LLM Thesis Research Proposal

Title -Addressing child mortality from a human rights perspective: challenges and prospects.

Student No - 11368391

Background of the study

The issue of child mortality is currently under international spotlight,[1] as the rates of neonatal mortality and under 5 mortality are sobering. It has been stated that 'about 29,000 children under the age of five[approximately] 21 each minute die every day, mainly from preventable causes'.[2] Although there has been a decline in global child mortality rates since 1990, sub Saharan Africa still has the highest rates, where 1 child in 8 dies before age five.[3] In addition it has been found that sub Saharan Africa bore half of the 8.8 million deaths in children under five in 2008.[4]

The causes of child mortality have been attributed to four diseases; pneumonia, diarrhoea, malaria and AIDS which was responsible for 43 percent of all deaths in children under 5.[5] It is clear that these deaths could have been prevented if there was adequate access to health services and medicines. It has also been stated that proper nutrition is a fundamental aspect of prevention as malnutrition increases the risk of death.[6]

From a much narrower perspective, this study will analyse child mortality within sub Saharan Africa. It will focus specifically on the rates and causes of child mortality in Uganda. According to UNICEF,[7] the leading causes of under five deaths in Uganda in 2008 were malaria,[8]diarrhoea,[9] and pneumonia[10] with the deaths caused by HIV/AIDS and measles constituting a smaller fraction. However it was also noted that neonatal mortality formed a huge part of child mortality as 24 percent of under five deaths were neonatal.

Another factor which plays a key role in child mortality in Uganda is the level of malnutrition affecting children under 5 years.[11] It has been observed that although food production in Uganda is sufficient the number of people who lack a balanced diet is increasing thus contributing to the rates of malnutrition.[12] Further, Uganda is struggling with reducing its rates of malnutrition and decreasing the number of children under 5 years who are underweight.[13] According to the World Health Organisation (WHO), 38 % of children under 5 years in Uganda suffer from stunted growth.[14] The correlation between malnutrition and child mortality has been emphasised by UNICEF as a factor which is responsible for

---

1 United Nations Millenium Development Goal 4 (MDG).
2 http://www.unicef.org/mdg/childmortality.html (accessed 14 June 2011).
3 http://www.childmortality.org/stock/documents/Child Mortality Report 2010.pdf (accessed 14 June 2011).
4 http://www.un.org/millenniumgoals/pdf/MDGReport2010Enr15-low res 20100615-.pdf (accessed 14 June 2011)
5 As above.
6 (n 4 above).
7 http://www.unicef.org/esaro/ACSD Profile 003UGA Uganda 2011.pdf (accessed 14 August 2011)
8 22 percent
9 16 percent
10 12 percent
11 http://www.observer.ug/index.php?option=com_content&view=article&id=10467%3Afeature-infant-mortality-ugandas-children-are-not-feeding-well&catid=34%3Anews&Itemid=59 (accessed 14 August 2011)
12 USAID The analysis of the nutrition situation in Uganda May 2010 1
13 As above.
14 http://www.unicef.org/infobycountry/uganda_statistics.html (accessed 14 August 2011)

global deaths in children under 5 years.[15] At the Mulago National Referral Hospital in Uganda, cases of malnutrition abound as the hospital receives cases from all over the country.[16] The situation is worse at its outpatient clinic , where according to Dr Kiboneka, there is an added problem of young mothers who do not know how to take proper care of their babies.[17] At the Mulago hospital 'severe acute malnutrition is the most common cause of death among children under 5 years'. The trouble with malnutrition is that it is hardly the only cause of mortality as some of the patients at the Mulago hospital suffer from other infections and are in critical condition. However, the Mulago hospital has problems of shortages of drug supplies and staff which it is currently tackling.[18] Generally the health system in Uganda is weighed down by lack of drugs, medical supplies and inadequate personnel.[19]

In order to reduce child mortality in Africa, immunisation must be extensively embarked on.[20] This is an issue for Uganda, in 2008 it was one of the 10 countries in Africa where large numbers of infants were not given the diphtheria, pertussis and tetanus vaccine (DPT3).[21] Also in 2009, Uganda's measles immunisation rate of 81% fell below its national goal of 90%.[22] In order to effectively reduce child mortality rates immunisation coverage must be sustained and extensive.

It is important to note that child mortality rates in Uganda have reduced since 1995 when it stood at 156 deaths per 1000 live births for children under 5 years and an infant mortality rate of 88 deaths per 1000 births.[23] In 2009, Uganda's under 5 mortality rate dropped to 128, and its infant mortality rate was 79.[24] However what must be determined is whether the drop in these rates are country wide, in other words is there an equitable reduction in child mortality rates in Uganda ? It has been observed that in countries with high child mortality rates there is a difference in urban and rural rates with the rural areas bearing a greater burden of child mortality.[25] However the rates in urban slums are also very high in some countries, an example of this is Nairobi, Kenya where the child mortality rates in the slums are even higher than in the rural areas.[26] In Uganda certain regions have higher mortality rates, it was reported that the under 5 mortality rates in Northern Uganda in 2009 was 177 and its infant mortality rate 106 deaths

---

15 UNICEF (n 7 above).

16 http://allafrica.com/stories/201004260894.html (accessed 14 August 2011).

17 As above.

18 (n 16 above)

19 APRM Country Review Report No 7 January 2009 Para 992.

20 UNICEF Progress for children Achieving the MDGs with equity. Number 9 September 2010 24.

21 As above.

22 Uganda MDG report 2010 21.

23 N 17 p 20.

24 http://www.unicef.org/infobycountry/uganda_statistics.html accessed 22 August 2011.

25 Where and why are 10 million children dying every year R E Black, S S Morris, J Bryce. Lancet 2003 vol 361 2227

26 African Population and Health Research Center (APHRC). 2002. *Population and Health Dynamics in Nairobi's Informal Settlements.* Nairobi

in 1000 births, this is much higher than the collective nationwide statistics.[27] According to UNICEF there is 'an acute child survival crisis' in the sub region of Karamoja.[28]

Addressing child mortality in Uganda from a human rights perspective will involve considering the above statistics against the government's international obligations under the International Covenant on Socio Economic Rights (ICESR), the Convention on the Rights of the Child (CRC) the African Charter on Human and Peoples Rights (ACHPR) the United Nations Millennium Declaration and other relevant statutes which aim at protecting children's right to life and health.

Statement of the problem

Uganda's international commitment[29] to dedicate 15 percent of its budget to the health sector has failed[30] and it is making very slow progress in reducing child mortality.[31] According to its National Development Plan, Uganda's health standards are poor even in comparison with sub Saharan African standards.[32] The health sector continues to face challenges of inadequate staff, in 2002, the ratio of doctors to patients was 1: 24,752, and for nurses 1: 1,634, this has a detrimental effect on the health service delivery.[33] Thus despite the fact that more health facilities have been built by the government, health service delivery is still poor.[34]

According to Uganda's 2010 Health Profile there are variations in infant and under 5 mortality in rural and urban areas. The under 5 mortality rate in rural areas is 147 deaths per 1000 births compared to 115 in the urban areas, also for infant mortality rates it is '172 [deaths] among the poorest 20% and 108 among the wealthiest 20%.[35]

In addition there is clear inequity in the availability of health care services in the country as people in the rural areas have less access to health care facilities, nurses and doctors than those in the urban areas. It has been stated that about '70% of Ugandan doctors and 40 % of nurses and midwives are based in urban areas serving only 12% of the Ugandan population'.[36] According to AMREF Uganda '13% of people do not seek medical attention because they can't afford it or reach clinics.' These facts paint a bleak picture for child survival in rural areas.

---

[27] http://www.unicef.org/har09/files/har09_Uganda_countrychapter.pdf accessed 22 August 2011.
[28] As above.
[29] Abuja Declaration on HIV/AIDS, TB and Other Related Infectious Diseases 2001.
[30] Budgeting for children in Africa. Rhetoric, reality and the scorecard 2011, 11.
[31] Millenium Development Goals report for Uganda 2010, iii.
[32] National Development Plan (2010/11 - 2014/15) Para 61
[33] Para 99
[34] Para 600
[35] http://globalhealth.mit.edu/home/uganda-health/ (accessed 27 August 2011).
[36] http://www.guardian.co.uk/katine/2009/apr/01/healthcare-in-uganda (accessed 27 August 2011).

The issue of child mortality has regained international focus with the UN Millennium Development Goals Programme. However most research carried out on this subject have analysed it from the medical and sociological perspective and mostly exists in policies. This study will analyse child mortality from a human rights lens as it relates to Uganda's international obligation to guarantee the right to health and life. It will also examine how the progress towards other MDGs affects the attainment of MDG 4 reducing child mortality..

Scope of the study

This study will be multi disciplinary in nature as most studies have not looked at the issue from the combined perspectives of medicine, sociology and human rights. This is necessary to provide holistic view and understanding of child mortality in Uganda. This study will cover certain districts in Uganda.

Objectives of the study

This study will examine the factors that influence child mortality and challenges faced in sustaining child survival in Uganda.

It will analyse the existing health services, laws and policies targeted at addressing child mortality

Research questions

What challenges exist in achieving the 2015 MDG target of reducing child mortality in Uganda and how do these challenges affect the attainment of MDG 4?

To what extent does the distribution of health services affect child survival?

Does the failure to achieve other MDGs affect the attainment of MDG 4?

How effective are national policies on health addressing the issue of child mortality?

Literature review

Academic works analysing child mortality from a human rights perspective are few and far between and mostly outdated since the currency of the issue is paramount, they may be misleading. Most research on child mortality in Uganda have analysed it from perspectives of economics, demography and geography. Kabagenyi[37] examines the effect of household characteristics such as the household size, household structure, the mother's education, the age of the mother, the number of children she has given birth to

[37]Kabagenyi Allen Household characteristics and child mortality in Uganda 2006 (unpublished masters thesis)

and environmental factors such as access to clean water and sanitary facilities and their effect on child mortality differentials.

Other studies have analysed factors contributing to child mortality in specific regions in Uganda such as Northern Uganda which for a period of time was affected by armed conflict.[38] Studies have also focused on infant and child morbidity rates in specific hospitals. Some researchers[39] have considered the prevalence of diseases among children under 5 years at the Mulago hospital against their social backgrounds in order to proffer suggestions for the reduction of such illnesses. Nassali[40] focused on the effect of malaria on the increasing rates of child mortality at the Naguru health centre.

In addition, child mortality has been analysed by many NGOS and international organisations including the United Nations which has as its target the reduction of child mortality as its Millennium Development Goal 4. In its Millennium Development Goals Report[41], the UN analysed the issue of child mortality from the medical and sociological perspectives basically stating the causes of child mortality and the need to redirect efforts towards combating diseases like pneumonia, diarrhoea, malaria and AIDS.[42] It has stressed the need to ensure proper nutrition in order to reduce the susceptibility to these life threatening diseases.[43] It examines the progress on the reduction of child mortality and has highlighted the regions which are lagging behind which includes sub – Saharan Africa.[44] Other reports [45] have analysed the issue from an international angle based on statistical data and have pointed out countries with high child mortality rates including Uganda. In addition, nongovernmental organisations such as Save the Children [46] have stressed the importance of equity in the reduction of child mortality strategies. The African Report on Child Wellbeing 2011[47] focuses on the importance of public investment in children's welfare and examines African governments' performance in achieving the regional and international health financing targets.

Although most studies carried out are multi disciplinary in nature there is little or no emphasis placed on the government's obligation to protect the right to life and the right to health, the need to ensure access, affordability and availability of health services. This thesis intends to shift the spotlight from statistics to

---

[38] Hadoto Phiona Irene An assessment of the the factors contributing to child mortality in Northern Uganda(1997-2002) 2009 (unpublished masters thesis).

[39] Amuge Nancy Infant and child morbidity in Mulago hospital 1997 (unpublished undergraduate thesis)

[40] Nassali Hajarah Bisegerwa The effect of malaria on child mortality rates. A case study of Naguru health centre in Nakawa division 2001-2006. 2007 (unpublished undergraduate thesis)

[41] 2010.

[42] (n 4 above) 27.

[43] As above.

[44] As above.

[45] . United Nations Inter-agency Group for Child Mortality Estimation. 'Levels & trends in child mortality report 2010'.

[46] 'A fair chance at life. Why equity matters for child mortality.' A Save the Children Report for the 2010 summit on the Millenium Development Goals. 2010.

[47] The African Child Policy Forum.

the underlying human rights dimension of this important issue and also discover if the existing national policies are equitable, an area which has not received much attention.

Research methodology

The research methodology will comprise of library based research and will depend to a great extent on internet based resources as research on child mortality is an issue which requires the most recent facts. It will also involve interviews with community members, nongovernmental organisations and government officials on children's right to health. These interviews will be mainly in depth interviews and focus group discussions. They are necessary to obtain a clearer picture on implementation or lack thereof of the state's legal obligations under children's right to health.

Limitations of the study

In writing a dissertation on child mortality, the challenges the researcher may encounter will relate to the fact that this topic is multi disciplinary in nature. It will be based on medical and sociological research within a human rights context of enforcement, protection, promotion and monitoring of Uganda's obligations under children's right to health and life and other related human rights. As a result most of the information found would only be partly legal and mostly sociological.

This study also has time limitations and its focus areas will be restricted to certain districts in Uganda.

Overview of chapters

This thesis will consist of five chapters. Chapter one will basically set out the objectives, the research question, and methodology of research. Chapter two will discuss the issue of child mortality, the causes, the multi faceted nature of the issue of child mortality in relation to existing national programmes and the UN Millennium Development Goals. Chapter three will examine the national and international legal and policy framework under which the relevant human rights related to the issue will be examined. Chapter four will discuss challenges and prospects of reducing child mortality and will close with conclusions and recommendations.

Chapter Two

The Reality of Child Mortality in Uganda

2.1 Introduction

This chapter will give an overview of the issue of child mortality in Uganda by looking at its major causes. It will also examine the link between child mortality and other MDGS that is the interdependence of child survival on factors such as access to safe water and sanitary facilities, girl child education amongst others.

2.2 Causes of child mortality in Uganda

Prior to examining the causes of child mortality in Uganda, definitions of infant mortality rate, under 5 mortality rate and neonatal mortality must be considered. According to the World Health Organisation (WHO), neonatal mortality or deaths may be defined as the 'number of deaths during the first 28 completed days of life per 1,000 live births in a given year or period.'[48] This includes deaths which happen in the first week of life known as 'early neonatal deaths' and deaths which occur subsequently but prior to the 28th day after birth, categorised as 'late neonatal deaths'.[49] Under 5 mortality has been described as the 'probability of a child born in a specific year or period dying before reaching the age of five, if subject to age-specific mortality rates of that period'.[50] Infant mortality rate on the other hand is the 'probability of dying between birth and exactly one year of age expressed per 1,000 live births.'[51] Child mortality in this thesis includes infant mortality rates, neonatal mortality and under 5 mortality rates.

According to WHO the under 5 mortality rate for Uganda in 2008 was 135 deaths per 1000 live births falling from 158 in 2000 and 186 in 1990.[52] Uganda's 2008 neonatal mortality rate was 31 deaths, while its infant mortality rates for both sexes in 2000 was 98, this fell to 84 in 2008.[53] Some progress has been made in reducing child mortality rates as UNICEF currently reports that Uganda's under five mortality rates is 128, its infant mortality rate 79 and neonatal mortality rate is 30.[54] However this progress is slow and intensive efforts must be made by Uganda to halve its present under 5 mortality rates if it is to achieve its MDG target of 61 deaths in 1000 births by 2015. Uganda's current levels of progress have been deemed insufficient as its average annual rate of reduction from 2000- 2008 was 2.0 %.[55]

As regards the causes of child mortality, WHO notes that its statistics may not be wholly accurate as monitoring mechanisms are weak in developing countries,[56] this also applies to Uganda. However it provides a detailed breakdown of the causes of mortality in children under 5 years in Uganda as follows ; HIV/AIDS- 5 percent, Diarrhoea-16 percent, Measles- 2 percent, Malaria- 22 percent, Pneumonia 14 percent, prematurity- 7 percent, Birth asphyxia- 7 percent, Neonatal sepsis- 5 percent, Congenital abnormalities -2 percent, other causes -16 percent and injuries 4 percent.[57]

A comparison of the major causes of child mortality in Uganda, malaria, diarrhoea and pneumonia reveals similarities in global[58] and regional causes of child mortality. It has been noted that the highest

---

48 http://www.who.int/healthinfo/statistics/indneonatalmortality/en/ (accessed 20 September 2011).
49 As above
50 http://www.who.int/healthinfo/statistics/indunder5mortality/en/
51 http://www.unicef.org/infobycountry/stats_popup1.html (accessed 20 September 2011).
52 WHO Health Statistics 2010 p 55.
53 As above.
54 UNICEF Country profile Uganda. Maternal, newborn and child survival January 2011
55 World Health Organisation and UNICEF Countdown to 2015 decade report (2000-2010):taking stock of maternal, newborn and child survival.p 9.
56 (n 5 above) p 59.
57 (n 5 above) p69.
58 (n 8 above) p 11

percentages of child deaths due to malaria are in Africa.[59] Also in 2008, malaria, diarrhoea and pneumonia constituted 52 percent of under 5 mortality in the African region.[60]

The levels of child mortality due to malaria, pneumonia and diarrhoea in Uganda can be directly linked to insufficient coverage of available health interventions. According to WHO, from 2000-2008, only 9 percent of children under 5 yrs slept under insecticide treated nets and 61 percent of children in the same period received treatment with anti malarial drugs.[61] According to the Demographic Health Statistics 2006, the total level of antibiotic use for pneumonia was 47 percent and the total percentage of children receiving 'diarrhoeal treatment – ORT and continued feeding' was 39 percent.[62] To improve child survival rates in Uganda, health interventions targeting these major diseases as well as other diseases must be increased and made affordable and accessible.

An indirect cause of child mortality is under nutrition, it increases 'the morbidity burden among children' although its impact is not uniform in all illnesses.[63] It has been shown that children who are undernourished are more prone to infectious diseases like pneumonia, diarrhoea and malaria.[64] Furthermore due to the connection between illness and malnutrition, children who are undernourished are at higher risk of dying from infectious diseases.[65] In Uganda, the rates of malnutrition are high, '38 percent suffer from chronic malnutrition (stunting), 16 percent are underweight and 6 percent suffer from acute malnutrition.[66] According to the Uganda Child Survival Strategy (check for it) malnutrition forms the proximate and ancillary cause of about 60 percent of child mortality in Uganda.[67] It is evident that in order to improve child survival and attain MDG 4 the rates of malnutrition must be substantially lowered.[68]

More bleak statistics on malnutrition are revealed by USAID which has shown that '[m]alnutrition starts before birth for children in Uganda'.[69] Estimates show that 11 percent of children are stunted at birth and 16 percent of children have low body weights for their heights at birth.[70] It must be noted here that the rates of stunting vary across the different regions in the country with the highest numbers in Karamoja

---

[59] http://www.globalhealth.org/images/pdf/gho/2009_ch_understanding.pdf (accessed 21 September 2011)
[60] Assessing Progress in Africa toward the Millenium Development Goals 2010 p 30
[61] (n 5 above) P 95
[62] n 7 above.
[63] Laura E Caulfield, Mercedes de Onis, Monika Blossner and Robert E Black Undernutrition as an underlying cause of child deaths associated with diarrhoea,pneumonia,malaria and measles American Journal of Clinical Nutrition 2004 vol 80 (193-8) P 197
[64] As above.
[65] Caulfield et al (n 16 above).
[66] USAID The analysis of the nutrition situation in Uganda p 1.
[67] Uganda MOH. 2009. *Ministry of Health Child Survival Strategy for Uganda – 2008-2015.* Draft. Kampala, Uganda: Uganda MOH. Cross check
[68] USAID (n 19 above) p 2.
[69] USAID(n 19 above) p 8
[70] As above

and then in the Southwest and North regions.[71] The East Central and North regions had the highest prevalence of underweight children while Karamoja, East Central, the South West and West Nile regions had the most predominance of wasting in children under 5 years.[72] It is pertinent to also note that the rates of malnutrition in Uganda are indicators of other problems such as 'inadequate access to food, suboptimal infant feeding practices and poor health, sanitation and hygiene practices by many within the country…'[73]

It is clear from the causes of child mortality in Uganda that other factors must be considered to fully understand child mortality in Uganda. The causes of child mortality are clearly symptomatic of bigger problems relating to inadequate access to health care, unhealthy environments, unsafe water, poverty and inadequate access to food amongst other problems.

2.3 The link between child mortality and other MDGS

To improve child survival in Uganda it is not enough that strategies solely consider child mortality from the perspective of accessibility, affordability and availability of health care services. There is a need to also address the issue of child mortality from a broader angle by analysing the root causes of the problem. Progress in the other MDGS such as the elimination of poverty and gender inequality, the improvement of universal basic education and maternal mortality all contribute in different ways to reducing child mortality, this shall be explored further.

2.3.1 The link between child mortality and the reduction of poverty and hunger

The importance of the eradication of extreme poverty and hunger, MDG 1, in the improvement of child survival is critical since poverty deprives one of the basic necessities of life such as food, water and health care. Also '[p]oor children are more likely to die as infants, and are sick more often and more seriously than better–off children.'[74] Uganda is on track to reduce its population living below poverty levels and may thus meet MDG 1, however there are regional variations in poverty reductions especially in sub regions like Karamoja where the poverty reduction rates are less than national figures.[75]

Uganda also produces adequate food for its needs, nevertheless its nationwide food supply is unequal and dependent on factors such as poverty, climate etc.[76] It must be noted that despite

---

[71] USAID(n 19 above) p 9

[72] As above.

[73] USAID(n19 above).

[74] Bruce Gordon, Richard Mackay and Eva Rehfeuss WHO 2004 Inheriting the World: The Atlas of Children's Health and the Environment p 10

[75] (n 28 above)p 14.

[76] USAID(n 19 above) p 1.

improvement in the national indicators on the number of people suffering from hunger,[77] there are still high levels of malnutrition among children under 5 years of age and the reduction in the percentage of underweight children under 5 years has been little, 'between 1995 and 2006, from 27 to 20 percent.'[78] According to USAID, Uganda will not substantially reduce hunger and malnutrition by 2015 and its gains in poverty reduction have no direct effect on eliminating malnutrition.[79]

As previously mentioned, malnutrition has a huge detrimental effect on child survival in Uganda and it must be tackled for significant reductions in child mortality rates to be seen. In order to drastically reduce malnutrition, the government of Uganda must deal with its fundamental causes which are 'inadequate water and sanitation safety and access, inadequate health infrastructure and access to health care, and food insecurity.'[80]

2.3.2 Child mortality and maternal education

The importance of maternal education has been stressed by the UN as crucial to a child's survival in the first five years of its life.[81] From 2000- 2008, it was found that in sub- Saharan Africa the ratio of under five mortality rate of children of mothers who were uneducated was 2.0 compared to children of mothers with primary education at 1.2.[82] Also '[a] child's chances of surviving increase even further if their mother has a secondary or higher education'.[83] This is also true of Uganda as it has been found that children of mothers who are older and more educated have increased survival probabilities.[84] In a study carried out it was shown that the infant mortality rates for children whose mothers had received primary education was '20 per 1,000 lower than those whose mother did not attend school.'[85] While the rates for children whose mothers were better educated with secondary school or more were '34 per 1,000 lower.'[86]

Uganda has made good progress in increasing enrolment in primary education 'from about 2.7 million in 1996 to 8.2 million in 2009'[87] in its bid to achieve universal primary education (MDG 2). Nevertheless, the number of children who complete primary school is low and this must be tackled.[88] It has been found that in Uganda a large number of girls failed to complete primary school and also that from 1997 to 2006,

---

77 Uganda MDG report (n 28 above)p 16.
78 USAID(n 19 above).1
79 As above.
80 USAID (n 19 above) iv
81 United Nations New York The Millennium Development Goals Report 2011. p 26
82 As above.
83 United Nations (n 39 above).
84 Sarah Ssewanyana Stephen D Younger Infant Mortality in Uganda: determinants, trends and the Millennium Development Goals Journal of African Economies Volume 17, Number 1 2007 p 40
85 (n 42 above) 46
86 As above.
87 Uganda MDG Report 2011 p 17
88 n 45 above.

just 11 percent of the girls who completed primary school enrolled for secondary school.[89] The importance of primary school completion for girls cannot be overemphasised as the effect of some primary schooling on the improved rates of child survival is tiny.[90] The estimates have been put at one death per 1,000 for children whose mothers did not complete primary school.

Generally, there is evidence that 'educated women tend to marry later and to have their first births later.'[91] The level of mortal risk is also cut down for women who have children after 18 years and their children. In addition, there is a trend for women who are uneducated to start childbearing earlier and these children are more vulnerable to 'excess mortality risks' related to early childbearing and also late childbearing.[92]

On the whole, education of parents particularly mothers improve the chances of child survival in aspects such as improved child nutrition, improved use of existing health facilities and immunisation and vaccination.[93]

2.3.1 Child mortality and gender equality

The promotion of gender equality and the empowerment of women is MDG 3,[94] its importance is vital to the development of any country and to child survival as well. Uganda is a state party to treaties which promote gender equality such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Beijing Platform of Action and also has national policies such as the Uganda Gender Policy to ensure equal participation of women in the different aspects of development.[95] While progress has been made in increasing the number of girls obtaining primary, secondary and tertiary education and a marked increase in the number of women participating in the political sphere of society especially the legislative arm of government has been noticed.[96] Women still face challenges in accessing credit facilities in the agricultural sector and this is where their services are predominantly engaged. [97] In addition, there is disproportionate access to land and this is a key factor which increases women's poverty and diminishes their power to make decisions which affect their lives and those of their children. [98]

---

[89] Nestar Lakot Okella unpublished Masters thesis in public policy and human development January 2009 The determinants of persistent child mortality trend in Uganda. p 26

[90] Ssewanya and Younger (n 42 above) p 53

[91] John Hobcraft Women's education,child welfare and child survival: a review of the evidence. Health Transition Review Vol 3 No 2 1993. p161

[92] Hobcraft (n 48 above) p 162.

[93] UNESCO ED-2011/WS/2 The central role of education in the Millennium Development Goals p 13

[94] What are MDGS check for website add

[95] Uganda MDG report 2010 p 19.

[96] As above.

[97] Ministry of Finance, Planning and Economic Development Gender inequality in Uganda: the status, causes and effects.Discussion Paper 11 August 2006. p 16. The 2010 MDG report states that women form approximately 70 percent of the workforce in the agricultural sector. (p 19).

[98] n 30 above p 19.

Gender inequality has been linked to the increasing high fertility rates especially among women in polygamous families in Uganda, who due to the importance placed by society on male children, are in constant competition to produce male heirs.[99] Also, evidence has shown that as a result of gender inequality in relation to education, women who have no education or little education have higher fertility rates than women who are more educated[100] The fertility rates of women are important as it is evidenced that '[h]igh fertility rates coupled with poverty, illiteracy and low status of women are key obstacles to safe motherhood' and child survival.[101] Due to a lack of decision making powers and income, women delay seeking for care and this endangers their lives and the lives of their children. Findings of a study revealed that '86.1 percent of maternal deaths in 74 facilities occurred within an hour of arrival'.[102] And the loss of a mother has been linked to reduced chances of child survival.[103]

Furthermore, the link between child mortality and gender equality is evident as it has been shown that where a woman is educated this improves her knowledge of health issues and makes her more equipped to take care of her children's health.[104] Also where a woman is financially independent or has a viable source of income, she can make better decisions regarding her children's nutrition and health.[105]

2.3.6 The link between maternal health and child mortality

The effect of maternal health on child survival is of great importance. According to UNICEF, ' at least 20% of the burden of disease in children below the age of 5 is related to poor maternal health and nutrition as well as the quality of care received at delivery and during the newborn period.'[106] In addition, the increased deaths in new born children have been connected to maternal health and survival.[107] Furthermore it has been discovered that 'when a mother dies, surviving children are 3- 10 times more likely to die within two years than children who live with both parents, and motherless children are likely to receive less health care and education as they grow up.'[108]

Uganda unfortunately has a high maternal mortality ratio of 435 deaths per 100,000 births and is making very slow progress to its goal of 131 deaths by 2015.[109] Based on the above facts, Uganda's maternal mortality ratio hinders the reduction in child mortality rates. An improvement in maternal survival will be

---

[99] n 30 above p 24.

[100] N 30 above p 30. The total fertility rate for women who were educated beyond primary school in Uganda was 3.9 in 2000 as compared to the total fertility rate of women who had no education which was 7.8 and women who had primary education 7.3.

[101] n 30 p 31.

[102] As above.

[103] As above.

[104] Dina Abu- Ghaida Stephan Klasen The costs of missing the MDG on gender equity 2002 p 7

[105] As above.

[106] http://www.unicef.org/mdg/maternal.html (accessed 8 October 2011).

[107] WHO and UNICEF 2010 Countdown to 2015 Decade Report(2000-2010)with country profiles. Taking stock of maternal, newborn & child survival

[108] (Moving towards universal coverage- series Issues in maternal-newborn health and poverty- sub series).2 The costs of maternal newborn illness and mortality. M Kamrul Islam Ulf G Gerdtham WHO 2006 p 14.

[109] Uganda MDG Report p 22.

noted if there are corresponding improvements in health facilities and health care such as antenatal care coverage, increased number of skilled staff at deliveries and family planning.[110] Advances must be made in maternal health in order to positively affect child survival in Uganda.

2.3.5 The effect of interventions against HIV/AIDS, malaria on child survival

The devastating impact of diseases like HIV/AIDS and malaria on the world has been widely researched and the need for more sustained effort is captured in MDG 6 which enjoins all state signatories to 'combat HIV/AIDS, malaria and other diseases', drastically reduce and reverse the spread of HIV/AIDS and malaria and embark on preventive and survival measures.[111] As regards efforts to provide access to treatment, the importance of increasing treatment for HIV- positive mothers in order to ensure the well being of their new born children has been highlighted.[112]

A study carried out in rural Uganda has shown that the mortality rate of HIV negative children born to HIV positive mothers was greater than children born to HIV negative mothers which implies that HIV negative children are at an increased risk from maternal HIV infection.[113] In addition, 'more than 50 % of children infected with HIV died by 24 months of age and maternal and infant HIV-1 viral loads were predictors of death.'[114] HIV/AIDS was identified as the cause of 5 percent of the under 5 deaths in 2008.[115] It is evident that progress made in attaining MDG 6 would also have a beneficial effect on child survival in Uganda. According to recent statistics, earlier progress made by Uganda in reducing the spread of HIV/AIDS is dwindling as estimates show that 'more than 130,000 people have been infected with HIV so far in 2010.'[116] On a positive note, gains are being made in improving access to Anti- Retroviral Therapy (ART) to people in need.[117] It is necessary for the government of Uganda to step up measures to reduce the spread of HIV/AIDS in order to improve adult and child survival.

In order to attain MDG 6, efforts must also be made by the government to combat malaria and other diseases; we will focus on malaria because of its deleterious effects on child survival. UNICEF states that malaria is responsible for the deaths of over 1 million people yearly and children under the age of 5 years are particularly affected with daily mortality rates of about 3,000.[118] Malaria also causes maternal mortality

---

110 Uganda MDG Report p 23.

111 http://www.un.org/millenniumgoals/aids.shtml#mdgs (accessed 7 October 2011).

112 As above.

113 Heena Brahmbhatt, PhD,* Godfrey Kigozi, MD,† Fred Wabwire-Mangen, PhD,‡ David Serwadda, MD,§ Tom Lutalo, MSc,† Fred Nalugoda,† Nelson Sewankambo, MD,|| Mohamed Kiduggavu, MD,† Maria Wawer, MD,¶ and Ronald Gray, MD* Mortality in HIV-infected and uninfected children of HIV-infected and uninfected mothers in rural Uganda. Journal of Acquired Immune Deficiency Syndrome April 1 2006; Volume 41 no 4 (504-508) p 507

114 Brahmbhatt et al(as above).

115 UNICEF Country Profile Uganda 2011 2

116 Uganda MDG report. 25

117 As above.

118 UNICEF Malaria A major cause of child death and poverty in Africa. P1. See also Jeffrey Sach and Pia Malaney The economic and social burden of malaria Nature vol 415 February 2002 p 682.

and low birth weight in infants in sub Saharan Africa.[119] According to the World Malaria Report 2008, Uganda has the third highest malaria load in Africa and the sixth highest in the world.'[120] Estimates show that malaria kills about 70,000 to 100,000 people yearly in Uganda and the most affected group are children under the age of five.[121] Uganda's National Malaria Control Programme for 2005-2010, which is at its end but will be substituted with a new plan, has increased coverage of long lasting insecticidal nets and the use of insecticide treated nets is on the rise.[122] The percentage of

children under five sleeping under an Insecticide Treated Net has increased from 8% in 2000 to 33% in 2009 and access to ITP2 treatment has doubled from 16% to 31% over the three year period from 2006- 2009.[123]

Nevertheless, more progress needs to be made in the execution of preventive interventions and access to anti malarial drugs increased to ensure that children and who require treatment receive it. Statistics show that 'less than 30% of children who needed treatment in 2005/2006 received treatment with appropriate anti malarial drugs.[124] It has been found that the use of insecticide treated nets can halve the transmission of malaria and cut down child mortality by 20 percent.[125] It thus follows that if Uganda accelerates the provision of insecticide treated nets, increases nationwide access to anti malarial treatment and its affordability it would increase Uganda's progress towards achieving the reduction of child mortality.

2.3.3 Child mortality and access to water and sanitation

The spread of diseases like diarrhoea which is still a main cause of mortality of children under 5 years reduced globally in 2008 due to interventions such as oral rehydration salts (ORS) treatment and enhanced access to safe water and sanitation.[126] However, there is evidence to prove that 'diarrhoea is now the biggest killer of children in Africa'[127] and still remains one of the main causes of under 5 mortality in Uganda.[128] According to Water Aid 'safe sanitation and water could prevent nine out of ten cases of diarrhoea' and use of a sanitary toilet can cut down the prevalence of the disease by up to 40 percent.[129] It is thus necessary to examine WHO statistics on elements of MDG 7- ensuring environmental sustainability which deals with increasing access to safe water and sanitation in Uganda. In

---

[119] As above.
[120] WHO Geneva 2008
[121] DFID Malaria Country Profiles version 1.1 31 August 2011 p 99
[122] DFID (n 81 above) p 102.
[123] Uganda MDG report p 28
[124] Uganda MDG report p 28
[125] UNICEF (n 78 above) p 5.
[126] Christa L. Fischer Walker, Ingrid K Friberg, Nancy Binkin, Mark Younf, Neff Walker, Oliver Fontaine, Eva Weissman, Akansa Gupta and Robert E Black Scaling up Diarrhea prevention and treatment interventions: A Lives Saved Tool Analysis PLos Medicine March 2011 Volume 8 Issue 3Citation: Fischer Walker CL, Friberg IK, Binkin N, Young M, Walker N, et al. (2011) Scaling Up Diarrhea Prevention and Treatment Interventions: A Lives Saved Tool Analysis. PLoS Med 8(3): e1000428. doi:10.1371/journal.pmed.1000428
[127] Black R et al. (2010) "Global, regional, and national causes of child mortality in 2008: a systematic analysis", Lancet 2010; 375: 1969–87.
[128] WHO (n 5 above) p 69.
[129] Water Aid look for citation.

2008, the percentage of urban population using improved drinking water sources was 91 percent whereas the rural population was 64 percent and the combined percentage of population using safer water was 67 percent.[130] On the other hand the population rates for the use of improved sanitation is lower on the whole is 38 percent with the rural population enjoying better sanitation at 49 percent than the urban population at 38 percent,[131] this may be due to the existence of slum dwellings in the urban areas. It must be noted that due to the drawn out conflict in northern Uganda access to water and sanitary facilities are well below the national rates.[132] In Karamoja 'only 30 percent of Karamajong have access to safe water' and just 2 percent access to improved sanitation,[133] these are dismal statistics.

In summary, the effect of improvement in access to safe water and sanitation on the reduction of children's vulnerability to diarrhoea and their increased survival is substantial.[134] Improved sanitation has been shown to have a diminishing effect on other causes of child mortality such as pneumonia and under nutrition.[135] Also, the spread of malaria can be drastically reduced by clearing small pools of standing water which form breeding sites for mosquitoes and other sanitary measures.[136] Furthermore, research has shown that there are even more public health gains to be made from improved sanitation than improved access to water.[137] However, what is apparent is that in order to improve child survival rates in Uganda substantial progress must be made in enhancing nationwide sanitation and the provision of safe water.

3 Conclusion

The reduction of current child mortality rates in Uganda rely on progress in other MDGs which are linked to children's health because they embody underlying elements of the right to health. Considering Uganda's slow progress in most of the MDGs, it will not be pessimistic to state that with a little above 4 years to the 2015 target, child mortality rates may reduce but in order to reduce substantially, progress on other MDGS alongside MDG 4 must be rapidly increased and sustained.

---

130 WHO (n 5 above) p108.

131 As above.

132 UNICEF Humanitarian Action Report 2009 Uganda.

133 As above.

134 The World Bank Development Economics Prospect Group April 2010 Policy Research Working Paper 5275 Isabel. Gunther Gunther FinkWater, sanitation and children's health. Evidence from 172 DHS Surveys p 30.

135 Water Aid look for citation.

136 Bruce Gordon, Richard Mackay and Eva Rehfeuss WHO 2004 Inheriting the World: The Atlas of Children's Health and the Environment 20.

137 (n 60 above).

Chapter Three

The legal framework for children's rights to life and health with specific focus on child mortality

3.1 Introduction

As has been discussed in the previous chapter, child mortality is a global issue of large numbers of children dying due to preventable diseases and lack of access to health services especially in sub Saharan

Africa. Considering child mortality from a human rights lens, involves a range of human rights, chief among which are the right to life and the right to health.

This chapter will discuss the legal framework within which the issue of child mortality is addressed, in other words what human rights and legal obligations arise from the problem of child mortality. It will look at the existing rights to life and the right to the highest attainable standard of health at the international, regional and national levels. It will also examine the policies created to address the problem of child mortality.

3.2 The rights to life and health under international human rights law (IHRL)

First and foremost, it is pertinent to discuss the right to life under IHRL as it relates to child mortality because although human rights are indivisible and inalienable, a person must have life before (s)he can enjoy other rights. That stated it is also important to note that the hampering or impeding of the realisation of other rights such as the right to the highest attainable standard of health affects the quality of life a person leads and may in extreme cases violate the right to life. Child mortality is one of such extreme cases were as a result of the non fulfilment of the right to health, the right to life is violated.

The International Covenant of Civil and Political Rights 1966 (ICCPR)[138] provides for the inalienable right to life existent in every person which cannot be divested and which must be protected by law.[139] The Committee on Civil and Political Rights has explained that 'inherent right to life' must not be interpreted or understood in a 'restrictive manner 'therefore states are obliged to take positive steps to guarantee this right.[140] In expanding the meaning of the right to life, the Committee also states although in less stronger terms

> ...that it would be desirable for States parties to take all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics.[141]

The word 'desirable' implies that this is a preferred position that the State parties should adopt however it seems to lack a mandatory or obligatory force which accompanies the wording of the right to life itself. The Committee on Civil and Political Rights perhaps was of the view that a mandatory wording as regards the reduction of child mortality and an increase in survival rates would be too great a burden for the state to bear.

The fulfilment of the right to highest attainable standard of health is vital in the reduction of child mortality rates around the world. A general scope of the right to health has been provided for in various

---

[138] Uganda acceded to the ICCPR on 21 June 1995.
http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-4&chapter=4&lang=en

[139] Art 6. The right to life is provided for alongside liberty and security of person in Art 3 of the Universal Declaration of Human Rights(1)

[140] Para 5 Gen Comment 6

[141] As above.

international instruments.[142] However the following statutes also include the reduction of child mortality as an element of the right to health. The International Covenant on Economic, Social and Cultural Rights 1966(ICESCR)[143] is regarded as 'the central instrument of protection for the right to health'.[144] Art 12 of the ICESCR provides for the right to health and also highlights key aspects of the right to health as follows

1. The State Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) the provision for the reduction of stillbirth rate and of infant mortality and for the healthy development of the child; …

The state's duty to ensure the realisation of the right to health through its policies to reduce infant mortality and promote child survival is restated by the Committee on Economic, Social and Cultural Rights where it provides that such policies should include 'child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.'[145]

The Convention on the Rights of the Child 1989(CRC)[146] is also instrumental in relation to child mortality, it provides for children's 'inherent right to life' and also the states obligation to guarantee 'to the maximum extent possible the survival and development of the child'.[147] Art 24 provides for children's right to 'the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health' and the state's duties to fulfil this right by providing 'access to health care services'.[148] It must be noted that while Art. 24 may be classified as an economic and social right and as such its implementation is subject to available resources, this is unsuitable for children's rights and thus the CRC does not distinguish between the genre of rights.[149] While economic and social rights are not justiciable in most countries including Uganda, state parties are however 'obliged in good faith to implement the treaties they have ratified, and they can be held morally and politically responsible, even if

---

[142] See Art 5(e) (iv) of the 1965 International Convention on the Elimination of All Forms of Racial Discrimination, the 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families: Art 28, 43(e) and 45 (c) the 2006 Convention on the Rights of Persons with Disabilities : Art 25.
[143] Uganda acceded to the ICESCR on 21 January 1987. See http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en
[144] The Right to Health Fact sheet No.31 9
[145] General Comment No. 14(2000) The right to the highest attainable standard of health para 14
[146] Uganda ratified the CRC on 17 August 1990.
[147] Art 6(1)
[148] Art 24(1)
[149] Asbjorn Eide and Wenche Barth Eide Martinus Nijhoff Publishers 2006 A commentary on the United Nations Convention on the Rights of the Child. Article 24 The Right to Health p 4 para 4

legal sanctions are not always available.'[150] The CRC imposes obligations on the state as regards the measures which must be taken to ensure the realisation of this right which include; reducing infant and child mortality;[151] 'provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care.[152] Art 24 also outlines state's obligations in relation to the fight against malnutrition and disease, the need for a balanced diet and safe drinking water to be afforded to children.[153] It recognises the importance of the provision of proper maternal health care[154] as relevant to children's right to health. The CRC thus recognises that the right of the child to the highest attainable standard of health is interdependent on the fulfilment of other human rights, both civil and political and economic and social like the right to life, the right to food, education, work and other rights.[155] Art. 24 also imposes duties on the state to provide relevant health information and support families in 'the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents'[156]. The state also has duties to ensure that it puts in place precautionary health care services for families.[157]

Furthermore, the state has a duty to prevent interference with children's right to health by eradicating harmful cultural practices which are detrimental to children's health.[158] The CRC also recognises the importance of international partnership in ensuring the achievement of the right to health especially for developing countries.[159]

The Committee on Economic, Social and Cultural rights, emphasizes state duties to lower infant and child mortality rates and also states the need to apply the principle of non discrimination in the provision of health care services and 'equal access to adequate nutrition [and] safe environments'.[160] The importance of equity in health services has been stressed as vital in improving child survival as more child deaths occur amongst poor children who are more vulnerable to disease due to various conditions ranging from unsanitary living environments to malnutrition.[161] The application of principles of equity, non discrimination and dignity are vital to the realisation of the right to health.[162]

Under the international legal framework for the protection of children's rights, the work of the Committee of the Rights of the Child must be mentioned as it is responsible for monitoring the

---

[150] Asjborn(as above)para 9
[151] Art 24(2) (a)
[152] Art 24(2) (b)
[153] Art 24(2) (c)
[154] Art 24(2) (d)
[155] Asjborn(n 12 above).
[156] Art 24(2) (e)
[157] Art 24(2) (f)
[158] Art 24(3)
[159] Art 24(4)
[160] Gen Comment 14 para 22.
[161] Global Health Council_ Health Equity for the world's children would save millions of lives
[162] n 13 above.

fulfilment of states obligations under the CRC and its optional protocols.[163] State parties like Uganda are obligated to submit reports to the Committee on the progress made in the realisation of the rights, they must submit an initial report two years after accession and then after five years.[164] Uganda has submitted two state party reports[165] which discuss the measures it has taken on the issue of child survival, development and health care. On the whole, the supervisory systems under the CRC have been criticised as being weak and the state reports have lacked the required depth, detail and definite and sustainable programmes of action.[166]

A key instrument in the promotion of child survival is the United Nations Millennium Declaration[167] which was adopted by all member states of the United Nations in 2000 to address global issues of poverty and inequality.[168] The Millennium Declaration sets out Millennium Development Goals(MDGs) that includes as one of its targets, the reduction of child mortality,[169] state parties report on their progress towards attaining these goals.[170] The MDGs have however been criticised by the former Special Rapporteur for the Right to the highest attainable standard of health, Paul Hunt, as not taking into cognisance the connection between health, human rights and development.[171]

The General Assembly of the UN has since its Millennium declaration resolved to create 'a world fit for children' recognising the issues children face amongst which are the high rate of child mortality, malnutrition, poverty and reiterating the commitment of member states of the UN to fulfil, protect and promote children's rights and all other rights which enhance children's rights. [172]

3.3 The rights to life and health under the African regional system

The principal human rights treaty which specifically provides for the rights to life and health of children under the African regional human rights system is the African Charter on the Rights and Welfare of the Child 1990(the Children's Charter).[173] The Children's Charter is an innovative treaty and it has been

---

163 www2.ohchr.org/endlish/bodies/crc/index.htm accessed 12 September 2011

164 As above.

165 Uganda's initial report was due in 1992 however it submitted it in 1996 and its subsequent report was also a late submission in 2003.

166 A Lloyd Evolution of the African Charter on the Rights and Welfare of the Child and the African Committee of Experts: raising the gauntlet International Journal of Children's Rights 10 2002 182

167 A/RES/55/2

168 http://www.beta.undp.org/undp/en/home/mdgoverview.html

169 n 22 above Para 19.

170 http://www.undp.org/mdg/basics.shtml

171 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health Addendum Missions to the World Bank and the International Monetary Fund in Washington D. C (20 October 2006) and Uganda (4- 7 February 2007) A/HRC/ 7/11/ Add.2 Page 11

172 UN General Assembly Resolution A/RES/S-27/2

173 Uganda ratified the Charter on 17 August 1994

described as 'the most progressive of the treaties on the rights of the child.'[174] Art 5 guarantees that 'every child has an inherent right to life', it further provides that state parties have the obligation to protect 'to the maximum extent possible, the survival, protection and development of the child'.[175]

Under the Children's Charter, every child has 'the right to enjoy the best attainable state of physical, mental and spiritual health'[176] It also includes state parties obligations to fulfil this right by taking steps to 'reduce the infant and child mortality rate;'[177] amongst other measures targeted at improving children's health. Some of the measures which a state party must take are targeted at providing 'medical assistance,[178] adequate nutrition,[179] and 'combat[ing] disease and malnutrition'[180] and other essential elements of health. Like the CRC, the Children's Charter also states the importance of catering to maternal health care as it is vital to children's health.[181] It reiterates provisions of the CRC on the duty of states to provide relevant health information and support to communities and families.[182] The Children's Charter obliges state parties to involve other stakeholders in creating and running of 'basic services programmes for children'.[183] Finally it places a duty on state parties to provide technical and financial support to communities in their creation of primary health care plans for children.[184]

The Children's Charter has a monitoring body known as the African Committee of Experts on the Rights and Welfare of the Child which is responsible for its implementation.[185] State parties are obliged to submit reports on the steps they have taken to implement the Children's Charter.[186] Under the African regional human rights system communications containing reports of alleged violations of the rights in the Children's Charter may be made by individuals, NGOs and states.[187] It is thus foreseen that the violation of the right to health may soon form the basis of a communication to the Committee.

Although the right to health of children is clearly stated under the Children's Charter, certain policies further explain the duties of states to guarantee the right to health and provide guidance on how national health programmes may be implemented. A relevant African Union (AU) policy which must be considered is the Africa Health Strategy,[188] whose goal is 'to contribute to Africa's socio-economic

---

[174] D Olowu 'Protecting children's rights in Africa: A critique of the African Charter on the Rights and Welfare of the Child' (2002) 10 *International Journal of Children's Rights* 130.
[175] Art 5(2)
[176] Art 14 (1)
[177] Art 14 (2)(a)
[178] Art 14 (2) (b)
[179] Art 14(2)(c)
[180] Art 14(2) (d)
[181] Art 14(2(e)
[182] Art 14(h)
[183] Art 14(i)
[184] Art 14(j).
[185] Art 42(b) ACRWC
[186] Art 43
[187] Guidelines for the consideration of communications Chapter 1 Art 1 (1)
[188] 2007-2015

development by improving the health of its people and by ensuring access to essential health care for all Africans, especially the poorest and most marginalised by 2015.'[189] The Strategy recognises that women and children have to a large extent been affected more by disease in Africa and acknowledges that little progress has been made in achieving the health related MDGs.[190] As regards child mortality, the strategy states that due to the few causes of under 5 mortality, good progress may be made through targeted efforts.[191] It calls for integrated projects which will target more than one disease[192] The Strategy enjoins all member states to improve their national health systems capacities as national health plans will have to include key elements of this Strategy.[193]

Another important regional convention which is relevant to understanding Uganda's health obligations is the African Union Convention for the Protection and Assistance of Internally Displaced Persons (AUCPAIDP).[194] Uganda's Northern region was until recently in the throes of conflict between the rebel groups of the Lord's Resistance Army and the government of Uganda military troops and as a result there was large scale internal displacement of people.[195] The AUCPAIDP places obligations on the state to ensure that humanitarian assistance which includes health care and access to health services is afforded to internally displaced persons (IDPs).[196] Also the state is obliged to cater to the needs of vulnerable groups within the IDPs such as women with children and separated and unaccompanied children.[197] This convention recognises the vulnerabilities of IDPS and provides a framework for their protection, unfortunately it has only been ratified by Uganda and it has thus not entered into force. Uganda's ratification of the AUCPAIDP is however an indication of its commitment to ensure the protection of IDPs.

3.4 The rights to life and health under Uganda's legal framework

The constitution of Uganda[198] provides for the right to life in a negative sense, Art 22 states that

> [n]o person shall be deprived of life intentionally except in execution of a sentence passed in a fair trial by a court of competent jurisdiction in respect of a criminal offence under the laws of Uganda…[199]

---

189 Para 26 pg 6
190 Para 6 pg 2
191 Para 98 pg 20
192 As above.
193 Para 108 p 22.
194 2009
195 http://www.globalsecurity.org/military/world/war/uganda.htm (accessed 12 October 2011)
196 Art 9(2)(b)
197 Art 9(2)(c)
198 1995
199 Art 22

In relation to the right to health, the constitution does not guarantee the right to health under its bill of rights, rather it is enumerated under the national objectives and directive principles of state policy, where it provides that the state shall 'ensure …access to health services…'[200]

However under the rights of children,[201] the constitution states that 'no child shall be deprived by any person of medical treatment…' It can be assumed that there is thus an implied right to health for children while not a full right as it is limited to medical treatment but a right of some sorts, this is a disadvantage.

The Children Act[202] provides more rights for the child; it expands on the constitutional provisions and incorporates the rights, protection and obligations contained in the CRC and the Children's Charter while taking into consideration the national situation.[203] The Children's Act sadly does not provide an explicit right to health for children rather it is couched under the duty of parents, guardians or any other person taking care of the child.[204] These provisions seem to shield the state from its responsibilities as rights are accessed from the parents firstly and the state as a secondary resort. According to the Children's Act, 'the duty gives a child the right to … immunisation … and medical attention.'[205] These provisions are disappointing considering that Uganda had ratified the CRC and the Children's Charter before enacting its Children's Act, it should have made more detailed provisions especially on the right to health. The Children's Act also does not recognise the importance of the underlying determinants of the right to health such as good nutrition, sanitation and safe water. Instead, in a rather confusing manner, it bundles the rights of the child under duties of the parents to provide maintenance, elements of which include an adequate diet, clothing and shelter.[206]

Another shocking difference between the Children's Act and the CRC is the lack of state obligations as per the right to health, the burden of care seems to be saddled entirely on the parents or guardians. While the CRC places the responsibility of guaranteeing the health of the child on its parents, it does not leave out the state's obligations to respect the rights of the parents or chiefly to create health programmes and institutions.[207] The Children's Act contains no such provision on any state obligations what exists in its place are duties of local government councils to 'safeguard and promote the welfare of children within its area…' and this is overseen by the secretary of children affairs.[208] This is a vague provision and offers flimsy protection at best as interpretation of the provision will depend on whether the courts choose to give it a generous meaning or not. One may assume that the sparseness of provisions on state obligations

---

[200] Art XIV
[201] Art 34
[202] Chapter 59 Laws of Uganda
[203] UNICEF FIDA Uganda A simplified handbook on international and national laws and policies on children
[204] Art 5
[205] As above.
[206] Art 5 Children's Act 1997.
[207] Ashbjord para 17
[208] Art 10 Childrens Act 1997

as regards the right to health in the Children's Act is due to the fact that Uganda does not guarantee economic and social rights in its constitution and unfortunately this seems to extend to children's rights as well.

On a positive note however, the Children's Act is not remiss in providing the state's obligation to protect the child's right to health from interference. Section 7 of the Children's Act provides that '[i]t shall be unlawful to subject a child to social or customary practices that are harmful to the child's health.' It also places a duty on community members to report violations of children's rights and situations of child neglect to the local government council.[209] Cases concerning child care and protection are to be handled by the family and children's court.[210]

As regards the duty of the state to respect the child's right to health and guarantee equal access. The provisions in the Children's Act place all the responsibility for the child on the parents with very little state obligation. It sadly does not include the non discrimination principle in access to health care. However, this lapse is slightly recovered by Art 34(3) of the constitution of Uganda which states;

> [n]o child shall be deprived by any person of medical treatment, education or any other social or economic benefit by reason of religious or other beliefs.

While this provision makes up for the lack of a non discrimination clause in the Children's Act, it disappoints by failing to include a very important factor which deprives children of medical treatment, the lack of money to pay for treatment. The argument on whether health services for children should be made free of charge is one which was debated during the preparatory process of the CRC and is contained in the *travaux prepartoires*.[211] The CRC provides that '[s] tate parties shall strive to ensure that no child is deprived of his or her right of access to health services.'[212] The interpretation given to this provision is that those who can afford to pay for services should pay for them whereas indigence should not constitute a bar to children's access to health care.[213] This implies that the state has a duty to make these health services 'economically accessible to all children and to their parents or guardians on behalf of the children.'[214] The Committee on Economic Social and Cultural Rights has emphasized the need for the application of the principle of equity to ensure that poorer families do not suffer greatly due to health expenses in contrast to well off families.[215] In Uganda, neither the Children's Act nor the constitution of Uganda provides that the state has obligations to make health services for children affordable.

---

[209] Art 11 Children's Act 1997
[210] Art 14(b)
[211] Sharon Detrick Martinus Nijhoff Publishers 1992 The United Nations Convention on the Rights of the Child. A Guide to the 'Travaux Prepartoires' Article 12 BIS (Health and Access to Care) -Article 24 P 343- 347
[212] Art 24(1)
[213] Asjborn para 32 p 12
[214] Asjborn Para 33 p 12
[215] General Comment 14 para 12 (b).

The problem of child mortality has bedevilled the world for a long time and the need for state parties to address this issue in expressly stated in Art. 24(2)(a). It is puzzling to note that for a country like Uganda with its high rates of infant and child mortality there is no similar provision obliging the government to reduce child mortality rates. It has been stated that infant and child mortality rates are crucial benchmarks of the importance and funding given by a state to the fulfilment of the right to health of its citizens.[216] Thus going by Uganda's current under five mortality statistics of 128 deaths per 1000 live births and its infant mortality rates of 79 deaths per 1000 births,[217] the realisation of the right to health of Ugandans appears not to be a top priority of the state.

On the policy side, the National Health Policy(NHP) 2010- 2020 does not focus on children in particular but includes them in the general population as entitled to access to good health care services.[218] It also has among its priorities the execution of plans for child survival and 'reducing maternal and neonatal morbidity and mortality.'[219] The right to health for children in Uganda exists in the above legal and policy framework which may be said to be insufficient and there is a need for the expansion of the right to health under this framework to ensure more protection for the children.

3.4 Conclusion

The existing legal framework for the right to life under the international, regional and national systems appears to be adequate for the protection of children's lives. However the lack of recognition or inadequacy of attention given to the link between the right to life and the right to health under the national systems is worrying as it allows for the lives of children to slip through the cracks existing between economic and social rights and civil and political rights.

---

[216] Asjborn p 17. para 45
[217] UNICEF Country Profile Uganda
[218] UNICEF FIDA (n 57 above) 103.
[219] As above.

as regards the right to health in the Children's Act is due to the fact that Uganda does not guarantee economic and social rights in its constitution and unfortunately this seems to extend to children's rights as well.

On a positive note however, the Children's Act is not remiss in providing the state's obligation to protect the child's right to health from interference. Section 7 of the Children's Act provides that '[i]t shall be unlawful to subject a child to social or customary practices that are harmful to the child's health.' It also

The problem of child mortality has bedevilled the world for a long time and the need for state parties to address this issue in expressly stated in Art. 24(2)(a). It is puzzling to note that for a country like Uganda with its high rates of infant and child mortality there is no similar provision obliging the government to reduce child mortality rates. It has been stated that infant and child mortality rates are crucial benchmarks of the importance and funding given by a state to the fulfilment of the right to health of its citizens.[216] Thus going by Uganda's current under five mortality statistics of 128 deaths per 1000 live births and its infant mortality rates of 79 deaths per 1000 births,[217] the realisation of the right to health of Ugandans appears not to be a top priority of the state.

On the policy side, the National Health Policy(NHP) 2010- 2020 does not focus on children in particular but includes them in the general population as entitled to access to good health care services.[218] It also has among its priorities the execution of plans for child survival and 'reducing maternal and neonatal morbidity and mortality.'[219] The right to health for children in Uganda exists in the above legal and policy framework which may be said to be insufficient and there is a need for the expansion of the right to health under this framework to ensure more protection for the children.

3.4 Conclusion

The existing legal framework for the right to life under the international, regional and national systems appears to be adequate for the protection of children's lives. However the lack of recognition or inadequacy of attention given to the link between the right to life and the right to health under the national systems is worrying as it allows for the lives of children to slip through the cracks existing between economic and social rights and civil and political rights.

---

[216] Asjborn p 17. para 45
[217] UNICEF Country Profile Uganda
[218] UNICEF FIDA (n 57 above) 103.
[219] As above.