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RESEARCH ARTICLE

The Contribution of Uganda's Constitutional Court Petition No 16 Judgment to the Right of Access to Quality Emergency Obstetric Care under International Law

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Abstract
On 19 August 2020, the Constitutional Court of Uganda handed down a landmark judgment on maternal health rights in Uganda. This judgment held that the State of Uganda was responsible for violating the right to health, non-discrimination, life and inhuman and degrading treatment of women under international law and Ugandan constitutional law for its failure by omission to provide basic emergency obstetric care in public facilities. This article examines the contribution of the Constitutional Petition No 16 judgment to the strengthening of women's reproductive health rights. By rejecting the "lack of resources" defence when complying with minimum core obligations under progressive realization in the provision of emergency obstetric services, the court makes an important contribution to the limited but growing body of jurisprudence holding governments accountable for a failure to ensure the protection of women's sexual and reproductive rights at both domestic and international levels.

Keywords: Emergency obstetric care; minimum core obligations; progressive realization; women's rights; sexual and reproductive health; lack-of-resources defence

Introduction

On 19 August 2020, the Constitutional Court of Uganda handed down a landmark judgment for maternal health rights in Uganda that has made a significant contribution to the growing body of jurisprudence on the right to maternal health, specifically the right to be free from avoidable maternal death. This ruling came after a nine-year judicial process brought by two individuals petitioning on behalf of their loved ones who died while in childbirth, along with Ugandan human rights scholar, Professor Ben Twinomugisha, and the Ugandan non-governmental organization, the Center for Health, Human Rights and Development (CEHURD).[1]

The arguments set forth in the Constitutional Petition No 16 judgment merit close analysis because of their important contribution to reproductive rights and ending preventable maternal mortality. The central question considered by the Constitutional Court was whether the State of Uganda could be held accountable for violating human rights under international law and Ugandan constitutional law for its failure by omission to provide basic emergency obstetric care

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1 *Center for Health, Human Rights and Development (CEHURD) and Three Others v Attorney General* (Constitutional Petition No 16 of 2011) [2020] UGCC 12 (19 August 2020).

(EmOC) in public facilities. The court held in the present case that the maternal deaths, which were the subject of the claim, could have been avoided if services had been available and that the State of Uganda had thus violated the rights to health, non-discrimination, life and the prohibition of inhuman and degrading treatment of women. However, beyond this conclusion, the judgment made a number of important contributions to international human rights law on maternal health rights by recognizing and upholding standards in international law which serve as guidance to hold states responsible for failure to comply with immediate and minimum core obligations to the right to health.

This article begins by contextualizing the problem of maternal mortality and morbidity as a global problem, focusing primarily on the situation in Sub-Saharan Africa. It will then provide the factual basis of the case and the dire maternal health context that gave rise to this litigation initially. Thereafter, it will move on to analyze the principle of "progressive realization" in international law and immediate and core obligations binding states in EmOC.[2] Lastly, the article will analyze how international law can strengthen claims to reproductive rights and also the contribution of Constitutional Petition No 16 to international law. This article aims to demonstrate the relevance and contribution of this judgment to the growing but limited body of jurisprudence on sexual and reproductive rights, specifically maternal health, focusing on EmOC.

Maternal mortality and morbidity as a global problem

Maternal death is defined as the "death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes".[3] Globally, approximately 295,000 maternal health care deaths occur each year, down from over 451,000 deaths per year in 2000.[4] The maternal mortality rate globally is approximately 223 per 100,000 live births, though these figures are significantly higher in developing countries, where a range of challenges make access to maternal health care limited.[5] Although substantial gains have occurred, the World Bank notes that during the period of the Millennium Development Goals, only nine countries between 2000 and 2015 reduced maternal mortality by 75 per cent or more.[6] Maternal mortality is an important indicator of maternal health overall in countries and provides a snapshot into broader questions of socio-economic development, respect for human rights and gender parity. Sub Saharan Africa, where women compose 52 per cent of the population, is the region of the world that suffers from the highest rates of maternal mortality, with a ratio of 545 deaths per 100,000 live births compared to 223 deaths per 100,000 live births globally.[7] Most countries in Sub Saharan Africa are unlikely to meet Goal 3.1 of the Sustainable Development Goals (SDGs), which envisages a reduction of maternal mortality ratio to 70 deaths per 100,000 live births by 2030.[8]

2 This article will focus on immediate obligations in EmOC and will exclude minimum core obligations in sexual and reproductive rights not specific to EmOC.

3 "Maternal deaths" (Global Health Observatory, World Health Organization), available at: <https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4622#:~:text=Definition%3A,and%20site%20of%20the%20pregnancy> (last accessed 7 September 2022).

4 "Maternal mortality: Maternal mortality declined by 34 per cent between 2000 and 2020" (UNICEF), available at: <https://data.unicef.org/topic/maternal-health/maternal-mortality/> (last accessed 7 September 2022).

5 "Trends in maternal mortality 2000 to 2020. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division" (2023, World Health Organization) at 37, available at: <https://iris.who.int/bitstream/handle/10665/366225/9789240068759-eng.pdf?sequence=1> (last accessed 4 January 2024).

6 "Maternal deaths fell 44% since 1990" (2015, The World Bank), available at: <https://www.worldbank.org/en/news/press-release/2015/11/12/maternal-deaths-fell-44-percent-since-1990#:~:text=Despite%20global%20improvements%2C%20only%209,%2C%20Rwanda%20and%20Timor%2DLeste> (last accessed 7 September 2022).

7 "Trends in maternal mortality 2000 to 2020", above at note 5 at 38.

8 "Transforming our world: The 2030 agenda for sustainable development" (21 October 2015, UN General Assembly) A/RES/70/1.

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There are a number of common challenges across the continent which limit significant advances in maternal health outcomes. One of the biggest challenges facing health care across Africa, and which negatively impacts maternal health outcomes, is the low levels of government spending. Current spending across governments in Sub Saharan Africa averages at 6 per cent of GDP, which amounts to USD 133 per capita across the region.[9] Comparatively, in Europe and Latin America, the average spending as a percentage of GDP is only about 8 per cent but this translates into per capita spending of almost USD 2,500[10] and USD 1,063, respectively.[11] African governments had committed under the 2001 Abuja Declaration to increase spending to 15 per cent of annual budgets, however, according to the World Bank, no country in the region has met this target, leading to continually underfunded and inadequate health care systems across the continent.[12] A report by the World Health Organization (WHO) for the Regional Committee of Africa notes, ironically, that "some member states cannot afford to absorb all HWs (health workers), leading to the paradox of HW unemployment amidst shortages to the health system".[13]

The limited investment in public health care by African governments has pushed individuals who can afford the costs into growing private sector health care, creating widening health / wealth disparities. In addition, including in public health systems, patients are often required to pay user fees, either through regulated payment or as the result of corrupt practices. Nearly 30 per cent of all of Africa's health care spending comes from out-of-pocket expenses, placing a substantial burden on poorer households which often have to enter into a so-called devil's choice – choosing between, for example, paying school costs for children, borrowing from friends and family or assuming health care costs or other health care shocks.[14] The costs associated with delivery are often high and impoverishing, even in public health care centres. In a study of maternal health care costs in Tanzania, Burkina Faso and Kenya, Perkins et al found that delivery costs constituted 6 per cent, 8 per cent and 17 per cent, respectively, of monthly income. They note that such costs "contribute to hardships" and were an "extreme burden" on households which they found had to sell crops and other assets to pay for delivery costs.[15]

The high cost of quality maternal health care and limited availability, particularly in rural areas, pushes many women to give birth without a skilled birth attendant. Only about 63 per cent of women in Sub Saharan Africa give birth with the presence of a skilled birth attendant and fewer deliver at health care facilities.[16] In Tanzania, for example, 52 per cent of births are attended by a nurse, midwife or other skilled birth attendant while only 12 per cent are attended by doctors.[17]

9 "Global health expenditure database (2000–2018)" (World Bank), available at: <https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=ZG&most_recent_value_desc=true> (last accessed 4 October 2022).

10 Id at European dataset, available at: <https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=EU> (last accessed 13 November 2024).

11 Id at Latin American dataset, available at: <https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=XJ> (last accessed 13 November 2024).

12 Id at Sub Saharan Africa dataset, available at: <https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=ZG&most_recent_value_desc=> (last accessed 13 November 2024).

13 "What needs to be done to solve the shortage of health workers in the African Region" (24 August 2017, World Health Organization), available at: <https://www.afro.who.int/fr/node/8513> (last accessed 9 October 2022).

14 "Out of pocket expenditures (% of current health expenditure) in Sub-Saharan Africa" (The World Bank), available at: <https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=ZG> (last accessed 5 October 2022).

15 M Perkins et al "Out-of-pocket costs for facility-based maternity care in three African countries" (July 2009) 24/4 *Health Policy and Planning Bulletin* 289 at 298.

16 "Birth attendant by skilled health staff (% of total) – Sub Sahara Africa" (The World Bank), available at: <https://data.worldbank.org/indicator/SH.STA.BRTC.ZS?locations=ZG> (last accessed 10 October 2022).

17 "Tanzania demographic and health survey and malaria indicator survey (TDHS-MIS) 2015–16" (2016, Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) (Tanzania Mainland), Ministry of Health (MoH) (Zanzibar), National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS) and ICF) at 172, available at: <https://dhsprogram.com/pubs/pdf/FR321/FR321.pdf> (last accessed 10 October 2022).

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The minimal investment in health care across most African countries, combined with the inability of states to retain health care professionals, has resulted in another problem: extreme shortages of health care workers, amongst them gynaecologists and obstetricians, estimated to reach a 6.1 million health personnel shortage by 2030.[18] Africa has 1.3 doctors per 1,000 people, which is significantly below the 4.5 per 1,000 threshold necessary to achieve universal health coverage under the SDGs.[19]

Additionally, significant disparities in maternal health care indicators between rural and urban populations demonstrate the stark disparity in access to maternal care between geographies, further exacerbating poor maternal health outcomes. In data which tracked rural-urban maternal health care access from 2013–18, UNICEF found that in rural areas, only 46 per cent of the population had at least four antenatal visits compared to 69 per cent in urban settings. Similarly, only 49 per cent of women delivered in a health care institution versus 78 per cent in urban areas.[20] Hanson et al found that in Tanzania, like in most countries throughout Africa, "distance to the nearest hospital has also been found to be positively correlated with direct obstetric mortality".[21] Poor maternal health outcomes depend on a number of factors as highlighted in this section that, often, together create inadequate and unsafe health care systems across much of Africa, denying vulnerable groups, such as the poor and women, quality access and care.

Factual background and Constitutional Petition No 16

Like other low-income countries, Uganda faces significant deficiencies in its provision of maternal health care. In Uganda, despite decreases in overall maternal mortality rates, deaths continue to be high and above global averages. According to the Ugandan Demographic Household Survey, maternal mortality fell slightly between 2006 and 2016. In 2006, there were 418 deaths per 100,000 live births, falling to 336 deaths per 100,000 live births in 2016, the year in which the maternal health deaths in question occurred.[22] This number increased to approximately 373 deaths per 100,000 in 2017[23] but has since fallen substantially to 189 deaths per 100,000 live births, according to the 2022 Demographic Household Survey for Uganda.[24] Other maternal health indicators have also undergone improvements. Since 2016, the percentage of women who gave birth in a health facility rose from 73 per cent to 91 per cent, and the number of women who gave birth with a skilled birth attendant present also rose from 74 per cent to 91 per cent.[25] More pregnant women are also attending four antenatal care visits (from 60 per cent in 2016 to 72 per cent in 2022) and pregnancy deaths are down from 368 deaths per 100,000 live births in the period from 2009–16, to 228 in the period from 2015–22.[26] Post partum haemorrhaging, an easily preventable death, continues to remain the leading cause of maternal death in Uganda (34 per cent of deaths), followed by death from hypertensive disorders (14 per cent), death by indirect causes such as malaria, HIV/AIDS, COVID-19 etc

18 Id at note 13.
19 Ibid.
20 "Healthy mothers, healthy babies: Taking stock of maternal health" (2 June 2019, UNICEF), available at: <https://data.unicef.org/resources/healthy-mothers-healthy-babies/> (last accessed 8 November 2022).
21 C Hanson et al "Access to maternal health services: Geographical inequalities, United Republic of Tanzania" (2017) 95/12 *Bulletin of the World Health Organization* 810 at 810.
22 "Uganda demographic and household survey" (2016, Uganda Bureau of Statistics) at 305.
23 "Maternal mortality ratio (model estimate per 100,000 live births): Uganda" (2023, The World Bank), available at: <https://data.worldbank.org/indicator/SH.STA.MMRT?locations=UG> (last accessed 17 April 2023).
24 "Uganda demographic and health survey 2022: Key findings" (2022, Uganda Bureau of Statistics - UBOS and ICF), available at: <https://www.health.go.ug/wp-content/uploads/2023/09/UDHS-2022-presentation-final.pdf> (last accessed 13 December 2023).
25 Ibid.
26 Ibid.

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(12 per cent), deaths caused by pregnancy-related sepsis (9 per cent) and antepartum haemorrhage (7 per cent).[27]

It was in this context that the CEHURD case was instituted in court. The case concerned the deaths in 2016 of two women from rural areas, Sylivia Nalubowa and Anguko Jennifer, and their unborn children during labour. At Mityana Hospital, nurses asked Nalubowa's mother-in-law for money and supplies, but she did not have the amount requested.[28] Nalubowa began haemorrhaging but a doctor on call never arrived. Both she and her baby died at the hospital.[29] The second case involved Anguko, who went into labour in Arua Regional Referral Hospital at 11:00 am and started bleeding at 2:00 pm. Nurses left Anguko unattended and told her sister and husband to stop her bleeding with old pieces of cloth.[30] The doctor was called at 7:30 pm but was delayed in arriving. Anguko and her baby died at the hospital.[31]

The case was first instituted in 2011 at the Constitutional Court. At that time, an objection was brought by the office of the Attorney General challenging the jurisdiction of the court based on the political question doctrine. The counsel to the respondent had argued that the petitioner was asking the Constitutional Court to make a judicial decision over political questions.[32] The Constitutional Court upheld the objection by striking out the case. This decision of the court was challenged on appeal and the Supreme Court overturned the decision of the Constitutional Court by ordering that the court examine the petition on the merits.[33] The Supreme Court had held that the Constitutional Court erred by refusing to hear the matter based on the doctrine of the political question. The political question doctrine is often a ploy raised to challenge the ability of the court to entertain socio-economic rights matters.

The matter was brought against the Ugandan government. The suit was premised on the government's failure to respect, protect and fulfil the right to health, life, the rights of women and the prohibition to be subjected to inhuman or degrading treatment. The appellants alleged that the failure of the Ugandan government to provide minimum health care services, which include non-provision of basic indispensable maternal care facilities, inadequate numbers of health care providers, inadequate allocation of resources, frequent stock outs of essential medicines and lack of EmOC services contributed to their deaths.[34] The Government of Uganda argued that, while tragic, the state had met its obligations to progressively realize the right to maternal health under international law since the right to health was a socioeconomic right, therefore progressive in nature, hence the capacity of the state fully to protect and fulfil the obligation depended on the availability of resources.[35] Nevertheless, this argument was not accepted by the Constitutional Court, finding the government in breach of international and domestic law.

Progressive realization as a principle towards the fulfilment of sexual and reproductive rights

Article 2(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) reflects a principal obligation of state parties to the covenant to take steps to achieve progressively the full realization of the rights recognized in the covenant, to the maximum of its available

27 "Sustaining public sector investments in health sector: Uganda budget brief | financial year 2023/4" (2023, UNICEF), available at: <https://www.unicef.org/esa/media/13261/file/UNICEF-Uganda-Health-Budget-Brief-2023-2024.pdf> (last accessed 13 December 2023).

28 Constitutional Petition No 16 of 2011, above at note 1 at 15.

29 Id at 16.

30 Ibid.

31 Ibid.

32 Id at 4.

33 See Constitutional Appeal No 01 of 2013.

34 Id at 2.

35 Id at 11.

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resources.[36] This obligation is known as "progressive realization".[37] Progressive realization recognizes "that full realization of all economic, social and cultural rights will generally not be able to be achieved in a short period of time … since it reflects the realities of the real world and the difficulties involved for any country in ensuring full realization of economic, social and cultural rights".[38] However, General Comment No 3 of the Committee on ICESCR (CESCR) states that realization over time should not be "misinterpreted as depriving the obligation of all meaningful content"[39] since it imposes the obligation on states to move as expeditiously and effectively as possible towards full realization and to justify any deliberately retrogressive measure.[40]

The CESCR has stated that, when "considering a communication concerning an alleged failure of a State Party to take steps to the maximum of available resources",[41] it will assess whether the measures were "adequate" or "reasonable".[42] The committee has indicated that, when assessing adequacy or reasonableness of measures it may consider, among other measures, "the extent to which the measures taken were deliberate, concrete and targeted towards the fulfilment of economic, social and cultural rights",[43] whether they are non-discriminatory and non-arbitrary, in accordance with international human rights standards, whether the option that least restricts ICESCR rights was taken, the time frame in which the steps were taken and whether "the steps had taken into account the precarious situation of disadvantaged and marginalized individuals or groups and, whether they were non-discriminatory, and whether they prioritized grave situations or situations of risk".[44]

As part of progressive realization, states are required to take steps to the maximum of their available resources. However, "the question of what resources must be used in realizing socio-economic rights is one of the most difficult in the human rights field".[45] The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)[46] requires that the obligation to use maximum available resources requires the allocation of sufficient economic resources[47] and even if the state has wide discretion in determining its maximum available resources, it does not have open-ended discretion.[48] A useful benchmark to evaluate a state's progress or a failure to comply with the right could be argued by comparing the country's relevant indicators with those of countries with similar resources.[49]

36 International Covenant on Economic, Social and Cultural Rights (1966), UN Treaty Series vol 993.

37 UN Committee on Economic, Social and Cultural Rights General Comment No 3: The Nature of States Parties' Obligations (art 2, para 1, of the Covenant), 14 December 1990, E/1991/23, para 9. See also the Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter (Nairobi Principles).

38 Ibid.

39 Ibid.

40 Ibid.

41 "An evaluation of the obligation to take steps to the 'maximum of available resources' under an Optional Protocol to the Covenant: Statement" (10 May 2007, CESCR) E/C.12/2007/1, para 8, available at: <https://www..ohchr.org/english/bodies/cescr/docs/statements/Obligationtotakesteps-2007.pdf> (last accessed 25 October 2024).

42 Ibid. The reasonableness standard is comparable to the reasonableness standard developed by the South African court in *Grootboom*. See *Government of the Republic of South Africa v Grootboom and Others* 2000 (11) BCLR 1169 (CC).

43 CESCR, ibid. See also CESCR General Comment No 3, above at note 37, para 2; 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, para 30.

44 "An evaluation of the obligation", above at note 41, para 8. These criteria are similar to the ones adopted in *Grootboom*, above at note 42.

45 RE Robertson "Measuring state compliance with the obligation to devote the 'maximum available resources' to realizing economic, social, and cultural rights" (1994) 16/4 *Human Rights Quarterly* 693 at 693.

46 Convention on the Elimination of All Forms of Discrimination against Women (1979), UN Treaty Series vol 1249.

47 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, para 17.

48 P Alston and G Quinn "The nature and scope of states parties' obligations under the International Covenant on Economic, Social and Cultural Rights" (1987) 9/2 *Human Rights Quarterly* 156 at 177.

49 "The right to contraceptive information and services for women and adolescents" (2010, UNFPA and Center for Reproductive Rights) at 22, available at: <https://www.unfpa.org/sites/default/files/resource-pdf/Contraception.pdf> last accessed 25 October 2024.

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Progressive realization has its limits in the minimum core doctrine. The CESCR has indicated in General Comment No 3 that "a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party".[50] Minimum core obligations are a subset of obligations "that must be immediately complied with in full by all states … to which the doctrine of 'progressive realization' is inapplicable"[51] and cannot be subject to limitations.[52] Any assessment as to whether a state has discharged its minimum core obligations will have to "take account of resource constraints applying within the country concerned"[53] and the state party "must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations".[54] However, "multiple obligations relating to sexual and reproductive health rights are not subject to resource availability",[55] such as, inter alia, the establishment of a national plan of action or the elimination of harmful practices and discrimination.[56]

In relation to maternal health, and more specifically to EmOC, several obligations have been recognized by human rights monitoring mechanisms and UN agencies as being part of the minimum core.[57] The following section will provide an analysis of immediate obligations relevant to Constitutional Petition No 16, when the lives of women are threatened by the lack of basic maternal health services.

Minimum core obligations in emergency obstetric care

Article 12(2) of the CEDAW obliges states to "ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary".[58] The wording "shall ensure" in article 12(2) of the CEDAW means that the obligation to ensure women's right to safe motherhood and emergency obstetric services is immediate[59] and that states "should allocate to these services the maximum extent of available resources".[60] Also, article 14(2)(b) of the Protocol to the African Charter on Human and Peoples Rights of Women in Africa (Maputo Protocol)[61] requires state parties to take all appropriate measures to "establish

50 CESCR General Comment No 3, above at note 37, para 10. On the essence of human rights law see: M Scheinin "Core rights and obligations" in D Shelton (ed) *The Oxford Handbook of International Human Rights Law* (2013, Oxford University Press) 527; P Thielbörger "The 'essence' of international human rights" (2019) 20/6 *German Law Journal* 924.

51 J Tasioulas "Minimum core obligations: Human rights in the here and now" (research paper, 2017, The World Bank) at V, available at: <https://openknowledge.worldbank.org/bitstream/handle/10986/29144/122563-WP-Tasioulas2-PUBLIC.pdf?sequence=1&isAllowed=y> (last accessed 10 February 2023).

52 A Müller "Limitations to and derogations from economic, social and cultural rights" (2009) 9/4 *Human Rights Law Review* 557 at 579–83.

53 CESCR General Comment No 3, above at note 37, para 10.

54 Ibid.

55 "Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity" (2 July 2012, UN Human Rights Council) A/HRC/21/22, para 21.

56 Ibid.

57 The identification of a minimum core obligation is contentious. See id at 492–95.

58 The Convention on the Rights of the Child (CRC) and ICESCR do not cover safe delivery or confinement. Art 24(2)(d) of the CRC requires that state parties "shall take appropriate measures … To provide appropriate pre/natal and post/natal care for mothers". Similarly, art 10(2) of the ICESCR provides that: "Special protection should be accorded to mothers during a reasonable period before and after childbirth".

59 MA Freeman, C Chinkin and B Rudolf "Article 12" in MA Freeman, C Chinkin and B Rudolf (eds) *The UN Convention on the Elimination of All Forms of Discrimination Against Women* (Oxford Commentaries on International Law, 2012, Oxford University Press) 311 at 329.

60 CEDAW General Recommendation No 24, above at note 47, para 27.

61 African Union Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, 11 July 2003.

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and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding".

The minimum core of economic, social and cultural rights and, specifically, the right to health and sexual and reproductive rights, has been developed by international human rights treaty bodies through their general comments. General Comment No 3 of the CESCR asserted that state parties to the ICESCR had to ensure, at the very least, minimum essential levels of each of the rights, whereby, if the individual were to be denied, the state would be failing to discharge its obligations under the covenant.[62] In relation to health, the CESCR referred to "essential primary health care",[63] without specifying what constituted essential primary health care. A few years later the committee adopted General Comment No 14 and refined the concept of essential primary health care. When specifying the minimum core, it referred to the Programme of Action of the International Conference on Population and Development and the Alma-Ata Declaration as instruments reflecting an international consensus on the core obligations arising under article 12.[64] As part of the minimum core, General Comment No 14 recognized the obligation "[t]o ensure reproductive, maternal (pre-natal as well as post-natal) and child health care".[65] More recently the CESCR adopted General Comment No 22 on the right to sexual and reproductive health[66] and acknowledged as guidance for the purposes of specifying the minimum core "contemporary human rights instruments and jurisprudence, as well as the most current international guidelines and protocols established by United Nations agencies, in particular WHO and the United Nations Population Fund (UNFPA)".[67] The comment included as core obligations specific to obstetric services "[t]o guarantee universal and equitable access to affordable, acceptable and quality sexual and reproductive health services, goods and facilities, in particular for women and disadvantaged and marginalized groups"[68] in addition to other core obligations of sexual and reproductive rights.

International treaties and general comments recognize a core obligation of states to guarantee reproductive health services. These instruments use the terms "appropriate", "adequate" and "affordable, acceptable and quality" services, specifically when applied to EmOC. Notwithstanding, these instruments, even if vague as to the scope of the obligations, refer to additional instruments such as the International Conference on Population and Development (ICPD) Programme of Action, WHO and UNFPA guidelines and international human rights law jurisprudence, as guidance. As such, the ICPD Programme of Action includes that "safe delivery … should be ensured" under the minimum core of women's right to health care.[69] As part of safe delivery the Programme of Action requires the "adequate delivery assistance that … provides for obstetric emergencies",[70] "referral services for pregnancy, childbirth and abortion complications"[71] and that all births are "assisted by trained persons, preferably nurses and midwives, but at least by trained birth attendants".[72] The WHO, UNPFA and UNICEF have developed standards for monitoring

62 CESCR General Comment No 3, above at note 37, para 10.
63 Ibid.
64 CESCR General Comment No 14, above at note 43, para 43.
65 Id, para 44(a).
66 UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment No 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), 2 May 2016, E/C.12/GC/22.
67 Id, para 49.
68 Id, para 49(c).
69 Programme of Action adopted at the International Conference on Population and Development Cairo, 5–13 September 1994 20th Anniversary Edition, para 7.6, available at: <https://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf> (last accessed 23 October 2024).
70 Id, para 8.17.
71 Id, para 8.22.
72 Ibid.

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the availability and use of obstetric services.[73] These guidelines identify interventions which, if implemented by states, have been found to reduce maternal mortality.[74] According to Yamin and Maine, these guidelines "establish the core content of standards for emergency obstetric care that can guide priorities in state parties' healthcare expenditures"[75] and:

> "[a]ny significant deviation from the minimum levels articulated in the UN Guidelines, any discrimination among sub populations in terms of emergency obstetric coverage, or any back-tracking or active deprivation with respect to the provision of such care should constitute an immediately recognizable violation of this aspect of the right to health. Moreover, combined with information about a country's resources, measured by per capita Gross Domestic Product (GDP), comparisons among state parties of similar resources can be made."[76]

Life-threatening obstetric complications are the same around the world (haemorrhage, sepsis and hypertensive disorders, such as eclampsia).[77] Most of these complications can be successfully treated[78] and treatment is not complicated.[79] However, the chances of women's survival depend on the "different legal and regulatory contexts and standards of medical care".[80] The UNICEF, WHO and UNFPA Guidelines identify two levels of essential obstetric care that should be available: basic and comprehensive.[81] According to the guidelines, a basic fully functioning EmOC facility is required to perform seven signal functions: administer parenteral antibiotics, uterotonic drugs (ie parenteral oxytocin), parenteral anticonvulsants for pre-eclampsia and eclampsia (ie magnesium sulfate), manually remove the placenta and retained products, perform assisted vaginal delivery and basic neonatal resuscitation.[82] A comprehensive fully functioning EmOC facility performs the basic functions as well as obstetric surgery (caesarean) and blood transfusion.[83] Many complications that are life-threatening can be treated at a basic EmOC facility, however, a woman experiencing complications can be given enough treatment at a basic EmOC facility so that she can reach a comprehensive EmOC facility.[84] According to the 2009 guidelines, the minimum acceptable number of basic and comprehensive EmOC facilities for a country or region are "five EmOC facilities, at least one of which provides comprehensive care" for every 500,000 population.[85] However, the guidelines alert that, even if a state meets the minimum ratio, "fully functioning basic facilities, however, are much less common".[86]

The guidelines additionally include as indicators the estimate of the proportion of women with major direct obstetric complications[87] who are treated in a health facility providing EmOC, either

73 *Guidelines for Monitoring the Availability and Use of Obstetric Services* (1997, UNICEF, WHO and UNFPA), available at <https://www.publichealth.columbia.edu/file/10730/download?token=LzW5VePB> (last accessed 23 October 2024). An updated version of the 1997 guidelines was published in 2009: *Monitoring Emergency Obstetric Care: A Handbook* (2009, WHO et al) available at: <http://apps.who.int/iris/bitstream/handle/10665/44121/9789241547734_eng.pdf;jsessionid=3F8EF3ED942E517C20DC99953631D9FB?sequence=1> (last accessed 23 October 2024).

74 AE Yamin and DP Maine "Maternal mortality as a human rights issue: measuring compliance with international treaty obligations" (1999) 21/3 *Human Rights Quarterly* 563 at 593.

75 Id at 592–93.

76 Ibid.

77 Id at 563–607.

78 Id at 572.

79 Id at 573.

80 Id at 568.

81 *Guidelines*, above at note 73 at 22.

82 Id at 7.

83 Yamin and Maine "Maternal mortality as a human rights issue", above at note 74 at 573; *Guidelines*, id at 10.

84 Yamin and Maine, id at note 74 at 578; *Guidelines*, id at 10–11.

85 *Guidelines*, id at 10.

86 Id at 11.

87 As major complications, the *Guidelines* include hemorrhage, prolonged and obstructed labour, postpartum sepsis, complications of abortion, severe pre-eclampsia and eclampsia, ectopic pregnancy and ruptured uterus: id at 19.

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basic or comprehensive.[88] Calculating met need highlights "the extent to which pregnant women are using the health system",[89] which ones are, and which ones are not, and the reasons why have "important implications for public health and human rights".[90] It is estimated that the total need for EmOC is 15 per cent of all births[91] and the guidelines recommend that the minimum acceptable level should be set at 100 per cent, since all women who have obstetric complications should receive EmOC.[92] In relation to comprehensive EmOC, the guidelines include whether the facilities in the country provide enough life-saving surgery as an essential standard. The 2009 guidelines alert that "both very low and very high rates of caesarean section can be dangerous"[93] and recommend states to keep the percentages recommended as minimum and maximum in the 1997 guidelines using a range of "5–15 %",[94] 5 per cent being the minimum and 15 per cent being the maximum that should not be exceeded, due to its possible overuse.[95] To assess whether the quality of these services is adequate, the guidelines recommend taking into consideration threes indicators: the direct obstetric case fatality rate, intrapartum and very early neonatal death rate, and the proportion of deaths due to indirect causes in EmOC facilities. In relation to the first, the standard measures are "the proportion of women admitted to an EmOC facility with major direct obstetric complications or who develop such complications after admission and die before discharge".[96] According to the 1997 guidelines, "the maximum acceptable level of 'case fatality rate' is set at 1%",[97] the 2009 guidelines set it at less than 1 per cent.[98] If given proper care, more than 99 per cent of women admitted for obstetric complications should survive.[99] In relation to the second, the intrapartum and very early neonatal death rate indicator measures the "proportion of births that result in a very early neonatal death or an intrapartum death (fresh stillbirth) in an EmOC facility".[100] This indicator was introduced to shed light on the quality of intrapartum care for foetuses and newborns delivered at facilities,[101] however the guidelines do not set a standard of a maximum acceptable level.[102] Lastly, the 2009 guidelines include a new indicator which measures the proportion of deaths due to indirect causes in EmOC facilities.[103] Indirect causes result from "previous existing disease or diseases that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by the physiologic effects of pregnancy".[104] This new indicator does not have a recommended or ideal level, instead "it highlights the larger social and medical context of a country or a region".[105]

The CESCR General Comment No 22 recognizes as a minimum core obligation the provision of essential medicine, equipment and technologies which are essential to sexual and reproductive health. In relation to medicine, the CESCR refers to medicine included in WHO Model List of Essential Medicines.[106] The list includes medicines which are important for preventing the leading

88 Ibid.
89 Id at 17.
90 Id at 18.
91 Id at 21.
92 Ibid.
93 Id at 25.
94 Ibid; Yamin and Maine "Maternal mortality as a human rights issue", above at note 74 at 580.
95 *Guidelines*, ibid.
96 Id at 31.
97 Yamin and Maine "Maternal mortality as a human rights issue", above at note 74 at 581.
98 *Guidelines*, above at note 73 at 31.
99 Yamin and Maine "Maternal mortality as a human rights issue", above at note 74 at 581.
100 *Guidelines*, above at note 73 at 34.
101 Ibid.
102 Ibid.
103 Id at 36.
104 Ibid.
105 Ibid.
106 CESCR General Comment No 22, above at note 66, para 49(g); CESCR General Comment No 14, above at note 43, para 43(d).

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causes of maternal morbidity and mortality[107] and are also essential to a basic fully functioning EmOC facility as mentioned earlier. To manage postpartum haemorrhage, pre-eclampsia and eclampsia, the WHO lists several drugs considered as essential which are "relatively cheap, easy to administer and [are] often available in healthcare settings".[108] Cook also argues that a fundamental aspect of this obligation is that access to medicine, equipment and technologies is guaranteed by the state, and supply chains facilitated as well, "particularly in rural and underserved areas and assist the ability of health workers to administer uteronic drugs".[109] States have also been held responsible for failing to provide appropriate EmOC due to professional negligence, inadequate infrastructure, worker absenteeism and lack of professional preparedness. In *Alyne da Silva Pimentel v Brazil*[110] the CEDAW Committee held the state responsible for "professional negligence, inadequate infrastructure and lack of professional preparedness".[111] According to the WHO, the minimum recommended ratio of health workers of "2.3 skilled health workers (physicians and nurses/midwives) per 1,000 population was generally necessary to attain high coverage".[112] However in 2016 the WHO designed a new indicator extending it to a broader range of health services that the SDG agenda requires, recommending the threshold of 4.45 skilled health workers (physicians and nurses/midwives) per 1,000 population.[113] According however to the Ending Preventable Maternal Deaths initiative, the threshold should be set at 5.9 skilled health professionals (midwives, nurses and physicians) per 1,000 population which has been identified as the workforce requirement to reduce global maternal deaths to 50 per 100,000 live births by 2035.[114]

In relation to the second obligation in article 12(2) of the CEDAW, services should be granted for free when necessary. However, the same as for appropriate, which has been progressively defined by UN monitoring mechanisms and agencies, the scope of the obligation defined by the wording "when necessary" is unclear. In *Alyne de Silva Pimentel v Brazil*, as Tobin argues, even if the CEDAW Committee did "not expressly consider the meaning of the phrase 'where necessary', its views tend to suggest that this threshold will be satisfied where the relevant maternal health services are reasonably necessary to prevent any genuine and real threat to the life of a mother"[115] or any other right which is essential in nature.[116]

Another important immediate and minimum core obligation is the right to access services on a non-discriminatory basis. The CESCR and the CEDAW Committee recognize the right to ensure universal and equitable distribution of all health facilities, goods and services,[117] in particular for women and disadvantaged and marginalized groups.[118] The Maputo Protocol also requires state parties to take all appropriate measures to "provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those

107 R Gill, B Ganatra and F Althabe "WHO essential medicines for reproductive health" (2019) 4/6 e002150 *BMJ Global Health* 1 at 1.

108 Ibid. See "WHO model list of essential medicines - 22nd list, 2021" (2021, World Health Organization) at 50, available at: <https://www.who.int/publications/i/item/WHO-MHP-HPS-EML-2021.02> (last accessed 23 October 2024).

109 RJ Cook "Human rights and maternal health: exploring the effectiveness of the Alyne decision." (2013) 41/1 *Journal of Law, Medicine & Ethics* 103 at 112.

110 *Alyne Da Silva Pimentel v Brazil* CEDAW/C/49/D/17/2008 10 August 2011.

111 Id, para 7.4.

112 *Health Workforce Requirements for Universal Health Coverage and the Sustainable Development Goals* (2016, WHO) at 12, available at: <https://aps.who.int/iris/bitstream/handle/10665/250330/9789241511407-eng.pdf> (last accessed 23 October 2024).

113 Id at 21.

114 F Bustreo et al "Ending preventable maternal deaths: The time is now" (2013) 1/4 *Lancet Global Health* e176 at e176–77.

115 J Tobin *The Right to Health in International Law* (2012, Oxford University Press) at 289.

116 Ibid.

117 CESCR General Comment No 14, above at note 43, para 43(e); CESCR General Comment No 22, above at note 66, para 49(c); CEDAW General Recommendation No 24, above at note 47, paras 2, 11 and 29.

118 CESCR General Comment No 22, id, para 49(c); CESCR General Recommendation No 24, above at note 47, paras 2, 11 and 29.

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in rural areas".[119] To eliminate discrimination against women, states should repeal or eliminate laws, policies and practices that criminalize, obstruct or undermine access by individuals or a particular group to sexual and reproductive health facilities, services, goods and information[120] as well as the removal of barriers to women even if "seemingly gender-neutral".[121] The CEDAW has addressed specifically the need to ensure effective access on a non-discriminatory basis in relation to rural women, those who are most affected by the unequal distribution of health facilities and resources "owing to … insufficient budget allocations to rural health services, the lack of infrastructure and trained personnel, the lack of information on modern methods of contraception, remoteness and the lack of transport".[122] In *Alyne da Silva Pimentel v Brazil*[123] the CEDAW Committee held the government accountable for a preventable maternal death due to the failure to implement a woman's right to "appropriate services in connection with pregnancy confinement and the postnatal period" and also to take all appropriate measures to eliminate discrimination in the field of health care on account of Alyne's sex and socioeconomic status, but also as a woman of African descent.[124] The UNICEF, WHO and UNFPA Guidelines consider as an essential standard to monitor states compliance with EmOC, the geographical distribution and accessibility of facilities.[125] Maternal health complications require urgent attention, therefore EmOC facilities should be distributed geographically, so that women in rural areas can reach them.[126] To ensure equity and access, the guidelines recommend that subnational areas should have at least five facilities (including at least one comprehensive facility) per 500,000 population[127] except in areas where the population is dispersed and travel is difficult, "it may be advisable for governments to exceed the minimum acceptable level".[128]

General Comment No 22 of the CESCR recognizes another minimum core obligation which is "to enact and enforce the legal prohibition of harmful practices and gender-based violence".[129] Both the CEDAW Committee and the Committee on the Rights of the Child have highlighted that harmful practices and gender-based violence put the health and lives of girls and women at risk.[130] States should ensure "privacy, confidentiality and free, informed and responsible decision-making, without coercion, discrimination or fear of violence".[131] These rights are instrumental to guaranteeing women's autonomy, which lies at the centre of the fundamental rights to liberty, dignity and equality.[132]

119 The Maputo Protocol, art 14(2)(a).

120 CESCR General Comment No 22, above at note 66, para 43(a).

121 Freeman, Chinkin and Rudolf "Article 12", above at note 59 at 320; CEDAW General Recommendation No 24, above at note 47, paras 11, 14 and 27; RJ Cook "State responsibility for violations of women's human rights" (1994) 7 *Harvard Human Rights Journal* 125 at 165.

122 Convention on the Elimination of All Forms of Discrimination against Women, 18 December 1979, A/RES/34/180, para 37.

123 *Alyne da Silva Pimentel*, above at note 110.

124 Id, paras 7.6 and 7.7.

125 *Guidelines*, above at note 73 at 13.

126 Id at 14.

127 Ibid.

128 Ibid.

129 CESCR General Comment No 22, above at note 66, para 49(d).

130 Joint General Recommendation / General Comment No 31 of the Committee on the Elimination of Discrimination against Women and No 18 of the Committee on the Rights of the Child on harmful practices, CEDAW/C/GC/31-CRC/C/GC/18, 4 November 2014 analyses the risks posed to the sexual and reproductive rights of women or girls who have been or are at risk of being subjected to harmful practices; UN Committee on the Elimination of Discrimination Against Women (CEDAW), CEDAW General Recommendation No 19: Violence against women, 1992, paras 19 and 20.

131 CESCR General Comment No 22, above at note 66, para 49(d).

132 C Shalev "Rights to sexual and reproductive health: The ICPD and the convention on the elimination of all forms of discrimination against women" (2000) *Health and Human Rights* 38 at 45–46. On dignity and autonomy see:

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Lastly, as part of the immediate core of health and sexual and reproductive rights, human rights monitoring bodies require that states adopt legislation[133] eliminating laws, policies and harmful practices that present direct and indirect barriers to the use of services by women.[134] As part of this obligation, states must elaborate a plan of action or strategy and this plan must be implemented.[135] The national plan "must contain a sexual and reproductive health strategy, encompassing maternal health"[136] which is devised, periodically reviewed and monitored through a participatory and transparent process.[137] The national health strategy should identify duty-bearers, assess institutional capacities and identify the resources available, in public and private sectors,[138] giving particular attention to all vulnerable or marginalized groups.[139] The plan must include adequate budget allocation disaggregated by prohibited ground of discrimination[140] and, specifically, a situational analysis of women's sexual and reproductive health rights,[141] corresponding right to health indicators and benchmarks.[142] The plan must ensure essential interventions[143] and essential medicines for improving maternal health,[144] capacity strengthening measures for the health workforce, number and distribution,[145] special measures in cases of discrimination in access to sexual and reproductive health services[146] and additional actions, necessary to enable women to enjoy their sexual and reproductive health.[147] The national plan must be assessed for its impact on the maternal health of different population groups and income quintiles.[148]

The CEDAW Committee has called on states to "allocate adequate budgetary, human and administrative resources to ensure that women's health receives a share of the overall health budget comparable with that for men's health, taking into account their different health needs".[149] Transformative equality requires "reallocation or reorientation of health care resources, including budgets and health personnel, to achieve universal coverage for women on a basis of equality with men"[150] and as part of this reallocation, state parties should "reasonably accommodate the different health situations of men and women".[151] For states to be able to devote the maximum available resources to sexual and reproductive health they must ensure "the establishment and sustainability of an adequate fiscal envelope".[152] If structural imbalances exist, "strengthened and

C McCrudden "Human dignity and judicial interpretation of human rights" (2008) 19/4 *European Journal of international Law* 655 at 685–86.

133 CESCR General Comment No 3, above at note 37, para 4.

134 UN Human Rights Council "Technical guidance", above at note 55, para 35.

135 CESCR General Comment No 3, above at note 37, para 11; UN Human Rights Council "Technical guidance", id, para 26.

136 UN Human Rights Council "Technical guidance", id, para 27.

137 CESCR General Comment No 14, above at note 43, para 43(b); CESCR General Comment No 22, above at note 64, para 49(f); UN Human Rights Council "Technical guidance", id, paras 30 and 43.

138 CESCR General Comment No 14, id, para 53; UN Human Rights Council "Technical guidance", id, para 29.

139 CESCR General Comment No 22, above at note 66, para 49(f).

140 CESCR General Comment No 14, above at note 43, para 43(b); CESCR General Comment No 22, id, para 49(b).

141 UN Human Rights Council "Technical guidance", above at note 55, para 28.

142 CESCR General Comment No 14, above at note 43, para 53.

143 UN Human Rights Council "Technical guidance", above at note 55, para 33 on essential interventions that should be included in the plan.

144 Id, para 34 on essential medicines for improving maternal health.

145 Id, para 39.

146 Id, para 42.

147 Id, para 35.

148 "Such ex-ante impact assessment should particularly consider the impact on vulnerable and excluded populations, including but not limited to women with disabilities, racial and ethnic minorities, conflict-affected and displaced women, adolescents and other marginalized groups, according to national context" (id, para 36).

149 CEDAW General Recommendation No 24, above at note 47, para 30.

150 Freeman, Chinkin and Rudolf "Article 12", above at note 59 at 325.

151 Ibid.

152 UN Human Rights Council "Technical guidance", above at note 55, para 45.

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rationalized revenue collection should be undertaken before cuts are made",[153] and if cuts are made, the government will have to demonstrate that it has taken all reasonable measures to avoid such reductions.[154] Budgets should ensure that access to the health system and sexual and reproductive rights are not limited by out-of-pocket costs.[155] In the same way as for the national plan, during budget formulation, participatory processes should be established.[156] Sexual and reproductive health spending should be identifiable and accessible, disaggregated by functional and programmatic classifications.[157] Sexual and reproductive spending "should not be reassigned, diverted or underspent during the fiscal year".[158]

Determining Uganda's compliance with immediate and minimum core obligations in emergency obstetric care

In Constitutional Petition No 16, the judgment determined whether the omission to adequately provide basic maternal health care services and EmOC in public health facilities violated the right to health, the right to life, women's rights and inhuman or degrading treatment.[159] In determining these issues the judgment addressed whether the State of Uganda complied with immediate and minimum core obligations in the provision of EmOC and concluded that the state, by not complying with these obligations, violated women's rights to health, life, non-discrimination and to not be subjected to inhuman or degrading treatment.

In determining whether the state had complied with the obligation to move as expeditiously and effectively towards full realization,[160] the Constitutional Court argued in favour of the petitioners that "unimplemented policies and strategies in Uganda … cannot be said to be expeditious and effective steps towards realization of the right to health".[161] According to the court, the measures adopted by the government could not be considered adequate, nor reasonable. It acknowledged that the government had put in place policies and programmes to improve maternal health leading to a decrease in maternal mortality, from 537 to 435 deaths per 100,000 lives in 11 years (1995–2006), that the use of contraceptives had increased from 5 per cent to 23 per cent and that adolescent pregnancy has also decreased from 43 per cent to 25 per cent (1995–2006).[162] However, the court sided with the petitioners that even if measures and policies had been adopted, the implementation of these policies remained a challenge.[163] First, because the decline of the maternal mortality rate was "still not good enough, taking into account the resources available to the government".[164] Second, because the time frame in which the steps were taken was not satisfactory, since it was now more than ten years since the policies had been adopted and did not "lead to any meaningful reductions in the leading causes of maternal deaths"[165] and, finally, the court highlighted that the leading causes of maternal deaths in 2007 remained the leading causes in 2016.[166] Policies had not been implemented, extended and evaluated,[167] therefore the court established that

153 Ibid.
154 Id, para 47(c).
155 Id, para 46.
156 Id, para 48.
157 Id, para 51.
158 Id, para 49.
159 Constitutional Petition No 16, above at note 1 at 6.
160 Id at 23.
161 Id at 25.
162 Id at 29.
163 Id at 27.
164 Id at 29.
165 Id at 30.
166 Ibid.
167 Id at 33.

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the state had not complied with the immediate obligation to move expeditiously and effectively towards the fulfilment of the right.

The judgment recognized the obligation to ensure adequate or appropriate services during childbirth to enable the reduction of maternal mortality rate as part of the minimum core that parties to the ICESCR and the African Charter on Human and Peoples' Rights[168] must fulfil.[169] The petitioners argued that "[t]he sad reality is that the nearest facility to give EmOC for women is an HC III facility, which provides maternal health services, but only 14% of these HC III have the facilities to provide EmOC and only 8.1 % of facilities in Uganda can provide comprehensive EMOC which are life-saving procedures, which should be available at the 1st referral facility".[170] They claimed that basic EmOC, which is a lifesaving procedure (parenteral sedatives, manual removal of placenta, removal of retained products, assisted vaginal delivery), is predominately missing.[171] The petitioners also contended that the capacity to provide life-saving surgery was below the minimum standards, indicating that "minimum caesarean section is at 2.7% as opposed to the minimum required 5% which means many women who need a C-section do not get one".[172] In relation to the direct obstetric case fatality rate, the petitioners explained this rose in Uganda to 5,840 women dying in child birth every year, translating to 16 women dying daily.[173] According to the Uganda Demographic Health Survey in 2016, 336 women die for every 100,000 live births due to maternal related complications most of which are preventable,[174] the pregnancy-related mortality ratio is at 368 deaths per 100,000 live births[175] and some health facilities have maternal mortality ratios up to 2,578 maternal deaths per 100,0000 live births.[176] The judgment did not refute these arguments.

The petitioners also addressed whether Uganda had complied with the immediate core obligation of providing essential medicine, equipment and technologies. They indicated that hospitals and clinics were lacking many essential medical items: they mentioned the lack of stock of Mama Kits (an all-in-one kit that contains everything needed to help provide a clean and safe delivery) at over 60 per cent of clinics, hospitals and stores and the lack of basic maternal health commodities such as blood for transfusion[177] and the lack of essential drugs for maternal health care in 67 per cent of regional hospitals,[178] where in 2016, 25 per cent of country-level healthcare facilities were stocked out of misoprostol, 14 per cent were stocked out of oxytocin and 29 per cent were stocked out of nifedipine-essential medications.[179] The petitioners also referenced the inadequate infrastructure of the health care sector, referring to the Health Sector Development Plan for 2015 which "showed that only 33% of the medical equipment in Uganda general hospitals was functional while 63% required repair or replacement".[180] Also, according to the petitioners, staffing across most levels of the health care system fell short of the required staffing norms and standards. These numbers were more critical "at parish level where the most vulnerable portion of the population lives and are caused mainly by inadequate and unpredictable wages".[181] Reasons behind high maternal death were due to inadequate trained staff, absence of doctors and lead clinicians to make decisions and interventions.[182]

168 African Union African Charter on Human and Peoples' Rights (27 June 1981).
169 Constitutional Petition No 16, above at note 1 at 24.
170 Id at 44.
171 Id at 46.
172 Id at 44.
173 Id at 17.
174 Id at 16.
175 Id at 29.
176 Id at 17.
177 Id at 42 and 44.
178 Id at 17.
179 Id at 44.
180 Id at 21 and 44.
181 Id at 31.
182 Id at 46.

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The petitioners also put forth the fact that the "ratio of doctors, nurses and midwives is at 0.4 per 1,000, significantly below the WHO recommended ratio of 2.5 per 1,000",[183] also caused by worker absenteeism. The judgment did not disagree with the standards and facts.

When considering if the services were necessary, in both cases the services Nalubowa and Anguko required were necessary to prevent a genuine and real threat to their lives. Nalubowa died from obstructed labour and could not get a caesarean section and Anguko died from absence of blood.[184] The Constitutional Court held that "the right to health, life and human dignity are inextricably bound … without the right to health, the right to life is in jeopardy"[185] and that "the right to health and other human rights are inseparably linked".[186] The court also referred to other precedents in international law where states were found responsible for violating the right to life by denying appropriate maternal health services or failing to provide a minimum standard of maternal health care to women who died in childbirth.[187]

The Constitutional Court also found that the government had not complied with the immediate obligation to ensure the right of access to health facilities, goods and services on a non-discriminatory basis. In both Nalubowa's and Anguko's cases, the women started haemorrhaging. In Nalubowa's case, the family did not have the money or resources to pay the nurses, and in both instances they were left unattended as their conditions deteriorated due to a lack of resources and because the doctor never arrived. The court recognized that the ICESCR and the African Charter on Human and Peoples' Rights provide for progressive realization and acknowledged the constraints due to a limitation of available resources. However, it stated that the ICESCR also "imposed on state parties various obligations of immediate effect. One such obligation which may not require resources is the guarantee that the right will be exercised without discrimination of any kind"[188] and that "[i]t is the responsibility of government to ensure that the services are physically accessible to women across the country especially in rural areas".[189] The judgment acknowledged that the continuing prevalence of maternal deaths indicated discrimination by the state of poorer women and of women in general due to the shortages and shortcomings in the delivery of maternal health care services caused by stockouts of maternal health care packages, drugs, professional negligence and limited budgetary provisions to the health sector.[190]

In addition, the judgment also considered whether immediate obligations include the prohibition of harmful practices and gender-based violence. The petitioners argued that the omission by the government to adequately provide EmOC in public health facilities had resulted in obstetric injury which subjected women to inhuman and degrading treatment.[191] The Constitutional Court defined medical care which causes severe suffering for no justifiable reason as cruel, inhuman and degrading treatment[192] and ultimately concluded that "[t]he actions caused utmost pain, degrading and cruel treatment of the deceased for the period they spent in the hospitals … This also caused suffering and loss to their families".[193]

183 Id at 18.
184 Id at 44.
185 Id at 36.
186 Id at 37.
187 The judgment referred to *Alyne da Silva Pimentel v Brazil*, above at note 110 and *Laxmi Mandal v Deen Dayal Harinagar Hospital & Others* Writ Petition No 8853/2008 (2010): id at 1.
188 Constitutional Petition No 16, id at 22.
189 Id at 25.
190 Id at 43.
191 Id at 51.
192 Citing Juan Mendez report of February 2013 "Failure by the prison authorities to provide regular antenatal and prenatal care to women who required it amounted to inhuman treatment by the prison": id at 53.
193 Ibid.

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To conclude, the arguments provided by the petitioners were challenged by the respondents by resorting to the lack of resources defence. However, the Constitutional Court found it unacceptable for the following reasons.

Uganda's lack of resources defence to compliance with immediate and minimum core in the provision of EmOC

Setting priorities among health problems, for the allocation of resources, is not an easy task.[194] In relation to sexual and reproductive rights, resource flows are very difficult to assess.[195] Expenditures are difficult to determine since countries do not budget according to the same categories, and high spending on for example AIDS has dwarfed other spending on sexual and reproductive health.[196] The Guttmacher-Lancet Commission in 2019 estimated the costs needed for, impact of and cost of fully investing in sexual and reproductive health care,[197] however, even if low-income countries have committed to increased sexual and reproductive rights investment, progress is slow "not only due to limited resources but also weak political will, persistent gender-based discrimination, and an unwillingness to address issues related to sexuality openly and comprehensively".[198]

The Ugandan government based its non-compliance with the minimum core on its lack of resources, which caused corruption and absence of trained doctors and nurses. In international law however, lack of resources, as the judgment stated, "should not be used as a blanket excuse and defense for failure to provide basic services to save life".[199] The state has the burden to demonstrate that every effort had been made to use all resources at its disposition to satisfy, as a matter of priority, those minimum obligations.[200] The Constitutional Court recognized that "the full realization of the right to health is difficult to attain because of structural and other obstacles resulting from factors beyond the control of states"[201] and stated that Uganda was no exception.[202] However, it found unacceptable that, in the case of Uganda, with vast natural resources, a lack of resources could not be an excuse. The court highlighted that the government had the responsibility to harness the resources and institute an effective and fair taxation system and a budgeting process to meet constitutional demands[203] and that this obligation needed to ensure that economic, social and cultural rights are prioritized in the distribution of resources.[204] Also, the judgment took into consideration the argument, provided by the petitioners, that Uganda had the capacity to reduce significantly maternal mortality by identifying and implementing strategies that reduce preventable deaths, even in the absence of significant funding. An important argument against the lack of resources defence was based on examples, cited by the petitioners, "from other low-income

194 RJ Cook, BM Dickens and MF Fathalla *Reproductive Health and Human Rights: Integrating Medicine, Ethics, and Law* (2003, Clarendon Press) at 56.

195 MF Fathalla et al "Sexual and reproductive health for all: A call for action" (2006) 368/9552 *The Lancet* 2095 at 2098.

196 Ibid.

197 T Riley et al "Adding it up: Investing in sexual and reproductive health 2019—methodology report" (2020, Guttmacher Institute), available at: <https://www.guttmacher.org/sites/default/files/report_pdf/adding-it-up-investing-in-sexual-reproductive-health-2019-methodology.pdf> (last accessed 23 October 2024).

198 M Schäferhoff et al "Funding for sexual and reproductive health and rights in low- and middle-income countries: threats, outlook and opportunities" (The Partnership for Maternal, Newborn & Child Health, Open Consultants and The Center for Policy Impact in Global Health) at 18–19, available at <https://pmnch.who.int/docs/librariesprovider9/meeting-reports/srhr_forecast.pdf?sfvrsn=d6d8c47c_3&download=true> (last visited 23 October 2024).

199 Constitutional Petition No 16, above at note 1 at 19.

200 CESCR General Comment No 3, above at note 37, para 10.

201 Constitutional Petition No 16, above at note 1 at 20.

202 Ibid.

203 Ibid.

204 Id at 23.

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countries in Eastern Africa that have managed to significantly reduce maternal mortality with almost the same budget to the health sector".[205]

On the issue of priority setting in relation to investing in maternal heath, the government argued that "it had an obligation to fund other areas of the health sector, and various other budget sectors that equally affect other human rights"[206] and even if constrained by competing interests and priorities and limited resources available, it had consistently increased budget allocation to health, set maternal health as a priority and had increased its resource allocation, including measures to reduce maternal mortality.[207] However the petitioners argued that the increases in budget allocation cited by the respondent were neither consistent nor significant, since the government's expenditure on health care had fluctuated between 5.3 per cent and 7.3 per cent since 2015.[208] In relation to investing in maternal health "amounts allocated to the health sector did not indicate and did not reflect the amounts released and spent. That out of the 6.3% allocated to the health sector in the Fiscal Year 2015/2016 only 93% was actually spent".[209] The claimants contended that this was not even half of what the Abuja Declaration required, and the judgment raised concern about the unspent 7 per cent "that could significantly contribute to improvement in maternal care".[210] Specific to sexual and reproductive rights, the judgment indicated that the WHO recommends that low-income countries spend at least 3 per cent of their GDP on health-related expenditure of which at least 25–30 per cent on sexual reproductive, maternal, newborn, child and adolescent health.[211] The Uganda's Health Sector Development Plan published in 2015 reported that only 1.3 per cent of the country's GDP was spent on health in the financial year 2011–12.[212] Therefore, the government was not able to demonstrate that every effort had been made to use all resources at its disposition to satisfy, as a matter of priority, the minimum core obligations.

The government also argued, as a defence, that corruption was rampant, and even if key areas and services had improved, this factor contributed to the poor outcomes in maternal health indicators. The Constitutional Court observed that this quiet corruption led to "delays in care, high rates of emergency surgery, unnecessary referrals and a multitude of other negative health outcomes".[213] It noted that, while the Health Ministry recognized absenteeism in its 2015 Health Sector Development Plan, "the goals were limited and lacked enforcement mechanisms to enable significant improvement in absenteeism or to any meaningful performance accountability in the sector".[214] The government admitted shortage of medical staff and inadequate training[215] and also provided numbers of health workers graduating annually.[216] The Constitutional Court recognized that "it may be true that the number of highly specialized lead obstetricians is limited, it is also true that many go out the country in search of greener pastures, while some of those who remain in the country join the private sector which offers better remuneration as opposed to the Ministry".[217] The court stated that "[t]o be able to provide proper obstetric services the Government must have enough skilled attendants covering 24 hours a day, seven days a week with support staff assisting them. There ought to be functional operating theatres with competent staff able to administer

205 Id at 49.
206 Id at 47.
207 Id at 48.
208 Id at 50.
209 Ibid.
210 Ibid.
211 Id at 43.
212 Ibid.
213 Id at 32.
214 Ibid.
215 Id at 47.
216 Ibid.
217 Ibid.

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safe blood transfusions and anesthesia".[218] Since these facts were not challenged or explained by the respondent, the court took them all as truthful.[219]

Conclusion: The contribution of Constitutional Petition No 16 judgment to reproductive justice

The Constitutional Petition No 16 judgment makes several significant contributions to reproductive justice. First, it adds to the not-so-abundant jurisprudence in international and national law which holds governments accountable for failing to comply with its maternal health obligations, specifically EmOC. Similar to *Alyne de Silva Pimentel v Brazil* and *Laxmi Mandal v Deen Dayal Harinagar Hospital & Others,* it moves "from understanding human rights as abstract and aspirational to obligatory and concrete, and in so doing achieve a paradigm shift from political to legal accountability".[220] The ruling acknowledges the binding character of complying with the minimum essential obligations, regardless of their controversial nature, and then finds unacceptable the lack of resources defence as a means to evade accountability to the right to be free from avoidable maternal death.

Second, the judgment also provides a unique contribution in international law to the minimum core of maternal health rights, concretely the obligations binding the state of Uganda in EmOC. Constitutional Petition No 16 goes one step further than previous jurisprudence; not only examining the structural causes in the Ugandan health system that undermine maternal health, but also by providing a detailed analysis of the core content of standards for EmOC in international law, validating it and requiring the state to comply with it, holding it accountable for not being able to justify its efforts in using all resources available to satisfy these minimum core obligations primarily. In this sense, this judgment builds on past jurisprudence and sets minimum standards for future litigation in this area of international human rights law.

Third, it avoids the depersonalizing and alienating reliance on statistics "disguising the human side of maternal mortality and losing sight of the women themselves"[221] addressing explicitly the tragedy of maternal death experienced by Sylivia Nalubowa, who died from obstructed labour and Anguko Jennifer, who died from not being able to receive a blood transfusion:

> "Maternal death is death of a mother while pregnant or within 42 days after termination of pregnancy irrespective of the duration and site of pregnancy from any cause related to or aggravated by the pregnancy or its management but not from an accident or incidental cause … maternal death is not just that it is a death that occurs at the time of expectation and joy; it is one of the most terrible ways to die. A woman can see herself bleeding to death with no help able to stop the bleeding. Severe sepsis after delivery exhausts the woman already weakened by trauma of childbirth. Seeing a woman in agony of convulsive fits in eclampsia is a terrible scene that one cannot forget. In obstructed labor, the uncountable involuntary severe uterine contractions continue until the uterus gives way and is ruptured, with internal hemorrhage taking place."[222]

Fourth, although difficult to determine whether there is a direct cause and effect, it is important to note that Uganda's maternal health indicators have improved in the years since the filing of Constitutional Petition No 16 in 2016 before the Constitutional Court. As discussed at the beginning, maternal mortality has nearly reduced by half between the period of 2016 and 2022, and other

218 Id at 49.
219 Id at 32.
220 Cook "Human rights and maternal health", above at note 109 at 106.
221 Ibid.
222 Constitutional Petition No 16, above at note 1 at 35–36.

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indicators have also shown marked improvement. A report by UNICEF highlights that, since 2016–17, the year in which the facts of the case occurred, the health sector budget has more than doubled from UGX 1,456 billion to UGX 3,094 billion in 2023–24 in real expenditure.[223] Additionally, this judgment might also be said to have galvanized greater support and constitutional backing for improvements to maternal health care. In May 2023, Members of the Ugandan Parliament (MP) called on the state to provide more adequate financing for maternal health care, with one MP echoing language similar to the decision of Constitutional Petition No 16: "the government's omission to adequately provide basic maternal health care services in public health facilities violates the right to health and is inconsistent with and in contravention of Articles 8A, 39 and 45 read together with objectives XIV and XX of the National Objectives and Directive Principles of State Policy of the Constitution".[224]

Fifth, the right to health is not explicitly included in the Ugandan Constitution. However Constitutional Petition No 16 renders the right to health justiciable, by reference to Objectives XIV and XX read together with articles 8A and 45 of the Constitution, contributing to existing jurisprudence in Uganda reaffirming the justiciability of socio-economic rights.[225] The judgment states without hesitation that National Objectives and Directive Principles of State Policy "oblige the government to provide health and basic medical services to the people of Uganda".[226] Additionally, together with the National Objectives and Directive Principles of State Policy, the judgment reinforces the justiciability of the right to health by referring to international law and international jurisprudence binding the state of Uganda.[227] Moreover, the judgment interestingly recognizes the national jurisprudence of other countries that has dealt with similar situations by upholding the right to health relying on other recognized rights such as life and dignity.[228] Therefore the judgment emphasizes the importance of the indivisibility and interrelatedness of human rights as well.[229]

Lastly, the judgment also provides for remedies. The Constitutional Court granted the petitioners remedies in the form of pecuniary damages for the loss of their loved ones as a result of the government's omissions.[230] The court also issued orders or directives to ensure the state fulfilled its responsibilities to make the right to health accessible. The court mandated the government to "prioritize and provide sufficient funds in the national budget for maternal health care"[231] in the following financial year. In addition, the court ordered that "all the staff who provide maternal health care services in Uganda are fully trained and all health centers are equipped within the next 2 financial years".[232] Notably, it also requires the government to submit a "full audit report on the status of maternal health in Uganda at the end of each of the next two financial years".[233] However, the judgment leaves undefined what it considers to be "sufficient funds" for

223 Id at 27.

224 Parliament of Uganda "MPs call for adequate financing of maternal health" (25 May 2023), available at: <https://www.parliament.go.ug/news/547/mps-call-adequate-financing-maternal-health> (last accessed 13 December 2023).

225 BK Twinomugisha "Exploring judicial strategies to protect the right of access to emergency obstetric care in Uganda" (2007) 7/2 *African Human Rights Law Journal* 283 at 296–301. See also "Review of constitutional provisions on the right to health in Uganda: A case study report" (2018, CEHURD), available at: <https://equinetafrica.org/sites/default/files/uploads/documents/CEHURD%20Constitutional%20Review%20Sep2018.pdf> (last accessed 23 October 2024).

226 Constitutional Petition 16, above at note 1 at 18.

227 Id at 18–42.

228 The judgment refers mainly to the Delhi High Court case, *Laxmi Mandal v Deen Dayal Harinagar Hospital & Others* writ petition no 8853/2008 (2010).

229 A similar approach has been adopted by Indian courts. While the right to health is not specifically recognized by the Indian Constitution, the courts have upheld this right by relying on other recognized rights such as life and dignity in constitutions. See for instance, *Paschim Banga Khel Mazdoor Samiti v State of West Bengal* 1996(4) SCC 37.

230 Constitutional Petition 16, above at note 1 at 56.

231 Id at 58.

232 Ibid.

233 Ibid.

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maternal healthcare. While health care expenditure has risen since the judgment, it remains unclear whether this expenditure is being invested in maternal health care and, more specifically, to prevent maternal deaths, which remain troublingly high throughout the country.

To conclude, this article has analyzed the contribution the Constitutional Court in Constitutional Petition No 16 judgment has made to the realization of women's rights to reproductive health care. The decision reaffirmed that failure of the state to prevent maternal health by ensuring access to EmOC amounts to a breach of the minimum core content of maternal health and thus constitutes a violation of the fundamental rights of women and that a lack of resources will not be an acceptable excuse for failing to provide essential obstetric care for women, especially disadvantaged women in Uganda. The decision reiterates that preventable maternal deaths constitute a violation of women's rights to health, dignity, life, non-discrimination and freedom to be free from inhuman and degrading treatment and sends a strong message to the Ugandan government and the international community to live up to their obligations to respect, protect and fulfil women's rights to healthcare. Most importantly, it contributes to the growing body of decisions holding governments accountable for failure to implement women's rights to EmOC and freedom from violence at domestic and international levels.

Competing interests. None.

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