity cases. This can be attributed to, among others, the non-recognition by communities of MMM as a human rights violation. Thus, more capacity building by the UHRC, to create awareness about maternal health rights, is required.

In undertaking its promotional mandate, the UHRC produces annual reports to the parliament with recommendations to various public departments on measures to be taken to

improve human rights. However, while some of these recommendations may be implemented, several others are not, as they are often included in the subsequent reports. The non-implementation of the UHRC recommendations can be attributed to the fact that there are no effective sanctions for the officials who fail to execute or take steps towards the implementation of the recommendations.

Accordingly, in order to strengthen its enforcement powers, it is recommended that the UHRC exercises its wide mandate of summoning public officials before the Commission to account for the non-compliance of the recommendations set out in the reports. It is acknowledged that although these summons are taking place on a small scale, they should be structured into the accountability system and conducted comprehensively. Beyond the summoning, if it is indeed established that their actions hindered the realization of the right to health, they should be penalised accordingly.

It is further noted that the UHRC has a tribunal which receives, hears, investigates and resolves complaints. The guidelines that establish the Commission gave it powers similar to that of a court. It is empowered to receive any complaints except those pending before the courts of law or tribunal. It is observed that, according to the latest report, while the Commission has received cases related to the violation of the right to health, none of these have been directly related to maternal health. It is thus recommended that the Commission should undertake more capacity building aimed at enabling communities identify violations of their rights directly or indirectly leading to MMM. This should be aimed at encouraging them to report such cases to the Commission.

6.1.3 Role of Administrative Accountability in Combating Maternal mortality in Uganda.

Chapter four deals with administrative accountability. Regarding administrative accountability, it is argued that the administrative side of accountability is still underdeveloped as it is often overlooked by human rights practitioners, yet it is the more direct channel of measuring performance. It is at the administrative level where policies are turned into action. Therefore, focusing accountability on this area is likely to bring about more change than any other external form of accountability. Administrative accountability has a huge role to play in combating MMM thus infusing human rights principles therein is likely to achieve more impact than any other form of accountability. This form of accountability directly interacts with the health systems where transformation is required to substantially reduce preventable maternal deaths and morbidities.

At the administrative level, accountability deals with policies and programmes devised to combat maternal mortality and morbidity. In advancing the accountability framework to administrative structures, the various accountability mechanisms are pointed out and strategies for enhancing them are proposed. Among the measures that are forwarded; the inclusion of effective accountability plans in the health plan/policies, ensuring that maternal death audits are fully functional, establishing an accountability body at the administrative level specially charged with maternal mortality and morbidity, facilitating health professional bodies/associations to effectively conduct their roles and effectively tracking the utilization of technical, human (health workers) and financial resources.

Under responsibility, tracking/supervisory provisions within MH policies and programmes are pointed out. The chapter emphasises the formulation of contextually-based, human rights compliant policies and programmes. By relying on Freedman's assertion, it is pointed out that often the process of policy formulation and implementation does not involve a robust contextual analysis. This is aimed at understanding the multifaceted power dynamics as well as the diverging interests prevailing at the health centres and in the communities as these, more than anything else affect the success of adopted policies. It is argued that, there is often a contrast between the way sexual and reproductive health rights challenges and interventions are framed at the global level and the lived realities of communities on ground. The best practices approach that is currently favoured, ignores the fact that, often norms and values rather than policies, determine behaviour in a particular community. Thus, merely transporting policies/laws from one context to another without undertaking a contextual analysis may be counter-productive. Also, in line with human rights principles, policies should be adopted to cater to the unique challenges facing the communities and should not be copy-paste versions of international and regional policy and legal frameworks.

Yet, an analytical look at Uganda's policies on maternal health quickly reveals that these are, to a large extent, influenced by external forces and thus are top-bottom in their formulation. The two major strategies for combating maternal mortality are notably the Sharpened Plan and the Road Map for Accelerating the Reduction of Neonatal and Maternal Deaths. These were adopted mostly in response to international developments rather than local developments. Consequently, these documents follow the same format as their regional counterparts. This greatly affects their implementation with a large group of administrative and health officials at the local level not being aware of these policies or not having the capacity to implement them. Consequently, more often than not, they remain grand designs on paper.

Regarding answerability, the formation of an organised and harmonised accountability body specifically charged with MMM is recommended. The centrality of monitoring under accountability is acknowledged, however it is pointed out that accountability goes beyond monitoring. It is further asserted that Uganda's reproductive health policies do not clearly elaborate upon a comprehensive accountability framework running from the national to the lowest local level. The closest they come to doing so is through setting out monitoring and evaluation plans. This runs counter to human rights guidelines that emphasise the conducting of regular diagnostic bottom-up exercises aimed at identifying bottlenecks and devising mechanisms to remedy these shortcomings. It is also pointed out that Uganda's accountability framework is characterised by the formation of several working/technical groups and committees, sometimes charged with similar functions and yet with very little or no interlinkages with each other. This creates potential for duplication, disorganization and haphazard implementation.

Subsequently, due to poor monitoring, the feedback from the systems is not consolidated enough to bring about the required change. Yet, if all these are interlinked with one body at the national level specifically charged with monitoring and supervision of maternal and child health related policies, the streamlining, harmonisation of such activities as well as their gradual improvement would be more possible. Therefore, it is proposed that there should be one oversight/accountability body at the national level specifically charged with monitoring/supervision of the implementation of maternal health related policies. This is in line with the recommendation from the Commission on information and accountability for women and children's health that countries should establish National Health Commissions for women's and children's health.⁸²⁹ This accountability body should subsequently feed into the lower bodies, right up to the lowest level.

Structures are already in place that can be streamlined and organised into a fully-functional body. For instance, it is proposed that the technical working group on maternal and child health be transformed into a fully-functional body aimed at tracking the implementation of maternal health policies/programmes including maternal deaths and morbidities. Subsequently this body should have direct linkage to all the structures at the various levels that track maternal health programmes such as the assistant district health officer-maternal and child Health, health unit management committees, village health teams and other related sectors. It is further pointed out that within each of these structures, a focal point person, specifically in charge of maternal health issues, is put in place to liaise with the accountability body. The formation of the body is also vital in connecting with other

⁸²⁹ Working group on accountability for results *Draft Final Paper* (19th April 2011) 6-9.

structures that are vital for strengthening accountability such as the Health Management Information Systems (HMIS), health sector review committees, the National Drug Authority, Uganda Medical and Dental Practitioners Council, Uganda Nurses and Midwives Council and Health Service Commission, among others.

With enforcement, it is emphasised that the remedial aspect of administrative accountability is still very underdeveloped, despite its vital role in the realisation of accountability. Thus, it is emphasised that strong enforcement mechanisms should be put in place to ensure effective financial resource utilization. These include; strengthening the anti-corruption institutions to sanction embezzlement/misuse of funds. Funds are at the heart of averting maternal deaths and morbidities. Even more significant than the availability of funds, is their maximum/effective utilisation. It is pointed out that, despite the continued diversion and misuse of finances meant for the health sector, there are weak or no sanctions aimed at holding those found liable accountable.

Therefore, it is recommended that the formation of an effective and functional accountability body will not only facilitate the uncovering of misuse of financial resources but also devise enforcement mechanisms to prevent the future occurrence of such actions. Another aspect that is emphasised is the role of skilled health personnel in averting MMM. To this end, bodies that have been established solely for the purpose of overlooking/monitoring the conduct of health professionals are briefly discussed. One of the vital functions of these bodies is sanctioning health personnel who have acted unethically. Subsequently, it is emphasised that the accountability function of these bodies should be enhanced by equipping them with the necessary financial, technical and human resources to be vigilant in enforcing health rights violations.

6.1.4 Implementing Social Accountability to avert MMM.

With the proliferation of civil society organizations, social accountability is increasingly becoming the most common form of accountability. In fact, the recent focus on social accountability, has helped in bringing to the fore the importance of accountability generally. With the shortcomings of other forms of accountability, rights holders, either individually or through organizations/groups are increasingly becoming accountability agents. The shortcomings of legal accountability include; lack of accessibility to courts, high cost of accessing the legal services, illiteracy and ignorance on legal processes, among others. With administrative accountability, the processes are usually so internalised or technical that the communities may not have an entry point.

Political accountability is one of the avenues through which people's participation can be enabled. Yet, it is fraught with challenges including the long periods between elections, vote rigging, majoritarianism and exploitation of citizens by politicians only for their demands to be forgotten when they get into power. Therefore, aside from directly empowering citizens, social accountability ensures that accountability is an ongoing activity that is not only reserved for elections. However, it is also not without its challenges including the diverse nature of the communities, difficulty in measuring the impact of accountability initiatives and minuscule accountability initiatives started on a small scale and thus having very little or no impact at the regional and national level. Ultimately, the success of accountability relies on all these vital forms of accountability being functional and implemented together

Chapter five specifically addresses the utilisation of social accountability towards curbing maternal morbidities and deaths. Under social accountability, the role of community involvement towards improving accountability is emphasised. Social accountability is ultimately about getting services closer to the people thus citizen-led accountability is at the core of accountability.

It is an ongoing engagement of policymakers by a series of actors with the aim of pushing them to implement certain interventions. Specific emphasis is put on the role played by CSOs working on maternal health issues towards making social accountability functional. It is pointed out that in addition to upholding rights pertaining to maternal health care, the realisation of social accountability is dependent on rights to access information, freedom of association, expression and assembly. In line with the proposed accountability framework (responsibility-answerability-enforcement) advanced throughout the study, it is posited that the realisation of responsibility requires putting in place legal and policy frameworks to set out how community participation shall be functionalized. Thus, international, regional and national provisions as well as case law on participation and access to information are briefly set out. Similarly, provisions within the reproductive health policies on participation are also set out.

Concerning answerability, two aspects are emphasised; awareness raising and tracking/monitoring maternal health services. Awareness raising is a prerequisite for community participation in the tracking and monitoring the implementation of maternal health programmes. Examples of awareness raising by CSOs are pointed out and it is emphasised that it should target both the community members as well as policymakers. Furthermore, that it should not be assumed that once awareness raising has been conducted, community participation in maternal health programmes will automatically take place. Rather, a further step should be taken to involve communities in tracking/monitoring.

Regarding tracking/monitoring, it is stressed that the emphasis should not be on specific strategies such as community dialogues and budget tracking, but rather on ensuring that the various strategies are utilised together in order to improve both the inputs and the outputs. A few challenges are pointed out which include; the conflict between CSOs conducting tracking/monitoring maternal health programmes while also being involved in service delivery; the limited reach of most organisations; inability to effectively coordinate with each other to amplify their voices; differing priorities from that of government; and lack of effective inclusion in government programming.

Despite these challenges, CSOs have played a substantial role in catapulting social accountability in the maternal health sector. This has been done through raising community awareness and either directly tracking or facilitating the communities to undertake the tracking/supervision of maternal health service delivery. Some of the methods employed include; community dialogues, budget tracking, press releases, use of the media, monitoring implementation of government health policies and presenting findings to concerned stakeholders within the Government.

Enforcement is a vital aspect of accountability, however just like under administrative accountability, this aspect is still underdeveloped. Therefore, this section recommends that in order to improve the enforcement aspect of social accountability, major approaches need to be undertaken; first, is to implement several strategies together to ensure the remedies are implemented for identified gaps. These strategies are; social mobilization, use of media and legal remedies. Examples where this approach has been successfully undertaken is in the cases of *Ministry of Health and Others vs. Treatment Action Campaign and Others* and *the CEHURD and others vs. Attorney General*. Another approach that is forwarded is the conversion of complaints mechanisms at the health centre into remedial mechanisms. At the moment, complaints mechanisms exist, but there is no institutional approach for comprehensively dealing with them. It is proposed that mechanisms for comprehensively attending to and resolving complaints are improved upon using community awareness raising fora, utilizing the various accountability bodies to monitor response to complaints raised and using the proposed accountability body to refer cases to regulatory bodies that directly deal with the raised complaints.

Another approach that can be used by CSOs is the direct usage of the strategies used while tracking the implementation of maternal health services such as community dialogues. These dialogues, which bring together policymakers and community members, allow for the interaction and direct response to complaints and challenges raised by community members in accessing maternal health services. Through such fora, community members can directly

hold leaders accountable for gaps or shortcomings in the system and the implementation of recommendations identified in these dialogues can be assessed in the subsequent meetings.

6.2 RECOMENDATIONS

From the onset, it is recommended that the continued elaboration on ‘human rights accountability’ by scholars, policymakers and practitioners is required especially, national level accountability, in order to allow for contextualised strategies. Therefore, this study proposes an accountability framework for combating MMM. The implementation of the suggested framework is based on the functionalisation of the building blocks of accountability - responsibility, answerability and enforcement (RAE) - which should be implemented together and continuously. Therefore, the specific contribution of the study is the application of the RAE framework to legal, social and administrative accountability in a bid to combat MMM in Uganda.

It is further pointed out that the operationalisation of human rights accountability should go beyond a narrow focus on legal remedies. A comprehensive outlook requires altering the perception that human rights accountability is a subject to be understood and implemented only by legal practitioners. Likewise, the prioritisation of accountability requires apportioning technical, human and financial resources towards oversight/tracking mechanisms in line with maternal health. Thus, it is submitted that the implementation of the various forms of accountability; legal, social and administrative accountability together, is more likely to have an impact on the delivery of maternal health services, thus averting the high number of deaths.

Additionally, since the implementation of accountability is principally about constraining power, it is vital that power dynamics operating within local communities are taken into consideration. This requires regular bottom-up diagnostic exercises aimed at examining the various local contexts in which health service delivery occurs. This is principally because the power centres operating at the local level often influence the extent to which policies and plans are implemented. Therefore, without such comprehensive contextual analysis, accountability shall remain superficial and even the best policies might not substantially contribute to the reduction of preventable maternal deaths and morbidities. In the African context, in order to make the law more ‘women’ inclusive, it is vital to reimagine a new order where laws are formulated and implemented in more local, inclusive and contextual manner to directly respond to the challenges facing African countries. In order to make the laws and polices applicable to the unique context of African women, it is vital to view laws/policies from the historical, social and political context in which it came to be.

6.2.1 Legal Accountability

The adjudication of cases pertaining to maternal deaths and morbidities is an uphill task especially in the context of Uganda where the justiciability of the right to health is still in question. In the absence of concise constitutional mandate, courts are in murky waters when it comes to adjudication of the right to health. Subsequently, in order to fully provide for the protection of reproductive health rights, there should be full recognition of the right to health, which is inclusive of maternal health rights within the constitution as well as other regulatory instruments. Also, restrictive regulatory provisions, specifically on termination of pregnancy, that contribute to MMM should be amended or removed.

As well, deciding on health issues entails making or balancing difficult decisions pertaining to resource allocation and contentious policy decisions. Therefore, awareness raising on human rights norms and principles should not exclude the judicial officials. Thus, various capacity enhancement sessions should be continuously conducted with the courts in order for them to develop the constitutional as well as institutional capacity to adjudicate maternal health cases. It should also be emphasised that enforcement of maternal health rights goes beyond litigation. Therefore, it is forwarded that a series of mechanisms should be adopted alongside litigation which include social mobilization, capacity building of various concerned stakeholders, coalition building and the use of administrative regulatory bodies such as the commissions or the professional associations to enforce rights. In order to ensure access to justice and to combat the challenge of judicial systems being removed from the lived realities of the local communities, judicial systems should be open to using inclusive/participatory mechanisms. One of those that has been pointed out is meaningful engagement commonly used in South African Courts.

Legal aid services should be provided in such a way that they do not mostly benefit the urban women. Likewise, since local council courts are the first point of contact for rural women, these should be continuously interacted with to identify underlying factors that often contribute to further marginalization of women. Women should also be informed of and facilitated to use higher avenues of access to justice such as Magistrates Courts, High Courts in case they are frustrated at the LCCs.

The draft legal aid policy should be fully adopted and functionalised to ensure that entities that provide legal aid are streamlined so that they reach the most vulnerable parts of the population. Furthermore, the Judicial Service Commission (JSC) is identified as a vital accountability body. If well facilitated, the JSC can substantially improve its constitutional mandate of bringing courts closer to the people as well as exercising disciplinary action over judicial officials who have acted unethically.

The role of the Uganda Human Rights Commission in the advancing of human rights is also pointed out. It is recommended that the UHRC should give priority to maternal mortality and morbidity by proactively recording cases, monitoring the access to services needed to avert maternal deaths and morbidities such as EMoC, skilled birth attendants, functional referral hospitals and quality contraceptives.

The UHRC should also strengthen its enforcement role by using its expansive mandate to sanction public officials to account for their failure to implement recommendations raised in the UHRC periodic reports. It should also build communities' capacity to identify and report complaints directly related to the violation of maternal health rights.

6.2.2 Administrative Accountability

Regarding administrative accountability, the policies and programmes aimed at combating MMM should directly respond to the unique challenges facing Ugandan women. In order for this to happen, women should be at the centre of formulating and implementing laws and policies aimed at combating MMM. In order for their participation to be comprehensive and not cosmetic, their daily lived experiences should be taken into consideration prior to and while undertaking interventions. These include the various power centres that operate within the health system and have a bearing on women's access to health care such as; health workers, health administrators, local leaders, close family, CSOs/CBOs working on maternal health issues and private health care institutions. These also involve norms and cultural practices that may hinder women from accessing maternal health care services. Without, putting into consideration these contextualised issues, any adopted laws and policies might not have considerable impact.

Likewise, the need for emphasis on administrative accountability is stressed as it directly impacts on health systems. The focus on administrative accountability should also include increased attempts at infusing human rights principles within the various accountability frameworks mentioned above. It is also recommended that there is need for the formation of an accountability body within the government structures charged with combating maternal mortality and morbidity. It is argued that the formation of such a body will enable the consolidation of all the supervisory, tracking, monitoring and enforcement mechanisms from the national to the lowest level. The formation of this body is also the most assured way of operationalising accountability and going beyond monitoring.

It is also pointed out that there is need to lay emphasis on tracking of the available financial, technical and human resources as their maximal utilization is more likely to directly avert a substantial proportion of maternal mortalities and morbidities. Therefore, enforcement

mechanisms aimed at identifying and curbing corruption at all decision making structures including those which formulate and implement budgets should be strengthened.

Civil society and the media should also play a robust role in bringing to light corrupt actions of both state officials and private institutions. It is also highlighted in the chapter, that the functionalisation of accountability requires the financial and technical facilitation of the existing health professional associations and councils. Furthermore, channels should be established whereby such regulatory bodies work together and learn from each other both at the national level and with other countries. Thus, it is pointed out that South Africa established the health ombudsperson in order to promptly respond to human rights violations and improve accountability in health care. The health Ombudsman is charged with receiving written and verbal complaints, investigating and disposing of the complaints in an expeditious, economical and fair manner.⁸³⁰ Thus, it is suggested that Uganda consider the establishment of a health ombudsperson to promptly receive and dispose of complaints in the health sector including those pertaining to MMM.

6.2.3 Social Accountability

With social accountability, focus is put on the role of Civil Society Organizations (CSOs) as part of the community in combating preventable maternal mortality and morbidity. Even so, CSOs' role should be a facilitatory one aimed at building communities' capacity to ably track the implementation of reproductive health programmes aimed at curbing MMM. The first step requires providing timely and updated information in easily understandable language on reproductive health laws, policies, programmes and budgets. Additionally, community members should be equipped with tracking/monitoring skills to enable them directly participate in tracking/supervisory mechanisms that are in line with access to maternal health care services.

It is further recommended that the implementation of accountability will require the deliberate combining of various strategies including use of litigation, the media as well as social mobilization. As earlier elaborated upon, cases such as the *CEHURD Case* of Uganda and the *Treatment Action Campaign Case* of South Africa used these approaches. It is also forwarded that the complaints mechanisms at the health facilities which for the most part are considered un-operational should be turned into fully functional mechanisms that provide remedies to complaints raised.

Some of the suggested avenues for improving complaints mechanisms are; raising community awareness on existing complaints processes, using the various accountability

⁸³⁰ National Health Amendment Act, No 12 of 2013.

bodies such as the UHRC to monitor the handing as well as the responses to the complaints that are raised at the health facilities and forwarding some of the complaints to concerned regulatory bodies such as Uganda Medicines and Health Services Delivery Monitoring Unit (charged with investigating and prosecuting corruption scandals in the health sector), Health Service Commission as well as the Health Professional Councils.

Answerability mechanisms such as community dialogues can also be used for holding duty-bearers accountable for remedying the human rights violation or the bottlenecks in the system raised by the community. In these fora, timelines for remedying violations can be established and independent mechanisms established to hold the policy makers accountable for meeting timeliness that have been agreed upon. Finally, in order to effectively implement their social accountability role, CSOs should improve their networking/coalition skills to enable the amplifying of their voices, avoid duplication of accountability initiatives and deal with the challenge of operating on a small scale.

6.3 CONCLUDING REMARKS

The persistence of high maternal mortality and morbidity rates in Uganda despite various programmatic, legal and policy strategies call for the re-thinking of approaches being used. One such approach is the operationalisation of human rights accountability. For the most part, accountability is an ignored aspect, despite its role in reversing the high MMM rates. Most scholarly work on accountability has focused on international and regional frameworks and very little on national level accountability. Yet, it is at the national level that human rights principles are turned into actions. Therefore, attention should be shifted to this level. To this end, this study analyses the implementation of accountability towards combating preventable maternal mortality and morbidity in Uganda.

In a bid to elaborate upon accountability, the study expounds upon an accountability framework for MMM. Under this framework, three major elements are emphasised; responsibility, answerability and enforcement. The study further acknowledges that numerous forms of accountability exist, however emphasis is put on legal accountability, social accountability and administrative accountability. Ultimately, it is argued that the operationalisation of each of these forms of accountability synchronically in Uganda will trigger the effective implementation of measures or approaches needed to combat maternal mortality and morbidity thus substantially reducing the pervasively high rates.

BIBLIOGRAPHY

BOOKS

BK Twinomugisha *Fundamentals of Health Law in Uganda*, (2015) Pretoria University Law Press.

Charlesworth H and Chinkin C, *The boundaries of International Law: A feminist Approach* (2000).

Blas E & Kurup AS (Eds) *Equity, Social Determinants and Public Health Programmes* (2010) World Health Organization.

Frisancho A & Vasquez ML (Eds), *Citizen monitoring to promote the right to health and accountability* (2014).

Hunt P & Gray T (Eds) *Maternal mortality, Human Rights and Accountability* (2013) Routledge.

Hunt P& Bueno De Mesquita J, 'Reducing Maternal Mortality: The Contribution of the right to the highest attainable Standard of Health,' (2010), Human Rights Centre, University of Essex.

Langford M et al *Socio-Economic Rights in South Africa: Symbols or Substance?* (2014) Cambridge University Press.

Ngwena C & Durojaye E (Eds), *Strengthening the Protection of sexual and reproductive health and rights in the African region through human rights* (2014) Pretoria University Law Press.

Peruzzotti E & Smulovitz C (Eds) *Enforcing the rule of law: Enforcing Social Accountability in New Latin American Democracies* (2006) University of Pittsburgh Press.

Schedler A, Diamond L & Plattner MF (Eds) *The Self-Restraining State: Power and Accountability in New Democracies* (1999) Lynne Rienner Publishers: Boulder, London.

CHAPTERS IN BOOKS

Maina CP 'Human Rights Commissions in Africa-Lessons and Challenges' in A Bosl and J Diescho(Ed) *Human Rights in Africa* (2009).

Cook RJ 'Gender, Health and Human Rights' in M Grondin et al *Health and Human Rights in a changing World* (2013).

Kabagambe AD 'The Impact of the African Charter and Maputo Protocol in Uganda', in VO Ayeni (Ed) *The Impact of the African Charter and Maputo Protocol in selected African States*, (2016) Pretoria University Law Press.

Liebenberg S 'Social and Economic Rights: A critical challenge' in S Liebenberg (Ed) *The Constitution of South Africa from a Gender Perspective* (1995).

Lobis S 'The role of indicators and benchmarks in reducing maternal mortality: the case of emergency obstetric care indicators' in P Hunt and T Gray (Eds) *Maternal mortality, Human Rights and Accountability* (2013) Routledge.

Mirugi-Mukundi G 'A Human Rights-based approach to the realising access to Sexual and Reproductive Health Rights in sub-Saharan Africa' in E Durojaye(Ed) *Litigating the Right to Health in Africa: Challenges and Prospects* (2015) Ash Gate Publishing Limited.

Namusobya S 'Litigating the Right to Health in Uganda: The Necessity for innovation and activism', in E Durojaye (Ed) *Litigating the Right to Health in Africa: Challenges and Prospects*' (2015) Ash Gate Publishing Limited.

Schedler A 'Conceptualizing Accountability' in Schedler A, Diamond L and Plattner MF (Eds) *The Self-Restraining State: Power and Accountability in New Democracies* (1999) Lynne Rienner Publishers: Boulder, London.

Zampus C and Todd-Gher J 'Abortion and the European Convention on Human Rights: A lens for abortion and advocacy in Africa' in Ngwena C and Durojaye E(Eds), *Strengthening the Protection of sexual and reproductive health and rights in the African region through human rights* (2014) Pretoria University Law Press.

JOURNAL ARTICLES

Bandali S et al 'Maternal death surveillance and Response systems in driving accountability and influencing change' (2016) 135 *International Journal of Gynecology and Obstetrics* 365-371.

Bartlett KT 'Feminist legal methods', (1990) 103 *Harvard law Review* 837-849.

Brinkerhoff DW 'Accountability and health systems: toward conceptual clarity and policy relevance' (2004)19 *Health policy and planning* 371-379.

Cabal L & Stoffroegen M 'Calling a Spade a Spade: Maternal Mortality as a Human Rights Violation' (2009)16 *Human Rights Brief* 1-5.

Campbell C, Papp SA & Gogoi A 'Improving maternal health through Social Accountability: A case study from Orrisa, India' (2013)8 *Global Public Health* 1-28.

Carver R 'A new Answer to an old Question: National Human Rights Institutions and the Domestication of International Law' (2010)10 *Human Rights Law Review* 1-32.

Cook RJ 'International protection of women's reproductive rights' (1992)24 *Journal of International law of politics* 645-727.

Cook RJ and Dickens BM 'Human Rights to safe motherhood' (2002)27 *International journal of Gynecology and Obstetrics* 225-231.

Darrow M & Thomas A 'Power, Capture and Conflict: A call for human rights accountability in development cooperation' 27(2005) *Human Rights Quarterly* 27471-538.

Dirks JM 'Accountability, History and Archives: Conflicting Priorities or synthesized strands?' (2003) 57 *Achivaria* 30-49.

Eboh MP 'The woman being: its nature and functions' (2016)26 *Journal of the International Society for Universal Dialogue* 8-17.

Edwards M & Hulme D 'Too close for comfort? The Impact of official aid on Non-Governmental Organizations' (1996)24 *World Development* 961-973.

Finer L & JB Fine JB, 'Abortion law around the world: Progress and pushback' (2013)103 *American Journal of Public Health* 585-589.

Flood CM & Gross A, 'Litigating the Rights to health: What can we learn from a Comparative Law and Health Care Systems Approach', (2014)16 *Health and Human Rights Journal* 62-72.

Fox JA 'Social Accountability: What does the Evidence Really Say?' (2015)72 *World Development* 346-361.

Freedman LP 'Averting maternal deaths and disability: Human rights, constructive accountability and maternal mortality in the Dominican Republic: A commentary' (2003)82 *International Journal of Gynaecology and Obstetrics* 111-114.

Freedman LP et al, 'Transforming the Health Systems to improve the lives of women and children' (2005)365 *Lancet* 997-1000.

Freedman LP & Shaaf M, 'Act Global but think local: Accountability at the frontlines' (2013)21 *Reproductive Health Matters* 103-112.

Frisancho A and Vasquez ML 'Citizen monitoring to promote the right to health and accountability' (2008)371 *The Lancet* 1-17.

Goetz AM & Jenkins R 'Hybrid forms of accountability: Citizen Engagement in institutions of public sector oversight in India,' (2001)3 *Public Management Review* 363-383.

Hatchard J, 'A new breed of institution: the development of human rights commissions in commonwealth Africa with particular reference to the Uganda Human Rights Commission' (1999)32 *The Comparative and International Law Journal of Southern Africa* 28-53.

Heywood M 'South Africa's Treatment Action Campaign Case: Combining Law and Social Mobilization to realize the Right to Health' (2009) 1 *Journal of Human Rights Practise* 14-36.

Htun M and Weldon SL 'Why do Governments promote women's rights? A framework for the comparative analysis of sex equality policy' (2010)8 *Perspectives on Policy* 207-216.

Hulton L et al, 'Using evidence to drive Action: A revolution in accountability to implement quality care for better maternal and new-born health in Africa', *International Journal of Gynecology and Obstetrics* (2010)127.

Hunt P & Backman G 'Health Systems and the right to the highest attainable Standard of health', (2008)10 *Health and Human Rights* 81-92.

Jayal NG 'New Directions in Theorizing Social Accountability?' (2008)38 *Institute of Development Studies* 105-112.

Jeong-Woo K & Francisco OR, 'National Incorporation of Global Human Rights: Worldwide expansion of National Human Rights Institutions, 1966-2004' (2009)87 *Social Forces* 1321-1353.

Joshi A 'Producing Social Accountability? The impact of service delivery reforms', *Institute of Development Studies* (2008)38 10-17.

Joshi A & PP Houtzager PP, 'Widgets or watchdogs? Conceptual explorations in social accountability' (2012)14 *Public Management Review* 145-162.

Khadiagala LS 'The failure of popular justice in Uganda: Local councils and women's property rights' (2001)32 *Development and Change* 55-76.

Kiberu VM et al 'Strengthening district based health reporting through the district health management information software system, the Ugandan experience', (2014)14 *BMC Medical Information and Decision Making* 1-9.

Kismodi E et al 'Human Rights Accountability for maternal death and failure to provide safe legal Abortion: the significance of two ground-breaking CEDAW decisions' (May 2012)20 *Reproductive Health Matters* 31-39.

Krishnan JR et al 'Grappling at the grassroots: Access to justice in India's lower tier', (2014)27 *Harvard Human Rights Law Journal* 501-539.

Liebenberg S 'Engaging the paradoxes of the universal and particular in human rights adjudication: The possibilities and pitfalls of 'meaningful engagement'', (2012)12 *African Human Rights Law Journal* 1-29.

Lindberg SI 'Mapping Accountability: Core Concepts and sub-types' (2013) 79 *International Review of Administrative Sciences* 202-226.

Lodenstein E et al, 'A realist synthesis of the effect of social accountability interventions on health service providers' and policy makers' responsiveness', (2013)2 *Systematic Reviews* 1-10.

Marston et al 'Community participation for transformative action on women's, children's and adolescent's health' (2016)94 *Policy and practice Bulletin of the World Health Organization*

Maru V, 'Social Accountability and Legal empowerment' (2010)12 *Health and Human Rights* 83-93.

Mathur A et al, 'Maternal Death Review in selected countries in South East Asia Region', (2014)121 *International Journal of Obstetrics and Gynaecology* 67-70.

Mbonye M et al 'Emergency Obstetric care as the priority intervention to reduce maternal mortality in Uganda' (2007)96 *International Journal of Gynecology and Obstetrics* 220-225.

Moore AM, Kibombo R and Cats-Baril D 'Ugandan opinion leaders' knowledge and perceptions on unsafe abortions' (2013) *Health Policy and Planning* 1-9.

Nash R, 'Financing access to justice: Innovating possibilities to promote access to all' (2013)5 *Hague Journal on the rule of law* 96-118.

NG Jayal 'New Directions in Theorizing Social Accountability?' (2008)38 *Institute of Development Studies (IDS) Bulletin* 105-112.

Ngwena C 'An appraisal of abortion laws in Southern Africa from a Reproductive Health Rights Perspective' (2004)32 *Journal of Law, Medicine and Ethics* 708-717.

Ngwena C, 'Scope and Limits of judicialization of the Constitutional Right to Health in South Africa: An appraisal of key cases with particular reference to justiciability', (2013)14 *Journal of Health Law* 43-64.

Obiora LA 'Feminization, Globalization and Culture: After Beijing' (1997)4 *Indiana Journal of Global Legal Studies* 355-406.

Okeke GN & Okeke C, 'The justiciability of the non-justiciable Constitutional Policy of Governance of Nigeria' 7(2013) *IOSR Journal of Humanities and Social Sciences* 09-14.

Oloka-Onyango J & Tamale S, "The personal is political, "or Why Women's Rights are indeed Human Rights: An African Perspective on International Feminism' (1995)17 *Human Rights Quarterly* 691-731.

Omach P 'Civil Society Organizations and Local level peace building in Uganda' (2016)51 *Journal of Asian and African Studies* 77-96.

Painter GR 'Feminist Legal Theory' 8(2015) *International Encyclopaedia of social and Behavioural Sciences* 919-925.

Ray S, Madzimbamuto F & Fonn S 'Activism: working to reduce maternal mortality through civil society and health professional alliances in sub-Saharan Africa' (2012)20 *Reproductive Health Matters* 40-49.

Shaw D & Cook RJ, 'Applying human rights to improve access to Reproductive Health Services' (2012) 119 *International Journal of Gynaecology and Obstetrics* 55-59.

Sheppard C "Bread and Roses": Economic Justice and Constitutional Rights' (2015) 5 *Oñati Socio-legal series* 225-245.

Rifkin SB 'Examining the links between community participation and health outcomes: a review of the literature' (2014) 29 *Health Policy and planning* 98-106.

Rutaremwa G et al 'Determinants of maternal health services utilization in Uganda' *BMC Health Services Research* (2015)15 1-8.

Tamale S 'Exploring the contours of African Sexuality: Religion, law and Power', (2014)14 *African Human Rights Law Journal* 150-177.

Travis P et al 'Overcoming Health Systems constraints to achieve the Millennium Development Goals' (2004)364 *Lancet* 900-906.

Twinomugisha BK 'Exploring judicial strategies to protect the right of access to emergency obstetric care in Uganda' (2007) 7 *African Human Rights Journal* 283-306.

Weeks AD et al 'A criteria-based audit of the management of severe pre-eclampsia in Kampala, Uganda' (2005)91 *International Journal of Gynecology and Obstetrics* 296.

Wiles E 'Aspirational Principles or Enforceable Rights? The future of Socio Economic Rights in National Law' (2006) 22 *American University International Law Review* 35-64.

Wojczewski S et al 'Portrayal of the Human Resource Crisis and Accountability in Health Care: A qualitative analysis of Ugandan newspapers' 2015(10) *PLoS ONE* 1-18.

Yamin AE, 'Beyond Compassion: The central role of accountability in applying a human rights Framework to health' (2008)10 *Health and Human Rights* 1-20.

Yamin AE, 'Promoting Equity in Health. What role for Courts?' (2014)16 *Health and Human Rights* 1-10.

Yamin AE 'Toward Transformative Accountability: Applying a Rights Based Approach to Fulfil Maternal Health Obligations' (2010)7 *International Journals on Human Rights* 95-121.

TREATIES AND OTHER NON-BINDING DOCUMENTS

'Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases', African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, OAU/SPS/ABUJA/3.

African Commission on Human and Peoples' Rights, General Comments on article 14 1(d) and (e) of the Protocol to the African Charter on Human and Peoples' on the Rights of Women in Africa. Available at <http://www.achpr.org/instruments/general-comments-rights-women/> (Accessed 27 October 2016).

African Commission on Human and Peoples' Rights, General Comments on article 14 1(a), (b), (c) and (g) and article 14.2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' on the Rights of Women in Africa. Available at <http://www.achpr.org/instruments/general-comment-two-rights-women/> (Accessed 27 October 2016).

African Union, Convention on Preventing and Combating Corruption (AUCPCC), 11 July 2003. Available at <http://www.au.int/en/treaties/african-union-convention-preventing-and-combating-corruption> (Accessed 04 November 2016).

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted and opened for signature, ratification and accession on 18 December 1979 and entered into force on 3 September 1981.

Committee on Economic Social and Cultural Rights, General Comment No 3, The Nature of state obligations (Art,2,Para 1 of the CESCR) 1990.Doc. No. E/1991/23.

International Covenant on Civil and Political Rights (ICCPR), GA resolution 2200A (XXI) of 16 December 1966.

International Covenant on Economic Social and Cultural Rights adopted and Opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966, entry into force 3 January 1976.

Optional Protocol to the International Covenant on Economic Social and Cultural Rights A/RES/63/117, 10 December 2008.

Organisation of African Unity (OAU), African Charter on Human and Peoples' Rights (Banjul Charter) 27 June 1981, CAB/LEG/67/3 rev.5, 21 I.L.M 58(1982).

Paris Principles 'National Institutions for the promotion and protection of Human Rights' A/RES/48/134, 85th Plenary Meeting, 20 December 1993.

Road Map for Accelerating the Attainment of the Millennium Development Goals relating to Maternal and New Born Health in Africa, AFR/RC54/R9, 3 September 2004, Brazzaville, Republic of Congo.

'The Lilongwe Declaration on Accessing Legal Aid in Criminal Justice Systems in Africa: Conference on Legal Aid in Criminal Justice: The Role of Lawyers, Non-Lawyers and other Service Providers in Africa', Lilongwe, Malawi, November 22-24, 2004.

UN Committee on the Elimination of Discrimination against Women, 'CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health)', 1999, A/54/38/Rev.1.

UN Committee on Economic, Social and Cultural Rights (CESCR), 'General Comment No. 22 on the Right to Sexual and Reproductive Health (Art.12 of the Covenant)', 2 May 2016, E/C.12/GC/22.

UN Committee on the Elimination of Discrimination against Women (CEDAW), CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health), 1999, A/54/38/Rev.1, chap.1.

United Nations Convention against Corruption (UNCAC) 31 October 2003, A/58/422.

United Nations General Assembly, 'Technical guidance on the application of a human-rights based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality', Human Rights Council, Twentieth Session, A/HRC/21/22, 2 July 2012.

UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), E/C.12/2000/4, 11 August 2000.

TREATY BODY AND SPECIAL PROCEDURE REPORTS

Asuagbor JL, 'Status of implementation of the African Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa', Commissioner, Special Rapporteur on the Rights of Women in Africa (African Commission on Human and Peoples' Rights), 60th Meeting-Commission on the Status of Women, 18 March 2016.

Committee on Economic Social and Cultural Rights, 'Consideration of Reports submitted by States Parties under articles 16 and 17 of the International Covenant on Economic Social and Cultural Rights: Initial reports submitted by Parties due in 1990, Uganda', E/C.12/UGA/1, 6 December 2012.

Committee on Economic Social and Cultural Rights 'Concluding Observations to Uganda', E/C.12/UGA/CO/1, 8 July 2015.

Committee on the Elimination of Discrimination against women 'Concluding observations of the Committee on the Elimination of Discrimination against Women, Uganda', C/UGA/CO/7, 47th Session, 4-22 October 2010.

Concluding observations of the African Commission on the 2nd Periodic Report of the Republic of Uganda': Presented at the 45th ordinary session of the African Commission on Human and Peoples' Rights held in Banjul the Gambia from 13 to 27 May 2009.

Concluding observations of the African Commission on the 4th Periodic Report of the Republic of Uganda': Presented at the 49th ordinary session of the African Commission on Human and Peoples' Rights held in Banjul the Gambia from the 28th April to 12th May 2011.

Concluding observations of the Committee on the Elimination of Discrimination against Women', Consideration of the combined 4th, 5th, 6th and 7th Report of Uganda, 47th Session, C/UGA/CO/7, 4-22 October 2010.

Economic and Social Council 'Concluding Observations on the initial Report of Indonesia' E/C.12/IDN/CO/1, 19 June 2014.

Economic and Social Council 'Concluding Observations on the combined second to fourth periodic reports of Egypt' E/C.12/EGY/CO 2-4, 13 December 2013.

Economic and Social Council 'Concluding Observations on the combined second and Third periodic reports of Albania' E/C.12/ALB/CO/2-3, 18 December 2013.

Human Rights Council 'Report of the Working Group on the Universal Periodic Review, Uganda', A/HRC/19/16, 22 December 2011.

Human Rights Council 'Practices in adopting a human rights based approach to eliminate preventable maternal mortality and human rights', A/HRC/18/27, 8 July 2011.

Human Rights Council, 'Promotion and protection of all human rights, Civil, Political, Economic, Social and Cultural Rights', Report of the Special Rapporteur on the Right of everyone to the enjoyment of the highest attainable standard of Physical and Mental Health, Paul Hunt, A/HRC/7/11,31 January 2008.

Hunt P, '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 E/CN. A/2006/48/Add 2, 19 January 2006.

Hunt P, '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/HRC/7/11, 31 January 2008.

Report of the joint promotion mission undertaken to the Republic of Uganda' 25-30 August 2013, presented at the 55th Ordinary Session of the African Commission on Human and Peoples' Rights, held from 28 April -12 May 2014, in Luanda Republic of Angola.

United Nations General Assembly 'Report of the Office of the United Nations High Commissioner for Human Rights on Preventable Maternal Mortality and Morbidity and Human Rights' A/HRC/ 14/39, 16 April 2010.

INTERNATIONAL/REGIONAL BODY REPORTS

Commission on information and accountability for women and children's health: Working group on accountability for results 'Draft Final Paper' (19th April 2011).

Commission on information and accountability for women and children's health, 'Keeping Promises, Measuring Results, Final Report of the Commission (19 May 2011).

Estimates by WHO, UNICEF, UNFPA, the World Bank and the United Nations Population Division Trends in Maternal Mortality (1990 to 2013) Executive Summary'.

Human Rights Watch, 'Letting the Big Fish Swim: Failure to prosecute high level Corruption in Uganda' (2013) United States of America.

Human Rights Watch 'Righting Military Injustice. Addressing Uganda's unlawful prosecutions of civilians in military courts' (2011).

Joint UN Expert Technical Opinion on *Maternal Health and the Right to Health*. In the matter of Constitutional Petition No.16 of 2011. At the request of Centre for Health, Human Rights and Development (20 June 2011).

Mills S, 'Maternal Death as audit as a tool: Reducing Maternal Mortality', HDNHE, World bank (March 2011)

Regional Network for equity in health and East and Southern Africa(EQUINET), 'Health Centre Committees a vehicle for social participation in health systems in East and Southern Africa', EQUINET Discussion Paper, 101 (March 2014).

Statement by Mrs. Hannah Forster, Executive Director, African Centre for Democracy and Human Rights Studies and Chairperson of the NGO Forum Steering Committee, at the official opening of the 50th Ordinary session of the African Commission on Human and Peoples' Rights (24th October 2011) The Gambia.

Transparency International, 'Corruption and Human Rights: Making the connection' International Council on Human Rights Policy (2009).

UNICEF, 'Access to Health Care through Community Health Workers in East and Southern Africa', Maternal New-born and Child Health Working Paper (July 2014)

UNDP 'Reflections on Social Accountability: catalysing democratic governance to accelerate progress towards the Millennium Development Goals' (2013).

United Nations Development Programme 'Reflections on Social Accountability: Catalysing Democratic Governance to accelerate progress towards the Millennium Development Goals' (July 2013).

United Nations General Assembly 'Report of the Office of the United Nations High Commissioner for Human Rights on Preventable Maternal Mortality and Morbidity and Human Rights' A/HRC/ 14/39 (16 April 2010).

United Nations Office of the High Commissioner 'Who will be accountable: Human Rights and the Post 2015 Development Agenda', New York and Geneva (2013).

United Nations Populations Fund, 'The State of the World's Midwifery: Delivering health saving lives' (2010).

Wolman LBY, 'African Maternal and New-born Health National Plans (Road Map) Assessment Report' UNFPA Technical Division, Sexual and Reproductive Branch, (July 2009).

World Health Organization 'Equity, Social Determinants and Public Health Programmes' (2010).

World Health Organization et al 'Maternal Death Surveillance and Response Technical Guidance: Information for action to prevent Maternal Deaths' (2013).

OTHER REPORTS/PAPERS

Action for Global Health 'Health Spending in Uganda: The impact of current aid structures and aid effectiveness', Country Briefing (April 2010).

Action group for Health, Human Rights and HIV/AIDs 'Evaluation of the Implementation of Sexual and Reproductive Health and Rights (SRHR) services against global and National targets for Uganda' (April 2015).

Atim OG 'Social Accountability in Uganda' Uganda National Health Consumers Organisation, Internal discussion paper (2012)

Baldwin CA, 'Combating Judicial Corruption in Uganda', The Brookings Institution, Washington DC (September 2009)

Bovens M 'Public Accountability: A framework for the analysis and assessment of accountability arrangements in the public domain' Unpublished Paper, Professor of Public Administration, Utrecht School of Governance, Utrecht University, The Netherlands (2005).

Boydell V and Keesbury J 'Social accountability: What are the lessons for improving family planning and Reproductive Health Programs? A review of the Literature' Evidence Project, Working Paper (October 2014).

Camargo CB and Jacobs E, 'Social Accountability and its conceptual challenges: An analytical frame Work, Basel Institute of Governance, Working Paper Series No.16 (2013).

Civil Society Budget Advocacy Coalition Group 'Position Paper on Health Sector BFP FY 2016/17'.

'Civil Society Organizations (CSOs) shadow report on the performance of the Health Sector in 2012/2013' (April 2014).

DSW 'Decentralisation, social accountability and family planning services: The Cases of Uganda, Kenya and Tanzania' (27 November 2011).

Graham WJ, Bell JS and Bullough CHW 'Can skilled attendance at delivery reduce maternal mortality in developing countries?' (2001).

Innovations Catalyst, 'Ministry of Health's Rapid SMS and Mubuzima', World Health Organization (2013).

Institute of International law and Human Rights, 'A comparative look at implementing Human Rights Commission Laws' (The March 2009).

Jelmin K, 'Democratic Accountability in Service Delivery: A synthesis of Case Studies', International Institute for Democracy and Electoral Assistance (International IDEA) (2011).

Judicial independence undermined. A report on Uganda' International Bar Association Human Rights Institute (September 2007) .

Kampala Capital City Authority, 'Kampala Capital City Authority submission to the sessional Committee on Health regarding renovation of Mulago National Referral Hospital and Relocation of medical services to Kiruddu and Kawempe Hospitals'.

Leary E and Akitobi E, 'A case study of reproductive health supplies in Uganda', Population Action International (June 2009).

Peters A 'Corruption and Human Rights' Working Paper, Series 20 (September 2015) Basil Institute of Governance.

Potts H 'Accountability and the Right to the Highest Attainable Standard of Health' Human Rights Centre: University of Essex (2008).

Potts H and Hunt PH, 'Participation and the right to the highest attainable standard of health Project Report. Human Rights Centre, Essex (2008).

National Democratic Institute for Internal Affairs 'Parliamentary Human Rights Committees: Working to strengthen and expand democracy worldwide' *Rule of law series paper*. Produced for distribution at the inter-Parliamentary union seminar held from 15-17 (March 2007).

The partnership for maternal, new-born and child health 'Human Rights and Accountability: Knowledge summary: women's and children's health'23 2013.

The Maputo Protocol 'A clear and present danger: The fight against the Maputo Protocol', Human life International (2011).

'The Role of National Human Rights Institutions in the Universal Periodic Review' A Paper presented by Med. S. Kaggwa, Chairperson Uganda Human Rights Commission, at the UPR Seminar for Parliamentarians-Geneva,12-13 (November 20120).

Office of the High Commissioner for Human Rights 'National Human Rights Institutions: History, principles, Roles and Responsibilities' United Nations, New York and Geneva, (2010).

Oloka-Onyango J and Tejan-Cole A, 'Reassessing Customary Law Systems as a vehicle for providing equitable access to justice for the poor', working paper produced for the World Bank Conference 'New Frontiers of Social Policy: Development in a Globalizing Word', December 12-15 2005.

Reproductive Health Uganda 'Annual Report 2014'

Rural Women and access to justice: FAO's contribution to a Committee on all forms of Discrimination against Women (CEDAW) half-day general discussion on access to justice Geneva (18 February 2013).

Samuel Senfuka S, 'Mapping Maternal Health Advocacy: A case study of Uganda', Family Care International (2013).

The Republic of Uganda, Ministry of Health 'Annual Health Sector Performance Report' Financial year 2013-2014 (October 2014).

The White Ribbon Alliance 'Preventing Maternal and New born deaths: Prioritizing emergency obstetric and new-born care in Uganda', (July 2014-February 2015).

Uganda National Health Consumer/Users Organization 'Client satisfactions with services in Uganda's public health facilities 'A study by the Medicines Transparency Alliance (MeTA) Uganda (February 2014).

Uganda Health Marketing Group 'Annual Report 2013-2014'.

Women's Democracy Network: -Uganda Chapter 'Best Practices for enhancing Social Accountability in Uganda. Lessons from Uganda' (April 2014).

PLANS/ POLICIES AND GOVERNMENT REPORTS

Department of Maternal, New-born, Child and Adolescent Health (MCA/WHO) *Maternal and Perinatal Health Profile*' Rwanda (2015).

Healthy New Born Network *Maternal and Perinatal Death Review Guidelines*. Available at <http://www.healthynewbornnetwork.org/resource/maternal-and-perinatal-death-review-guidelines> (Accessed 21 September 2015).

Judicial Service Commission *Annual Report Financial Year 2013/14*.

Judicial Service Commission *Annual Report Financial Year 2014/15*.

Ministry of Health *Annual Health Sector Performance Report* Financial year 2013-2014 (October 2014).

Ministry of Health *The National Policy Guidelines and Service Standards for Reproductive Health Services* Reproductive Health Division: Community Health Department (May 2001).

Ministry of Health *Road Map for accelerating the reduction of maternal and neonatal mortality and morbidity in Uganda* (2007-2015).

Ministry of Health 'Committing to Maternal and Child Survival, a promise renewed: Reproductive Maternal, New-born and Child Health Sharpened Plan for Uganda', November (2013).

Ministry of Health *Safe motherhood 'Maternal and Perinatal Death review guidelines* Third edition, Reproductive Health Division (March 2010)

Ministry of Health *National Adolescent Health Policy for Uganda* Reproductive Health Division (October 2004).

Ministry of Health *National Village Health Teams in Uganda* Path Finder International, (March 2015).

Ministry of Health, 'National Village Health Teams (VHT) assessment in Uganda (March 2015).

Ministry of Health *Reducing Morbidity and Mortality from Unsafe Abortion in Uganda: Standards and Guidelines* (April 2015).

Ministry of Health *The Second National Health Policy* Promoting Peoples' Health to enhance Socio-economic Development (July 2010).

The Parliament of Uganda '*Report of the Parliamentary Committee on Health on the Ministerial Policy statement for the health sector for the financial year 2012/2013* (August 2012).

The Republic of Uganda *Second National Development Plan 2015/16-2019/20*.

The Republic of Uganda *Special Theme: Accelerating progress towards improving Maternal Health, Millennium Development Goals Report for Uganda* (2010).

Uganda Bureau of Statistics *Demographic and Health Survey* (2011) Kampala, Uganda 236.

Uganda, *Draft National Legal Aid Policy* (2012).

Uganda Human Rights Commission, '*NHRI submission for Uganda's second Universal Periodic Review* (October 2016).

Uganda Human Rights Commission *17th Annual Report to the Parliament of Uganda, 2014* Published by Ugandan Human Rights Commission.

United Nations 'Report of the International Conference on Population and Development *Programme of Action on the International Conference on Population and Development* Cairo 5-13 September 1994, A/CONF.171/13/Rev.1.

UN WOMEN, Fourth World Conference on Women, Beijing, China September 1995, Action for Equality, Development and Peace *Platform for Action*. Available at <http://www.un.org/womenwatch/daw/beijing/platform/> (accessed 14 July 2014).

CASE LAW

Britain

Rex v Bourne 1 King's Bench 687, 3 All E.R.615 (Central Criminal Court, London, 1938).

Ghana

Ghana Lotto Operators Association and others v National Lottery Authority (2009)3 SCGLR 235.

India

A.P. Pollution Control Bd.v. Prof.M.V. Nayudu, 2000 S.C.A.L.E.354.

LaxmiMandal v. Deen Dayal Harinagar Hospital & Ors, W.P. (C) Nos. 8853 of 2008.

Olga Tellis & ors. v. Bombay Municipal Corporation & ors. Etc. July, 10, 1985 scr 51.

South Africa

Abahlali BaseMjondolo Movement SA and Another V Premier of the Province of KwaZulu-Natal and Others (CCT12/09) (2009) ZACC 31; 2010 (2) BCLR 99(CC) (14 October 2009).

Doctors for Life International V Speaker of the National Assembly and Others (CCT 12/05) (2006) ZACC 11; 2006 (12) BCLR 1399 (CC); 2006 (6) SA 416 (CC) (17 August 2006).

Government of the Republic of South Africa and Others v Grootboom and Others (CCT11/00) [2000] ZACC 19; 2001 (1) SA 46; 2000 (11) BCLR 1169 (4 October 2000).

Minister of Health and Others V Treatment Action Campaign and Others (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002).

Occupiers of 51 Olivia Road, Berea Township and 197 Main Street of Johannesburg v City of Johannesburg and Others (24/07) (2008) ZACC 1;2008 (3) SA 208 (CC); 2008 (5) BCLR 475 (CC) (19 February 2008).

Residents of Joe Slovo Community, Western Cape v Thubelisha Homes and Other (CCT 22/98) (2009) ZACC 16; 2009 (9) BCLR 847 (CC); 2010(3) SA 454 (CC) (10 June 2009).

Treaty Bodies

Committee on the Elimination of all forms of Discrimination against women, 'L.C v Peru', C/50/22/2009, 4 November 2011.

Committee on the Elimination of Discrimination against Women, Alyne da Silva Pimentel v. Brazil, Decision CEDAW/C/49/D/17/2008. 27 September, 2011.

Purohit and another v The Gambia (2003) AHRLR 96 (ACHPR 2003), Para 73-76.

Uganda

Centre for Human Rights and Development (CEHURD) and others v Attorney General', Constitutional Petition No.16 of 2011, Decided 5 June 2012.

Centre for Health, Human Rights and Development and Others v Nakaseke District Local Government ', Civil Suit No 111 of 2012, Decided 30 April 2015.

Centre for Health Human Rights and Development (CEHURD) and others v The Attorney General', Constitutional Appeal No 1 of 2013, Decided 30 October 2015.

Dr. Kizza Besigye & 10 Ors V The Attorney General (Constitutional Petition no.07 of 2007) (2009) UGCC 3 (1 September 2009).

Ismael Serugo vs. KCC & Anor (Constitutional Petition No.14 of 1997) (1998) UGCC 6 (30 April 1998).

Karuhanga v Attorney General (Constitutional Petition No 39 of 2013) (2014) UGCC 13 (4 August 2014).

Kyamanywa Simon vs. Uganda (Constitutional petition no.10 of 2000) 14 December 2001.

Oloka Onyango and others vs. Attorney General (Constitutional Petition No.08 of 2014) UGCC 14 (1 August 2014).

Paul K Semogerere and Anor vs. the Attorney Genera.l- Supreme Court Civil Apli.No.5 of 2001 (20 February 2003).

Paul Semwogerere and ors vs. the Attorney General (Constitutional Appeal No.1 of 2002) (2004) UGSC 10 (28 January 2004).

Salvatori Abuki and another v Attorney General (Constitutional Case No.2 of 1997) UGCC 5 (13 June 1997),

Susan Kigula and 416 others v The Attorney-General (2005) AHRLR 197 (Ug CC 2005). Available at <http://www1.chr.up.ac.za/index.php/browse-by-country/uganda/1170.html> (Accessed 02 July 2016).

Uganda Law Society V Attorney General of the Republic of Uganda (Constitutional Petition No. 18 of 2005) (2006) UGCC 10 (30 January 2006).

United States of America

Baker v. Carr 369 U.S. 186 9 (1962)

Marbury v. Madison 5 U.S.137 (1803)

ACTS/STATUTES

Ghana

Constitution of the Republic of Ghana, 1992.



South Africa

Constitution of the Republic of South Africa, 1996

South Africa, Health Professions Act 56 of 1974.

South Africa, National Health Amendment Act, No 12 of 2013.

Uganda

Access to Information, Act 2005.

Constitution of the Republic of Uganda, 1995.

Constitution (Amendment) Act 2005, Insertion of Article 8A.

Health Service Commission Act, 2001.

Local Council Courts Act, 2006.

Local Government Act, Cap 243.

Magistrates' Court Act Cap 16, (Amendment) 2007.

National Drug Policy and Authority (NDP/A) Act, CAP 206.

Non-Governmental Organizations Act, 2016. Available at <http://chapterfouruganda.com/resources/acts-bills/non-governmental-organisations-act-2016>.

Nurses and Midwives Act 1996, Cap 274.

Penal Code Act 1950, Cap 120.

Uganda Medical and Dental Practitioners, Act 11 of 1996.

WEBSITES AND OTHER ONLINE SOURCES

Action Aid 'Strategies for success access to justice for women, 2011, 8. Available at <http://www.actionaid.org/publications/strategies-success-access-justice-women?width=960&inline=true> (Accessed 11 July 2016).

Africa Review 'Ugandan hospital nurses suspended over Besigye visit', December 11 2015. Available at <http://www.africareview.com/News/Hospital-nurses-suspended-over-Besigye-visit/-/979180/2992274/-/oxx77xz/-/index.html> (Accessed 08 May 2016).

All Africa 'Uganda's Museveni Assent to NGO Act will cost us all', 26 February 2016. Available at <http://allafrica.com/stories/201602260831.html> (Accessed 09 May 2016).

All Africa 'Uganda: Repressive NGO Act', 9 March, 2016. Available at <http://allafrica.com/stories/201603090704.html> (Accessed 10 June 2016).

Association of Obstetricians and Gynaecologists of Uganda' Maternal Death Reviews'. Available at <http://sogc.org/aogu/index395a.html?contentID=55> (Accessed 27 September 2015).

'Besigye in Abim Hospital, situation, Alarming', December 5, 2015. Available at <https://www.youtube.com/watch?v=G1wFq8YNguM> (Accessed 08 May 2016).

Centre for Health Human Rights and Development 'Launching the Standards and guidelines on unsafe abortions to confront the Public Health Crisis in Uganda', 5 June 2015. Available at <http://www.cehurd.org/2015/06/launching-the-standards-and-guidelines-on-unsafe-abortions-to-confront-the-public-health-crisis-in-uganda/>. (Accessed 8 July 2016).

Centre for Health Human Rights and Development 'Global trends in Maternal Mortality: How does Uganda Fair?' Available at <http://www.cehurd.org/2014/06/global-trends-in-maternal-mortality-how-does-uganda-fare/> (Accessed 30 September 2015)

'Civil Society demands Government of Uganda halt plan to export lifesaving health workers'. Available at http://www.who.int/pmnch/media/news_events/2015/health-workers-uganda-press-statement.pdf (Accessed 28 April 2016).

'Civil Society Coalition to Stop Maternal Mortality in Uganda: Reaction to the Financial year 2013/14 Budget Speech. Available at <http://wouqnet.org/download/general/Civil%20Society%20Coalition%20to%20Stop%20Maternal%20Mortality%20in%20Uganda%20Reaction%20to%20FY%202013-14%20Budget%20Speech.pdf> (Accessed 28 April 2016).

Development Cooperation, Sexual and Reproductive Health 'Uganda's budget speech FY 2015/16: Highlights Health Sector Priorities'. Available at <http://blog.dsw.org/2015/06/ugandas-budget-speech-fy-201516-highlights-health-sector-priorities/> (Accessed 28 September 2015)

Development Cooperation, Sexual and Reproductive Health 'Highlights from the budget Speech 2014/15'. Available at <http://blog.dsw.org/2014/06/highlights-from-the-budget-speech-201415/> (Accessed 29 September 2015).

'Every Child deserves a 5th birthday USAID's contribution to a promise renewed'. Available at <http://5thbdy.usaid.gov/pages/responsesub/event.aspx>.

Fact Sheet Health and Human Rights in Uganda. Available at http://www.who.int/hhr/news/hhr_factsheet_uganda.pdf (Accessed 12 June 2016).

FIDH 'Uganda becomes the 28th State party to the Maputo protocol'. Available at <https://www.fidh.org/International-Federation-for-Human-Rights/Africa/uganda/Uganda-becomes-the-28th-State> (Accessed 25 August 2015).

Goals: 17 Goals to transform our World'. Available at <http://www.un.org/sustainabledevelopment/peace-justice/> (Accessed 16 Feb 2016).

Green A, 'A victory in the Path to Maternal Health Care in Uganda', Women across Frontiers, 25 August 2015. Available at <http://wafmag.org/2015/08/a-victory-in-the-path-to-maternal-health-care-in-uganda/> (Accessed 06 July 2016).

Guttmacher Institute, 'Abortion in Uganda', Fact Sheet, January 2013. Available at <https://www.guttmacher.org/fact-sheet/abortion-uganda> (Accessed 08 July 2016).

Guttmacher Institute 'Contraception and unintended pregnancy in Uganda' *Fact Sheet*. Available at <https://www.guttmacher.org/fact-sheet/contraception-and-unintended-pregnancy-uganda> (Accessed 13 December 2016).

'Health Service Commission' Available at <http://www.hsc.go.ug/content/background> (Accessed 20 September 2015).

Human Rights Commission 'UNHRC holds a multi stake holder meeting on the Status of implementation of the Universal Periodic Review Recommendations on the Right to Health', November 27 2015. Available at <http://uhrc.ug/uhrc-holds-national-multi-stakeholder-meeting-status-implementation-universal-periodic-review> (Accessed 11 July 2016).

Into SA 'Revised Budget focuses on energy and Transport', 25 May 2015. Available at <http://www.into-sa.com/countries/UG/news/revised-budget-2015-2016-focusses-on-energy-and-transport> (14 August 2016).

Judicial Service Commission 'The justice, Law and Order Sector: An Overview'. Available at http://www.jsc.go.ug/index.php?option=com_content&view=article&id=73&Itemid=90 (Accessed 03 July 2016).

'Justice Centres Uganda'. Available at <http://www.justicecentres.go.ug/index.php/2014-11-27-11-30-03/about-us> (Accessed 07 July 2016).

Mahoro B 'Uganda's Legal System and Legal Sector', Globalex. Available at http://www.nyulawglobal.org/globalex/Uganda.html#_High_Court (Accessed 11 July 2016).

Republic of Uganda 'Ministry of Health'. Available at <http://www.health.go.ug/about-us/about-ministry-health> (Accessed 20 September 2015).

Nakatudde O, 'Parliament approves FY 2016/2017 Budget Framework Paper', URN, 7 January 2016. Available at <http://ugandaradiionetwork.com/story/parliament-approves-fy-20162017-budget-frame-work-paper> (Accessed 12 July 2016).

Parliament of the Republic of Uganda (2005) *Hansard Report* August 15. Available at <http://www.parliament.go.ug/new/index.php/documents-and-reports/daily-hansard> (accessed 20 October 2013).

Revised budget focuses on Energy and Transport', 25 May 2015. Available at <http://www.into-sa.com/countries/UG/news/revised-budget-2015-2016-focusses-on-energy-and-transport> (Accessed 12 July 2016).

'SA to get medical ombudsman' News 24 10 March 2015. Available at <http://www.health24.com/Medical-schemes/News/SA-to-get-medical-ombudsman-20150310> (Accessed 12 November 2016).

Simavi 'It all starts in the community: Social Accountability' *Fact Sheet*. Available at https://simavi.org/wp-content/uploads/2015/03/Factsheets_Simavi_Kenya_Community_Dialogue.pdf (Accessed 20 November 2016).

'State Reports and Concluding Observations'. Available at <http://www.achpr.org/states/reports-and-concluding-observations/> (Accessed 26 August 2015)

State of the Nation Address, 2016. Available at <https://www.yowerikmuseveni.com/statements/state-nation-address-2016> (Accessed 13 August 2016).

Signature and ratification Status as of 21 September 2016'. Available at <https://www.unodc.org/unodc/en/treaties/CAC/signatories.html> (Accessed 23 October 2016).

'The hierarchy Composition and functions of Courts in Uganda'. Available at <http://lawschoolguide.blogspot.co.za/2011/03/heirarchy-composition-and-function-of.html> (Accessed 05 July 2016).

Turyamubona E 'The law applicable for enforcement of Fundamental Rights and Freedoms in Uganda'. Available at www.academia.edu. (Accessed 03 January 2017).

'Uganda Economy' Denmark in Uganda: Ministry of Foreign Affairs of Denmark. Available at <http://uganda.um.dk/en/about-uganda/country-facts> (Accessed 20 October 2016).

'Uganda's Health Care system explained'. Available at <http://www.theguardian.com/katine/2009/apr/01/uganda-healthcare-system-explained> (Accessed 18 May 2016).

UNFPA Uganda 'Reducing Maternal Mortality: Katakwi does it', 8 August 2011. Available at http://countryoffice.unfpa.org/uganda/2011/08/08/3658/reducing_maternal_mortality_katakwi_does_it/ (Accessed 21 September 2015).

United Nations Human Rights Office of the High Commissioner, 'Status of Ratification Interactive Dashboard'. Available at <http://indicators.ohchr.org/> (Accessed 12 June 2016).

USAID 'Fact Sheet: Call to action sets course to end preventable child deaths', July 10, 2012. Available at <https://www.usaid.gov/news-information/news/fact-sheet-call-action-sets-course-end-preventable-child-deaths> (Accessed 18 May 2016)

World Health Organization ‘Civil Society’. Available at <http://www.who.int/trade/glossary/story006/en/> (Accessed 20 April 2014).

World Health Organization Media Centre ‘Maternal Mortality’ Available at <http://www.who.int/mediacentre/factsheets/fs348/en> (accessed 30 June 2014).

World Health Organization ‘Global Health Observatory: Maternal and Reproductive Health’. Available at http://www.who.int/gho/maternal_health/en/ (accessed 28 May 2014)

World Health Organisation ‘WHO Guidelines for measuring Maternal Mortality from a Census’ (2013) Available at <http://www.who.int/reproductivehealth/publications/monitoring/9789241506113/en/index.html> (Accessed 10 November 2014).

NEWSPAPERS AND NEWSLETTERS

Afro Barometer ‘Fighting Corruption in Uganda: Despite small gains, citizens pessimistic about their role’, *Dispatch* No 77.

‘Besigye eludes police to visit health centre’, *The Daily Monitor* December 21, 2015. Available at <http://www.monitor.co.ug/Elections/Besigye-eludes-police-to-visit-health-centre/-/2787154/3004252/-/6bdxIk/-index.html> (Accessed 08 May 2016).

Corruption Plague in the Judiciary’ *Black Monday Newsletter*, Issue 21, September 2014.

Edema D, ‘Jinja Hospital Medics ask patients for Kits’, *The Daily Monitor*, 10 June 2016. Available at <http://www.monitor.co.ug/News/National/Jinja-hospital-medics-ask-patients-for-kits/688334-3241970-14l0bo4z/index.html> (12 October 2016).

Editorial ‘Tax Injustice’ *Black Monday Newsletter* (June 2013) Issue 7. 31 October 2003, A/58/422.

‘Global Fund in new scandal’, *The Observer*, 2 March 2016. Available at <http://observer.ug/news-headlines/42898-global-fund-in-new-scandal%5C> (Accessed 13 August 2016).

‘Health Unit Launched’. *The New Vision* Available at <http://www.newvision.co.ug/PA/8/13/652335> (Accessed 1 July 2015).

‘Hospital renovated after Besigye visit’, *The Daily Monitor* February 13 2016. Available at <http://www.monitor.co.ug/News/National/Hospital-renovated-Besigye-visit/-/688334/3074020/-/abfu98/-index.html>. Accessed 8 May 2016).

Jaramogi P, ‘District Compensates family of Dead Patient’ *The New Vision* 16 August 2015. Available at http://www.newvision.co.ug/new_vision/news/1332742/district-compensates-family-dead-patient (Accessed 06 July 2016).

‘Judiciary not free, says Odoki’, *Sunday Monitor* 11 September, 2011. Available at <http://www.monitor.co.ug/News/National/-/688334/1233650/-/bijam4yz/-index.html> (Accessed 03 July 2016).

Kagumire R, 'Uganda's radiotherapy machine has broken –but crowdfunding is not the fix', *Guardian African Network*, 12 April 2016. Available at <https://www.theguardian.com/world/2016/apr/12/uganda-mulago-radiotherapy-machine-crowdfunding>. (Accessed 17 May 2016).

Karuhanga J, 'EAC 2016/17 Budgets prioritize infrastructure, energy sectors', *The New Times*, 09 June 2016. Available at <http://www.newtimes.co.rw/section/article/2016-06-09/200605/> (Accessed 13 August 2016).

Kirunda A, 'Residents grill health boss over missing drugs', *The Daily Monitor*, 29 July 2016. Available at <http://www.monitor.co.ug/News/National/Residents-grill-health-boss-over-missing-drugs/688334-3320370-r7ty45/index.html> (Accessed 29 July 2016).

Kizza J, 'Reading of the 2015/16 National Budget', *The New Vision*, 11 June 2015. Available at http://www.newvision.co.ug/new_vision/news/1328084/live-reading-2015-national-budget (Accessed 13 August 2016).

'Ministry of Health Officials fail to account for Billions', *The Independent*, 12 August 2016. Available at <https://independent.co.ug/?p=9485> (Accessed 13 August 2016).

Mukunda J, Civil Society Budget Advocacy Group –Coordinator, 'Budget Indiscipline fuels public resource wastage' *Black Monday Newsletter* (June 2014) Issue 18.

Mugerwa Y, 'State house Mulago boss clash over hospital decay', *Daily Monitor* 12 April 2016. Available at <http://www.monitor.co.ug/News/National/State-House--Mulago-boss-clash-over-hospital-decay/688334-3155062-132wpftz/index.html>. (Accessed 13 August 2016).

Mugerwa Y, 'State House gives MPs hospitals rot evidence', *The Daily Monitor*, 16 April 2016. Available at <http://www.monitor.co.ug/News/National/State-House-gives-MPs-hospitals-rot-evidence/688334-3159648-spi0qc/index.html>. (Accessed 01 September 2016).

Nassaka F, 'Uganda ranked among most corrupt nations' *The independent* 13 December 2015. Available at <http://allafrica.com/stories/201512142509.html> (Accessed 13 October 2016).

'Real Justice could finally be delivered in Uganda by key ruling on maternal health' *The guardian*. Available at <http://www.theguardian.com/global-development/2015/nov/02/real-justice-could-finally-be-delivered-uganda-key-ruling-maternal-health> (Accessed 28 April 2016).

'Resolve Drug Shortage Problem once and for all', *The Daily Monitor*, 29 August 2016. Available at <http://www.monitor.co.ug/OpEd/Editorial/Resolve-drug-shortage-problem-once-and-for-all/689360-3360872-itof9e/index.html>. (Accessed 30 August 2016).

'Rotting Hospitals have been exposed' *The Observer* 23 December 2015. Available at <http://www.observer.ug/viewpoint/editorial/41787-rotting-hospitals-have-been-exposed> (Accessed 14 July 2016).

Senfuka S 'The impact of Public Sector Corruption on delivery of Health Care services', *Black Monday Newsletter* Issue 4 (March 2013) 2.

Ssekika E, 'How judges cut Museveni's wings' *The Observe* 8 August 2014. Available at <http://www.observer.ug/component/content/article?id=33206:-how-judges-cut-museveni-wings> (Accessed 11 July 2016).

'Uganda: Quickly approve policy on Legal Aid' *The Monitor* 8 April 2016. Available at <http://allafrica.com/stories/201604080068.html> (Accessed 03 July 2016).

