6 Judging beyond gender

Maternal and infant mortality as an emerging gender-related issue in Ugandan courts

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Introduction

The legal profession was historically fashioned as solely open to men. In the last couple of decades, however, women have joined the legal profession and, more specifically, the judiciary across Africa (Dawuni, 2016, p.1). As some of the chapters in this collection have demonstrated, judicial decisions from different parts of the continent indicate an increased jurisprudence on gender issues such as cyber sexual harassment, domestic violence, dissolution of marriage, and access to land. These changes have led to questions on the relationship between gender and judging, which have been advanced under two main schools of thought.

The first school consists of differential theorists with foundations in the works of Carol Gilligan, an American developmental psychologist best known for her work *In a different voice: Psychological theory and women's development*, where she studied the effects of gender on women's psychology and girls' development (Gilligan, 1982). The differential school of thought argues that women are naturally inclined to advance gender issues based on the inherent differences compared with men due to their sex and gender (Gilligan, 1982, p.1). Adopting this biological positioning, differential theorists argue that the increased jurisprudence on gender-related issues results from the increased number of women on the bench (Hunter, 2015, pp.123–125; Kenney, 2012, p.40; Rackley, 2012, pp.180, 186). However, other scholars note that not all women advance gender issues, and the differential theory does not explain feminist decisions written by men (Hunter, 2015, p.121; Kenney, 2019, p.416).

The second school of thought is the anti-essentialist theory, which helps explain some of the gaps that the differential theory does not cover. The anti-essentialist theory proposes that sex and gender are not the only factors that affect a person's decisions (Hunter, 2015, p.124; Kenney, 2009, pp.416–417). In the judiciary, judicial decisions result from a judge's lived experience, including experiences shaped by sex, gender, class, education, and other cutting axes of difference that ultimately create a person's identity. Under this theory, both men and women judges may or may not highlight gender-related issues based on their lived experiences (Albertyn & Bonthuys, 2016, pp.166–167; Kenney, 2012, pp.41–42; Kenney, 2019, pp.416–417; Rackley, 2012, pp.186–187).

Within the framework of these two theories, this chapter seeks to determine whether the gender of the judge might make a substantive difference to judicial reasoning and decision-making. In doing so, the chapter situates the gender-focused jurisprudence of maternal and infant mortality as an emerging issue in Ugandan courts within the existing literature on gender and judging. The chapter focuses on Uganda as a case study for a number of reasons. First, there is limited literature on gender and judging in African judiciaries. The paucity of scholarly knowledge and current data on the connections between gender and judging across Africa makes for an exciting scholarly project and one that promises to introduce a broader research agenda. Second, a Ugandan case decided under Justice Lydia Mugambe has been at the fore of internationally recognized recent jurisprudence on maternal and infant health (*CEHURD v. Executive Director*, 2013), making Uganda and its jurisprudence an ideal place to start the analysis.

The chapter is divided into five sections. The first section lays the theoretical framework on which the chapter is based by highlighting the differential and anti-essentialism theories and reviewing the existing scholarship on gender and judging. The second section discusses maternal and infant health as a human rights issue using the human rights legal framework as well as international and regional policy work. This section further examines the relationship between maternal and infant health and the legal principles of progressive realization and justiciability. The third section introduces Uganda as a case study by discussing the country's historical and legal background and considering the jurisprudence on maternal and infant health in the country. The fourth section investigates whether Ugandan women judges have had a singular effect on maternal and infant health in Uganda by analyzing court cases addressing maternal and infant health in Uganda. The fifth section concludes the chapter with recommendations for continuity in increasing the positive jurisprudence on gender-related issues and possibilities for more research.

A review of existing scholarship on gender and judging

The scholarship on gender and judging has been advanced under two main theories: the differential theory and the anti-essentialism theory. As introduced earlier, the differential theorists build on the works of Carol Gilligan. Her works suggest that men and women develop different perspectives about the world and different ways of thinking about themselves and their relationship to the world (Sherry, 1986, p.163; Hunter, 2015, p.125; Kenney, 2019, p.405). As individuals, “men see themselves as fundamentally autonomous and independent of others,” but “women instead see themselves as fundamentally connected” to those around them (Sherry, 1986, p.163). Women perceive themselves as members of communities, while men perceive themselves as individuals who simply live in a community (Sherry, 1986, p.163; Bekker and van Assen, 2008, pp.540–541; Rackley, 2012, p. 139).

The differential theory further proposes that men tend to adhere to traditional values and beliefs about the nature of men and women and their proper roles in

society (Rackley, 2012, p.160; Wikler, 1980, p.203). In the judicial context, differential theorists argue that women judges are responsible for influencing court outcomes by advancing gender issues that may otherwise be neglected by their male counterparts (Rackley, 2012, p.180; Ruiz, n.d.). Men judges tend to adhere to traditional rules of law and may not look deeply into a case's social circumstances. They may become anxious when a case tends to veer off course with a witness who gives more information beyond a simple "yes" or "no" (Wilson, 1990 pp.520–521).

Under the differential theory, women judges are focused on preserving relationships within communities. Their style of judging tends to take into account issues that broaden the context of the dispute that might solve a moral dilemma (Hunter, 2008, p.12; 2015, p.131; Kenney, 2012, pp.15–16). Judging is seen not only in terms of winning or losing but also with the goal "of achieving an optim[al] outcome for all individuals" (Wilson, 1990, p.520). The differential theory suggests that this style of difference is due to women judges' ability to "produce gender sensitive judgments that take into consideration the gendered factors that male judges may tend to overlook" (Dawuni, 2016, p.421).

Women judges have already made decisions that reflect the characteristics of the differential theory. Judge Navanethem Pillay helped broaden the definition of acts of genocide to include rape and other forms of sexual violence in *Prosecutor v. Akayesu* (1998) at the International Criminal Tribunal for Rwanda (Pillay, 2009, p.461). In Uganda, in 2018, Supreme Court Justice Lillian Ekirikubinza Tibatemwa put an end to the cautionary rule in sexual offenses, which required corroborative evidence in sexual assault cases beyond the victim's testimony (*Ntambala v. Uganda*, 2015, pp.2–3).¹ Justice Tibatemwa found that the cautionary rule "affects far more women than men" and therefore violated Uganda's constitutional guarantee of equality before the law (*Ntambala v. Uganda*, 2015, p.4). These women made judicial decisions to achieve optimal outcomes for all parties and considered factors that men would likely not have considered, therefore supporting the differential theory of judicial decision-making.

However, not all women advance gender issues. For example, even though Eleanor Roosevelt played a central role in drafting the Universal Declaration of Human Rights, her presence "did not generate a special recognition of gendered harms" (Kenney, 2019, pp.408–409). Further, when analyzing gender and judging under the differential theory, women judges "are highly likely to face motions to recuse and challenges as to their objectivity" (Kenney, 2019, p.408). For example, defense counsel objected to Judge Navanethem Pillay during the *Anto Furundzija* case in the International Criminal Tribunal for the former Yugoslavia because she had served on the U.N. Commission on the Status of Women (Kenney, 2019, p. 408). Additionally, the differential theory does not explain why men judges also advance gender issues (Hunter, 2015, p.121; Kenney, 2019, p.416).

This gap in the differential theory gives rise to the anti-essentialism theory. The anti-essentialism theory suggests that both men and women judges use their life experiences, including their social, economic, and political experiences, to

make decisions, and not only their biological differences (Hunter, 2015, p.126; Kenney, 2012, p.175; Rackley, 2012, pp.144, 147; Wikler, 1980, pp. 207). The theory argues that the expectation that women judges will be more attentive to emotions or feelings through gender essentialism is gender stereotyping and is wrong (Kenney, 2019, p.419). While women judges may bring “experiences of pregnancy, child-birth, child-rearing, and juggling work and family responsibilities and gender discrimination to the bench” (Hunter, 2015, p.124), their gender is not the only thing that influences their judicial decision-making.

Neither men nor women judges are a homogeneous group (Olivier, 2013, p.452; Rackley, 2012, p.144). The anti-essentialism theorists propose that apart from gender, there are other cross-cutting axes of differences, such as race, class, education, “sexual orientation, rural origins, religious affiliation, and cultural heritage,” that affect the life experiences and decisions of judges (Albertyn & Bonthuys, 2016, p.165). Under the anti-essentialism theory, all experiences and identities, and not sex or gender alone, may be responsible for advancing gender issues (Belcher, 2014, pp.423–424). Based on this tension between the differential and anti-essentialism theories, the scholarship is conflicted over whether the gender of a judge influences his or her decision. The case studies in the subsequent sections will help identify which theory best explains the jurisprudence in Uganda.

Maternal and infant health as a human rights issue

The World Health Organization (WHO) defines maternal death 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” (WHO et al., 2019, p.8). Maternal mortality is measured by the number of women dying of pregnancy-related causes out of 100,000 live births in a given year (WHO et al., 2019, p.9). Most maternal deaths are caused by “hemorrhage (severe bleeding) after childbirth, post-delivery infections, obstructed (difficult) labor, or blood pressure disorders during pregnancy” and other indirect causes that result from pre-existing medical conditions (Bohren et al., 2015; World Health Organization, n.d.b). Trained birth attendants and high-quality reproductive health services can help prevent these conditions (Bohren et al., 2015; WHO et al., 2018, pp.viii, 9–10). The infant mortality rate is measured by the number of infants who die below one year of age per 1,000 live births (World Health Organization, n.d.a). The causes of death in newborns range from “prematurity [to] intrapartum-related events such as birth asphyxia ... birth trauma, and neonatal sepsis” (World Health Organization, 2019, p.2).

Maternal and infant health, as defined here, are pertinent issues at the heart of development. The United Nations adopted goals four and five of the Millennium Development Goals (MDGs) of 2000 as measures to reduce child mortality and improve maternal health (United Nations, n.d.). The Sustainable Development Goals (SDGs) followed in 2015 and adopted the third goal, to address maternal

and infant health, by aiming to reduce the maternal mortality ratio to 70 per 100,000 live births and infant mortality to 12 per 1,000 live births (General Assembly, 2015, p.16).

The legal framework and barriers to quick implementation: Progressive realization and justiciability

Maternal and infant health have been regarded as a human rights issue within the broader right to health (General Assembly, 1948, Art. 25; OHCHR and WHO, 2008, pp.3–4). Several human rights instruments address the right to maternal and infant health and provide for the progressive realization of human rights rather than immediate or quick enactment. At the international level, the Universal Declaration of Human Rights (UDHR) recognizes the right to medical care and specifically provides that mothers and children are entitled to special care and assistance (General Assembly, 1948, Art. 25). The International Covenant on Economic, Social and Cultural Rights (ICESCR) further operationalized the right to health as recognized in the UDHR (General Assembly, 1966, Art. 12). The ICESCR enjoins States Parties to recognize the right of everyone to enjoy and attain the highest standard of physical and mental health, and especially demands that states take necessary steps to ensure the healthy development of the child and to reduce stillbirth and infant mortality rates (General Assembly, 1966, Art. 12 (2)(a)).

The Committee on Economic, Social and Cultural Rights emphasizes that the right to health contains both freedoms and entitlements (Economic and Social Council, 2000, Part I (8)). The freedoms include “the right to control one’s health and body, including sexual and reproductive health, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment, and experimentation” (Economic and Social Council, 2000, Part I (8)). The entitlements under the right to health “include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health” (Economic and Social Council, 2000, Part I (8)). General Comment No. 14 interprets the essential elements of the freedoms and entitlements to mean that States Parties should take measures to improve child and maternal health services by making them available, accessible, acceptable, and of good quality (Economic and Social Council, 2000, Part I (12)(a-d)). Although General Comment No. 14 allows for the progressive realization of the rights, it “also imposes on States parties various obligations which are of immediate effect” and should not be interpreted as a way to remove the “meaningful effect” of the requirements (Economic and Social Council, 2000, Part II (30)).

The 1979 United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) was enacted to address the rights of women internationally. The treaty requires States Parties to ensure that women receive appropriate services in connection with “pregnancy ... and the post-natal period, granting free services where necessary, as well as adequate nutrition during

pregnancy and lactation” (United Nations, 1979, Art. 12 (2)). The existence of a special treaty for women’s rights is based on the understanding that women have a unique role in reproduction and thus require special social and legal protections to compensate for this biological difference (Twinomugisha, 2007, pp.285–287). Pregnancy and childbirth increase the risk of mortality, and women therefore have unique health concerns and a basic right to be protected (Twinomugisha, 2007, p.286). Finally, the Convention on the Rights of the Child addresses the right to health of children (United Nations, 1989). This treaty requires States Parties to take appropriate measures to diminish infant and child mortality and provide pre- and post-natal health care for mothers (United Nations, 1989, Art. 24(a)).

At the regional level, in 2003, African states enacted the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, commonly known as the Maputo Protocol (African Union, 2003). It mandates States Parties to take all appropriate measures to “establish and strengthen existing prenatal, delivery, and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding” (African Union, 2003, Art. 14 (2)). Despite this requirement, millions of women across the African continent are not fully enjoying their right to health.

In its decision in *Purohit and Moore v. The Gambia*, the African Commission on Human and Peoples’ Rights (the “African Commission” or “Commission”) recognized that “African countries are generally faced with the problem of poverty which renders them incapable of providing the necessary amenities, infrastructure and resources that facilitate the full enjoyment of this right” (African Commission on Human and Peoples’ Rights, 2003, p.14). Maternal and infant health services require massive financial investments, which the states simply do not have (Twinomugisha, 2007, pp.291–292; UNICEF, 2018). Most African states, therefore, must at a minimum take steps to achieve the human rights as agreed to in the various international conventions. States then have a legal duty to take part in progressively realizing the agreed upon rights in light of available resources (International Covenant on Economic, Social and Cultural Rights, 1966, p.2).

This progressive realization of rights ensures that states fulfill their duties and responsibilities, as treaties may otherwise not invoke change on their own unless enforced by domestic governments. To help states implement these rights even with limited resources, the African Commission published guidelines on the implementation of economic, social, and cultural rights, showing that state parties have a duty “to respect, protect, promote and fulfill” all rights (African Commission on Human and Peoples’ Rights, 2011, Part II (4)). The obligation to *respect* rights requires states “to take positive measures to ensure that all branches of government (legislative, executive and judicial) at all levels (national, regional and local), as well as all organs of state, do not violate economic, social and cultural rights” (African Commission on Human and Peoples’ Rights, 2011, Part II (6)).

The obligation to *protect* rights requires that states regulate and monitor non-state actors to ensure they do not infringe on rights, along with implementing

relevant legislation “to provide remedies for such violations” (African Commission on Human and Peoples’ Rights, 2011, Part II (7)). The duty to *promote* rights requires states “to adopt measures to enhance people’s awareness of their rights ... to provide accessible information relating to the programs and institutions adopted to realize [the rights, and] ... to promote the values and objectives of economic, social and cultural rights,” such as through the training of the judiciary or administrative officials (African Commission on Human and Peoples’ Rights, 2011, Part II (8–9)). Finally, the duty to *fulfill* rights mandates the states to take positive steps to advance the realization of the rights, with special attention to the rights of vulnerable and disadvantaged groups (African Commission on Human and Peoples’ Rights, 2011, Part II (8–9)). Such measures should be “comprehensive, coordinated, and transparent, [with] clear goals, indicators, and benchmarks for measuring progress” (African Commission on Human and Peoples’ Rights, 2011, Part II (10)).

As part of the guidelines for implementation of rights, the African Commission emphasized that “States must implement a reasonable and measurable plan, including set achievable benchmarks and timeframes, for the [realization] of economic, social, and cultural rights within the resources available to the state party” (African Commission on Human and Peoples’ Rights, 2001, Part II (14)). On resources, the African Commission noted the variety of means through which states may raise the required finances, including through taxation and regional or international aid (African Commission on Human and Peoples’ Rights, 2001, Part II (13, 15)). Because the African Commission suggested taxation as a form of raising finances, the Commission therefore “implies that there is an obligation on the State to institute an effective and fair taxation system and a budgeting process that ensures that economic, social and cultural rights are prioritized in the distribution of resources” (African Commission on Human and Peoples’ Rights, 2001, Part II (15)).

The language of progressive realization from these guidelines has appeared in decisions by the African Commission. In *Purohit and Moore v. The Gambia*,² the Commission stated that there is an “obligation on part of States party to the African Charter to take concrete and targeted steps, while taking full advantage of available resources, to ensure that the right to health is fully realized in all its aspects without discrimination of any kind” (African Commission on Human and Peoples’ Rights, 2003, para. 84). Therefore, the notion of progressive realization within available resources must not be viewed as an excuse to deny economic, social, and cultural rights, including the right to health. As verified by case law and Commission decisions, the guidelines provide concrete steps that states must take to ensure movement towards full realization of rights.

Apart from the principle of progressive realization, the principle of justiciability also acts as a barrier to the full realization of socio-economic rights. Justiciability is the legal standing (or *locus standi*) to bring a claim before the courts (Deshpande, 1971, p.156). Some theorists argue that socio-economic rights cannot be adjudicated upon by the courts due to the doctrine of separation of powers, whereby the implementation of those rights is left to the legislative

and executive branches rather than the judicial (Twinomugisha, 2007, pp.292–293). Despite this challenge, there has been significant progress at the regional and domestic levels in the adjudication of socio-economic rights.³

Due to this growing adjudication, there are more possibilities now than ever before for bringing forward socio-economic rights claims in many different institutional contexts and different ways.⁴ In *SERAP v. Nigeria*, for example, the ECOWAS court ruled that “it is also well established that the rights [which include the right to education under Article 17] guaranteed by the African Charter on Human and Peoples’ Rights are justiciable before this Court” (*SERAP v. Federal Republic of Nigeria*, 2009, p.10). By holding the right to education justiciable, the court therefore rejected the government’s contention that “the right to education is not justiciable as it falls within the directive principles of state policy” (*SERAP v. Federal Republic of Nigeria*, 2009, p.10). In noting the difference between human rights in domestic legal frameworks and the African Commission of Human and Peoples’ Rights requirement, the court stated that it “clearly has jurisdiction to adjudicate on applications concerning the violation of human rights that occur in Member States of ECOWAS” (*SERAP v. Federal Republic of Nigeria*, 2009, p.6) and that it “has jurisdiction over human rights enshrined in the African Charter and the fact that these rights are domesticated in the municipal law of the Federal Republic of Nigeria, cannot oust the jurisdiction of the Court” (*SERAP v. Federal Republic of Nigeria*, 2009, pp.6–7).

From the foregoing, the principle of justiciability becomes especially important with issues such as maternal and infant health rights. If the court is unwilling to hear a dispute and leaves the legislative or executive bodies of government to address the problem, the grievance may not actually be addressed, since many human rights violations, including violations related to infant and maternal health rights, are a result of the executive’s or legislative’s failure to protect those rights. The case of *Centre for Health Human Rights and Development (CEHURD) v. Attorney General*, as will be discussed in the following section, highlights the importance of justiciability of maternal and infant health rights.

Despite the formal recognition of maternal health in the international and regional human rights regime, women continue to experience disrespectful and abusive treatment during pregnancy, childbirth, and post-partum. Research shows that complications related to childbirth and early motherhood have significant negative effects on women’s health (Šimonović, Women & Secretary-General, 2019, pp.4–5; Yamin & Maine, 1999, p.566). The WHO has also gathered reports of disrespectful and abusive treatment, ranging from physical abuse to violations of confidentiality.⁵ Such treatment violates a woman’s and baby’s right to the “highest attainable standard of health, which includes the right to dignified, respectful health care” (World Health Organization, 2015, p.1). This mistreatment also threatens the “rights to life, health, bodily integrity, and freedom from discrimination” (World Health Organization, 2015, p.1).

The U.N. has also identified a similar pattern. In 2006, the statement of the U.N. Special Rapporteur on the right of everyone to enjoy the highest attainable standard of physical and mental health stressed that no single cause of death and

disability for men between the ages of 15 and 44 reaches the magnitude of maternal mortality and morbidity (Hunt, 2006, p.5). The statement detailed that “[f]or every woman who dies from obstetric complications, approximately 30 more suffer from injuries, infection, and disabilities” from those complications (Hunt, 2006, p.5). The statement argued that the availability of and access to maternal health services is a human right.

This section has shown that maternal and infant health falls within the human rights regime. Although the principles of progressive realization and justiciability hinder the quick and full realization of economic, social, and cultural rights, the African Commission and other international organizations have provided guidance on the best ways to implement these rights. Even with this guidance, however, access to health services remains difficult for many women and children.

Uganda’s history and the rights-based legal framework

Beginning in 1894, the previously independent and diverse region of what is now Uganda was ruled as a protectorate by the British until 1962, when it regained its independence (Kanyehamba, 2010, pp.1, 62–63). Uganda operates a common law system reflecting the legal structure left by the British colonial governance system.

The structure, powers, and functions of the judiciary are detailed in Uganda’s constitution (1995), the Judicature Act (1996), Magistrates Courts Act (1971), and other legislative instruments and by-laws. Uganda’s judicial system is two-tiered. At the top are the superior courts, consisting of the Supreme Court, the Court of Appeal, the High Court, and any tribunals that parliament establishes, such as the land tribunals (Adonyo, 2012, p.12). The lower courts, which form the second tier, consist of the Chief Magistrates’ Courts, the Grade One and Grade Two Magistrates’ Courts, the Local Council Courts (divided further into three levels), and any other such lower courts as parliament may establish by law (Adonyo, 2012, p.12).

In 1995, Uganda adopted a new constitution. The Ugandan constitution does not specifically mention maternal and infant health services, either within its human rights legal framework found in Chapter 4 or elsewhere in the constitution (Constitution, 1995). However, the rights can be read into the general social and economic objectives. Under General Objective XIV, the constitution provides that “the State shall endeavour to fulfill the fundamental rights of all Ugandans to social justice and economic development and shall, in particular, ensure that ... (b) all Ugandans enjoy rights and opportunities and access to ... health services” among others (Constitution, 1995). General Objective XV recognizes the “significant role that women play in society,” though it does not elaborate on the meaning of women’s roles (Constitution, 1995). Further, General Objective XX requires that Uganda as a state “shall take all practical measures to ensure the provision of basic medical services to the population” (Constitution, 1995). Several Articles of the constitution also suggest the right to maternal and infant health. Under Article 33 (3), labeled Rights of Women,

the constitution mandates the state to “protect women and their rights, taking into account their unique status and natural maternal functions in society,” while Article 24 provides that “no person shall be subjected to any form of torture or cruel, inhuman or degrading treatment or punishment” (Constitution, 1995).

Even though Uganda is a signatory of the 2001 Abuja Declaration,⁶ which mandates signatories to spend at least 15% of their annual budget on the health sector, Uganda has not met that commitment (Organization of African Unity, 2001, p.5). As published in Uganda’s National Budget Framework Paper, the country’s Medium-Term Expenditure Framework allocated 7.9% of the budget to the health sector in the 2019/2020 fiscal year, but only 5.1% for the 2020/21 fiscal year (Ministry of Finance, 2019, p.xxxi).

Maternal and infant health and its jurisprudence in Uganda

Maternal and infant health data

Data from 2017 show that an estimated 66% of all maternal deaths occur in sub-Saharan Africa (WHO et al., 2019, p.xi). In 2017, Uganda registered a maternal mortality ratio, measured by the number of maternal deaths from pregnancy-related complications per 100,000 live births, of 375 (World Bank Data, 2019). Neighboring East African countries are equally in dire need of improvement. In 2017, Rwanda reported a maternal mortality ratio of 248, Kenya reported 342, Burundi reported 548, and Tanzania reported 524 (World Bank Data, 2019). In 2013, the UN estimated that 40% of pregnant women globally did not receive antenatal care (World Health Organization, 2018, p.5). Antenatal care “enables the early management of conditions which may adversely impact upon the pregnancy, thus potentially reducing the risk of complications for women and newborns during and after delivery” (World Health Organization, 2018, p.5). In the same study, the WHO revealed that fewer than half of all births in developing countries benefited from the presence of a trained midwife, doctor, or nurse (World Health Organization, 2018, p.5). A study in 2018 found that 3% of pregnant women in Uganda did not receive antenatal care, and 26% of women delivered without a skilled provider (Uganda Bureau of Statistics, 2018, p.141). The presence of a skilled provider is affected by the mother’s geographic location, education, whether the birth was in a health facility, and the birth order (Uganda Bureau of Statistics, 2018, pp.145–146).

In 2017, the global infant mortality rate was reported at 29 per 1,000 live births (Infant mortality, n.d.). The WHO estimated that in 2017, 4.1 million infant deaths occurred within the first year of life globally; the Africa region had the highest infant mortality rate of 51 per 1,000 live births (Infant mortality, n.d.). In 2018, Uganda’s infant mortality rate was estimated at 34 (World Bank Data, n.d.). The situation in other neighboring countries was also found to be wanting: Rwanda reported 27, Kenya reported 31, Tanzania reported 38, and Burundi 41 (World Bank Data, n.d.).

The right to maternal and infant health jurisprudence in Uganda

Maternal and infant health have not traditionally been litigated in the Ugandan court system. Nevertheless, cases of this nature have slowly found their way into Ugandan courts and successfully been determined by both male and female judges. *Joyce Nakacwa v. Attorney-General & Others* (2001) was one of the first cases that sought to advance maternal and infant health in Uganda. In this case, the petitioner was turned away from a medical facility while she was in labor, since she did not have money to pay at the hospital (*Joyce Nakacwa v. Attorney-General*, 2001, p. 3). Later, under suspicion of her having stolen the baby, her newborn was taken away from her and the petitioner was detained (*Joyce Nakacwa v. Attorney-General*, 2001, pp.4–6). She was released a week later only to find her baby dead (*Joyce Nakacwa v. Attorney-General*, 2001, p.7). The petitioner went to the Constitutional Court alleging that the denial of maternal care violated Article 33 (3), which obliges the state to “protect women and their rights, taking into account their unique status and natural maternal functions in society” (Constitution of the Republic of Uganda, 1995; *Joyce Nakacwa v. Attorney-General*, 2001, p.2). An objection was raised challenging the Constitutional Court’s jurisdiction (*Joyce Nakacwa v. Attorney-General*, 2001, p.9). The Constitutional Court ruled that it had jurisdiction to interpret whether the alleged acts and omissions had contravened the petitioner’s constitutionally guaranteed rights. Unfortunately, the court did not handle the petition on its merits as the petitioner died before the petition could be heard, leading to its abatement.

Centre for Health Human Rights and Development (CEHURD) v. Attorney General is a landmark case in Uganda’s Constitutional Court jurisprudence on maternal and infant health. This public litigation case was brought after the deaths of two mothers, Sylvia Nalubowa and Anguko Jennifer (*CEHURD v. Attorney General*, 2011, p.2). Before the court heard the case, the court had to determine whether the provision of maternal and infant health services met the principle of justiciability, therefore warranting the plaintiffs’ standing and the chance to have their issue adjudicated by the court.

The petitioners contended that the distressing numbers of maternal deaths in Uganda resulted from the government’s failure to provide basic minimum maternal health care and the unethical behavior of health workers (*CEHURD v. Attorney General*, 2011, p.2–4). The Attorney General, represented by state attorney Ms. Mutesi Patricia, argued that provision of maternal and infant health services involves determining political questions, which in effect interferes with political discretion, which is considered a preserve of the executive and the legislative branches (*CEHURD v. Attorney General*, 2011, p. 8). The justices on the court consisted of two women and three men.⁷ The justices unanimously agreed with the Attorney General and ruled that the concerns raised by the petitioner were not under the discretion of the court and should instead be left to the executive and legislative branches of government (*CEHURD v. Attorney General*, 2011, p.15). The case was summarily dismissed without hearing the

merits (*CEHURD v. Attorney General*, 2011, p.15). With this ruling, the justices determined that maternal and infant health rights are not justiciable issues. Under a strict interpretation of the Constitutional Court's decision, all acts and omissions of the executive would be shielded from judicial scrutiny (*CEHURD v. Attorney General*, 2011, p. 30).

The ruling was appealed, presided over by a quorum of two women and five men justices in the Supreme Court (*CEHURD v. Attorney General*, 2013, p.1).⁸ Ms. Patricia Mutesi again represented the Attorney General. The Supreme Court unanimously overturned the ruling of the Constitutional Court. In her lead judgment,⁹ Honorable Lady Justice Kisaakye held that the Constitutional Court had erred in law when it abdicated its constitutional mandate to hear and determine the merits of the appellant's petition before reaching the decision of striking it out on the basis of the political question doctrine (*CEHURD v. Attorney General*, 2013, p. 31). While directing the Constitutional Court to hear the petition on its merit, Justice Kisaakye stated that the petition before the Constitutional Court had specified acts and omissions that were within the ambit of the powers vested in the Constitutional Court (*CEHURD v. Attorney General*, 2013, p.28). Justice Kisaakye further stated that the application of the political question doctrine had limited application in Uganda and should not be used to oust the court's jurisdiction (*CEHURD v. Attorney General*, 2013, p.31).

Justice Kisaakye added that the political question doctrine only extends to shielding both the executive arm of government and parliament from judicial scrutiny where either institution is properly exercising its mandate. Former Chief Justice Katureebe wrote in his concurring judgment that the petition before the Constitutional Court had created a significant opportunity in which the court could determine on the content and application of the right to life and health in Uganda (*CEHURD v. Attorney General*, 2013, p.2).

The Supreme Court decision is celebrated for paving the way for lower courts to deal with the political question doctrine and making it easier for courts to adjudicate on infant and maternal health (Nanima, 2018, p.15). The Constitutional Court heard *CEHURD v. Attorney General* on its merits and decided in 2020 after a long history moving through the courts, including the original dismissal at the Constitutional Court for lack of jurisdiction and the Supreme Court's reversal and remand back to the Constitutional Court. This time, when the case was heard with an all-male quorum¹⁰ and an international human rights law lens that mandates a state to protect its citizens, the court found for the petitioners.

The lead judge, Justice Barishaki Cheborion, noted that the omission to adequately provide basic maternal health care services in public health facilities violates women's rights. He declared that the government's failure to adequately provide emergency obstetric care in public health facilities violates the right to health and life along with women's rights (*CEHURD v. Attorney General*, 2011, p.57). Those violations were inconsistent and in contravention of Articles 8(A), 22, 33 (1–3), 39, 45, and 287 as read together with objectives XIV and XX of the constitution (*CEHURD v. Attorney General*, 2011, p.57). He also found that the government's conduct subjects "women to inhuman and degrading treatment

and is inconsistent with and in contravention of Article 24 and 44 (a) of the Constitution” (*CEHURD v. Attorney General*, 2011, pp.57–58).

Justice Barishaki called upon the state to henceforth prioritize and provide sufficient funds to improve maternal and infant health services in the country when making financial budgets (*CEHURD v. Attorney General*, 2011, p.58). The ruling mandated the Ministry of Health to ensure that “all the staff who provide maternal health care services in Uganda are fully trained and all health centers are equipped within the next [two] financial years (2020/2021 and 2021/2022)” (*CEHURD v. Attorney General*, 2011, p.58). The justice required the Minister of Health to compile and submit to parliament and the court an “audit report on the status of maternal health in Uganda at the end of each of the next two financial years (2020/2021 and 2021/2022)” (*CEHURD v. Attorney General*, 2011, p.58). The Attorney General was directed to submit a report at the end of the financial year 2020/2021 showing the progress and implementation of these orders (*CEHURD v. Attorney General*, 2011, p.58).

On an individual level, Justice Barishaki awarded two petitioners general damages for the psychological torture; violation of the rights to life and health; and cruel and degrading treatment of their loved ones (*CEHURD v. Attorney General*, 2011, p.58). They were further awarded exemplary damages for the loss suffered as a result of acts and omissions of the medical personnel at Mityana Hospital and Arua Regional Referral Hospital (*CEHURD v. Attorney General*, 2011, p.58).

The ruling in this case showed that on August 19, 2020, after a long nine-year wait, the rights to infant and maternal health care and emergency obstetric care were granted a place in Uganda’s constitution.

Before *CEHURD v. Attorney General* was filed and determined by the Supreme Court in 2015 and the Constitutional Court determined the case on its merits in 2020, cases concerning infant and maternal health were being filed, heard, and determined by the High Court. It is praiseworthy to note that even without the decisions of the superior courts, the High Court was forging a path in uncharted waters and building its independent positive jurisprudence on maternal and infant health.

The case of *Watsemwa and anor v. Attorney General* (2006) is the first High Court case considered by this research. The case involved the baby David Goseltine, who suffered from asphyxia and was born by an emergency cesarean section after a cord prolapse during his birth (*Watsemwa and anor v. Attorney-General*, 2006, p.2). In 2015, Justice Elizabeth Musoke, a woman judge, found the hospital staff negligent. She held that “there is no doubt that the lapses at the ward caused by the nurses, which also led to delays in getting out the baby by caesarean as quickly as possible to get a normal baby; ... caused that chain reaction of cord prolapse and asphyxia” (*Watsemwa and anor v. Attorney-General*, 2006, p. 18).

Justice Musoke further contributed to the infant and maternal health jurisprudence in her decision in *Kanyamugule and Another v. Attorney-General and 3 Others* (2011), which was decided later that same year. In this case, Namakula

Kate was admitted to Mulago Hospital for an emergency cesarean section, but the next day, before the surgery could be carried out, she had a stillbirth (*Kanyamugule and Another v. Attorney General and 3 Others*, 2011, p. 1). Justice Musoke once again found the hospital staff culpable in negligence, holding that “the defendants owed a duty of care to the [second] plaintiff and her unborn child the moment she was accepted and admitted into the hospital; they had a duty to exercise due caution and skill in ensuring her safety and the safety of the unborn child who had been confirmed to be alive ... the doctors strayed beyond the bounds of what is expected of a reasonably skilled or competent doctor when they neglected to take the plaintiff to the theater within a reasonable time” (*Kanyamugule and Another v. Attorney General and 3 Others*, 2011, pp.5–6).

CEHURD v. Nakaseke District Local Administration (2012) was also decided in 2015. The case is centered on the passing of Irene Nanteza, who died of hemorrhage and a ruptured uterus after a nurse identified signs of obstructed labor and called the doctor on duty; the doctor did not arrive until eight hours later (*CEHURD v. Nakaseke District Local Administration*, 2012, pp.3, 8). The plaintiffs petitioned the Court for damages from violations to the right to life, the right to health, and inhuman and degrading treatment. After analyzing the health and human rights of Nanteza and her unborn child, Honorable Justice Benjamin Kabiito, a male judge, highlighted the negligence by the doctor and found the case for the plaintiffs (*CEHURD v. Nakaseke District Local Administration*, 2012, p.16). He also found that there had been a violation of the human and maternal rights of the deceased and the rights of her children and surviving spouse (*CEHURD v. Nakaseke District Local Administration*, 2012, p.17).

Judge Kabiito is also remembered for his contributions in *Hon. Bernard Mulengani v. Attorney General and 2 others* (2011). This case involved a suit to recover damages after the death of Gloria Kyesimire during childbirth due to a blood mismatch shortly after a transfusion (*Hon. Bernard Mulengani v. Attorney General and 2 others*, 2011). Judge Kabiito found for the petitioner and determined that the hospital staff's negligence was responsible for the death of the petitioner's wife (*Hon. Bernard Mulengani v. Attorney General and 2 others*, 2011).

In 2017, Uganda got another decision on maternal and infant health with the decision of *CEHURD v. The Executive Director, Mulago National Referral Hospital*. In this case, the plaintiff and her husband asserted she delivered two babies at the hospital, but she was discharged a day later with only one newborn (*CEHURD v. The Executive Director, Mulago National Referral Hospital*, 2013, p.1). The plaintiff and her husband demanded the hospital return the body of their second baby, but after biological testing, the government laboratory determined that the body that the hospital gave the couple had no biological relation to them (*CEHURD v. The Executive Director, Mulago National Referral Hospital*, 2013, p.2). Honorable Lady Justice Lydia Mugambe found negligence on the hospital's part for failing to account for the plaintiff couple's missing baby (*CEHURD v. The Executive Director, Mulago National Referral Hospital*, 2013, p.15). She determined that when the hospital denied the couple closure and burial rights for their child, the hospital subjected the parents to psychological torture as defined by Articles 24

and 44(a) of the Ugandan constitution (*CEHURD v. The Executive Director, Mulago National Referral Hospital*, 2013, pp.17, 19).

Even though Uganda's constitution does not explicitly refer to maternal and infant health protections, Justice Mugambe used both the international and the regional human rights legal framework to support her decision. She cited instruments such as General Comment 14 of the Committee on Economic, Social and Cultural Rights; General Comment No. 20 of the Committee on Civil and Political Rights; the African Commission on Human and Peoples' Rights Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples Rights; and the Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa (*CEHURD v. The Executive Director, Mulago National Referral Hospital*, 2013, pp.6, 7, 16). Justice Mugambe held that the facts of the case pointed to a failed health system, implying that the state had failed to fulfill its obligation to ensure the right to health expected of it under the African Charter (with a particular emphasis on the failure to address the needs of rural women) (*CEHURD v. The Executive Director, Mulago National Referral Hospital*, 2013, p.16).

The maternal and infant health jurisprudence continued with the 2019 decision of *Kabiito Telesphorus v. Attorney General & 2 Others* (2012). The suit was brought after Katusabe Elizabeth died from an emergency cesarean section due to uncontrolled heavy bleeding (*Kabiito Telesphorus v. Attorney General & 2 Others*, 2012, p.3). The male Justice Musalu Musene found for the plaintiff. He held that "[Katusabe Elizabeth's] death was caused by the negligence of the [medical staff] ... there was ultimately no proper medical attention towards the deceased who was in labour. Furthermore, there was failure by the Defendants' workers to provide lifesaving blood leaving the deceased to bleed without rescue and resulting into her death" (*Kabiito Telesphorus v. Attorney General & 2 Others*, 2012, p.7).

Apart from maternal and infant health, other notable emerging gender issues have received progressive judgments by both men and women judges. For example, Honorable Justice E.S. Lugayizi (a male judge) called out against the discriminatory nature of the cautionary rule in sexual offenses as regards evidence of a single identifying witness (*Uganda v. Kasumba Joseph*, 2002). As discussed in the previous section, Honorable Lady Justice Lillian Ekirikubinza Tibatemwa built on Justice Lugayizi's judgment and declared the cautionary rule unconstitutional (*Ntambala v. Uganda*, 2015). Justice Batema N.D.A. (a male judge) used the battered woman syndrome defense as a mitigating factor while sentencing an offender in a case involving continuous domestic violence (*Uganda v. Kamuhanda Emmanuel*, 2012, pp.6–7). Justice Musoke Kibuuka (a male judge) is also celebrated for interpreting Uganda's Penal Code Act under Section 123 not to include an exception for married people in rape charges and for using Article 31 of the Ugandan constitution on equality in marriage and Article 33 on women's equality to recognize marital rape as an offense, a rare occurrence in Ugandan courts (*Uganda v. Yiga Hamidu*, 2002, p.9).

The relationship between the gender of a judge and maternal and infant health jurisprudence in Uganda

As discussed previously, Uganda's legal profession has largely been a preserve of men until recently. The first woman to join the Ugandan bench was the former Deputy Chief Justice Laetitia Eulilia Mary Mukasa Kokonyongo, who joined as a Magistrate Grade One judge in 1971 (URN, 2017). She was followed by Justice Constance Byamugisha in 1976, who also joined as a Magistrate Grade One judge (Wekasa, 2013). Justice A.E.N. Mpagi-Bahigeine followed as the third woman in 1988 as a High Court judge (Women in Leadership Conference Award Bios, 2018). With the gradual growth of the economy (World Bank, 2020) and the introduction of human rights policies such as affirmative action as enshrined in the Ugandan constitution (Constitution, 1995), Uganda has seen more women attain law degrees and join the legal profession, which has greatly increased the number of women judges on the bench. The Ugandan judiciary currently boasts 45.8% women judicial officers on the bench (Judiciary, Republic of Uganda, 2020) (see Table 6.1).

With the case law examples and the data on the total number of women in the Ugandan judiciary, the remainder of this section will analyze whether more positive jurisprudence on gender-related issues is due to the increased number of women judges on the bench. The evidence found in maternal and infant health jurisprudence in Uganda as identified in the previous section suggests that there is no direct relationship between the increased number of women on the bench and the increase in maternal and infant health jurisprudence.

The court cases have demonstrated that gender essentialism, which is at the heart of the differential theory, does not fully explain the type of decision a judge will make concerning gender-related issues. The ruling in *CEHURD v. Attorney General* (2011) demonstrated both men and women judges failing to advance maternal and infant health issues. Two women judges, Justice A.E.N.

Table 6.1 Number of judicial officers as of January, 2020 as posted on the Ugandan Judiciary Website

Courts	Number of women	% women	Number of men	% men	Total
Supreme Court	5	41.6	7	58.3	12
Court of Appeal	5	35.7	9	64.3	14
High Court	27	45	33	55	60
Registrars	0	0	2	100	2
Deputy Registrars	14	58.3	10	41.6	24
Assistant Registrars	4	40	6	60	10
Chief Magistrates	24	51.1	23	48.9	47
Magistrates Grade 1	92	48.7	97	51.3	189
Magistrates Grade 2	8	25	24	75	32
Total	179	45.8	211	54.1	390

Mpagi-Bahigeine as lead judge and Justice C.K. Byamugisha, unanimously agreed with three men judges that maternal and infant health issues had no *locus standi* in court. When the ruling was appealed at the Supreme Court in *CEHURD v. Attorney General* (2013), with Lady Justice Esther Kisaakye as a lead judge and the author of the opinion in a court with a majority of men justices, the Court unanimously voted to do away with the political question with regard to maternal and infant health. When the case was heard on its merits, an all-male bench with Justice Barishaki Cheborion as lead judge and author of the opinion unanimously agreed to read the right to maternal and infant health care services in public health facilities into the human rights framework laid down in Chapter 4 of the Ugandan constitution.

The jurisprudence emanating from the High Court shows that Judge Musoke, Judge Kabiito, Judge Mugambe, and Judge Musene, judges of different sexes, found the various defendants culpable of negligence. Considering the numbers of male and female judges in the cases discussed earlier, this chapter's finding shows that women judges are not the sole bearers of the duty to advance gender-related issues (Albertyn & Bonthuys, 2016; Bauer & Ellett, 2016; Dawuni, 2016). The findings in this chapter have shown that men judges also have the ability to identify and address gender issues and have done so; however, the reasoning behind those decisions that may be classified as "gender-progressive" may differ between women and men. Therefore, the differential theory does not explain the increased positive jurisprudence on maternal and infant health in Uganda.

A further look at the decisions of Judge Musoke, Judge Kabiito, Judge Mugambe, and Judge Musene reveals that all judges agreed that the right to maternal and infant health exists and ruled for the petitioners. However, even though all these judges agreed on the outcome, Judge Mugambe's decision analyzed the issues further than the rest of her colleagues. Judge Musoke, Judge Kabiito, and Judge Musene found for the plaintiff only by focusing on the traditional factors of duty and negligence. Judge Kabiito decried the inadequate resources that the local governments (organs in charge of hospitals at the district level) had for their operations and management. Judge Musoke, Judge Kabiito, and Judge Musene fell short of reminding the state of its role in protecting the people by providing maternal and infant health services.

In contrast, Judge Mugambe looked not only at the factors of negligence but also at the psychological torture of the parents and the state's failure under international human rights law to provide reasonable maternal and infant health services. This analysis, however, does not mean that Judge Mugambe identified human rights violations because she is a woman. However, since Justice Mugambe is a woman and is aware that her judgment may raise issues as to her objectivity, she may have felt pressured to exercise judicial restraint or rule in a legally conservative manner. This pressure to exercise judicial restraint is supported in statements made in an interview conducted with Judge Mugambe¹¹ while writing this chapter. She stated that even though she advances gender issues, she does not see herself as an extremist in feminism who will rule in favor of women whenever gender-related issues arise in her court (L. Mugambe,

personal communication, May 24, 2019). She further stated that she sees herself as a human rights judge, who objectively uses human rights lenses to give a balancing act to the law (L. Mugambe, personal communication, May 24, 2019). She was eager to point out that if she sees a wrong being done to a woman, she will not be held prisoner by the “gender card” (L. Mugambe, personal communication, May 24, 2019). Judge Mugambe opined that it is not only gender that dictates one’s inclination to bring about social justice, but also education and training that contribute to an individual’s appreciation of social wrongs (L. Mugambe, personal communication, May 24, 2019). Judge Mugambe’s analysis, therefore, has more to do with her scholarly experience than with her gender and sex.

Other justices similarly emphasize the importance of experience. For example, Justice N.D.A. Batema¹² (a male judge) argues that even if men are not naturally inclined to advance gender issues, they can be educated to do so (Wamboga, 2019). He confesses that as a young judicial officer, he never considered gender issues while adjudicating; it was not until he was educated on human rights issues that his perspective changed and he began to analyze his cases with a gender perspective (Wamboga, 2019).

Despite the increase in women’s representation in the judiciary in Uganda, judicial decisions in the cases reviewed in this section on infant and maternal health show that both men and women judges make decisions favorable to the protection of these rights. The variety of experiences in the judges making positive rights-based decisions, including but not limited to their sex and gender, highlights how different axes of experiences guide a judge’s decisions.

The anti-essentialism theorists call us to look beyond sex and gender when determining whether a judge will contribute positively to gender-related issues. A review of the jurisprudence on maternal and infant health in Uganda shows that judicial decision-making is based on a multiplicity of factors, including the individual judge’s experiences, judicial training, and awareness of the gendered nature of laws, and cannot be restricted to their sex or gender alone.

Conclusion

This chapter has demonstrated the need for continued studies to analyze whether there are gendered patterns in judicial decision-making across a broad spectrum of cases that come before the Ugandan courts. The cases and data analyzed in this chapter suggest that there is no gendered pattern to the decisions judges make regarding gender-related issues. Both men and women judges are capable of advancing issues relating to women as much as they are capable of discarding these issues. As discussed in this chapter, there is no discernable pattern to neatly categorize the voices of women and men judges. The difficulty to categorize does not mean that women should not be on the bench or that they are redundant additions. Women should be on the bench because they deserve to be there in their own right based on their own merit.

However, to increase positive jurisprudence on gender-related issues, the analyses of both men and women need to be developed to advance gender-related issues through education and training. As judiciaries plan and budget their resources, their training and education departments need to be adequately catered for, and these departments must prioritize themes around gender-related issues in their training manuals.

Because this study focuses on the jurisprudence on infant and maternal health in Uganda, the findings are limited to a particular subject, number of cases, and time period. Maternal and infant health jurisprudence is an emerging gender-related issue that this chapter has only been able to trace from the early 2000s. The findings are therefore limited and may change with more jurisprudence on the same subject matter or with consideration of other gender-related issues. Future research may address the changing landscape of maternal and infant health jurisprudence or include other gender-related issues that have been litigated.

Notes

- 1 In *Ntambala v. Uganda*, the appellant claimed that the evidence that the victim of the sexual assault provided was not corroborated (as the cautionary rule would require) and was therefore insufficient to uphold his conviction of 14 years in prison (2015, p.1). Justice Tibatemwa challenged the belief that sexual offenses required greater caution in establishing evidentiary rules by highlighting research that does not support claims that women falsify stories of sexual assault and showing the discriminatory nature with which the cautionary rule has been applied (*Ntambala v. Uganda*, 2015, p.3). She used Ugandan and international case law, international human rights instruments, and social science to uphold her point that the cautionary rule violated the equal protection guaranteed in the Ugandan constitution (*Ntambala v. Uganda*, 2015).
- 2 *Purohit and Moore v. The Gambia* concerned an investigation in the definition of the term “lunatic,” the process of being found to be a “lunatic,” and the treatment thereafter of those found to be “lunatics.” The African Commission read into and interpreted its Article 16 concerning the right to health to determine the case (African Commission on Human and Peoples’ Rights, 2003, Part II (14)).
- 3 One collection of developing jurisprudence can be found on the website for the International Network for Economic, Social, and Cultural Rights (ESCR-Net, n.d.).
- 4 See cases decided by the African Commission on Human Rights, e.g., *Purohit and Moore v. The Gambia*, which discussed the right to health of mentally ill patients (African Commission on Human and Peoples’ Rights, 2003) and *SERAC and CESR v. Nigeria* discussing the implied rights to food and housing contained within the right to health (African Commission on Human and Peoples’ Rights, 2001).
- 5 The WHO report specifies the forms of abusive treatment, including “physical abuse, ... humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, [negligence of] women during childbirth to suffer life-threatening and avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay” (World Health Organization, 2015, p.1).
- 6 The 2001 Abuja Declaration was a pledge made by members of the African Union at a conference in Abuja, Nigeria, where member nations pledged to increase their health

budget to at least 15% of the state's annual budget and also requested Western donor countries to increase their support (Organization of African Unity, 2001, p.6).

- 7 The justices on the Constitutional Court were Honorable Lady Justice C.K. Byamugisha; Honorable Lady Justice A.E.N. Mpagi-Bahigeine; Honorable Justice S.B.K. Kavuma; Honorable Justice A.S. Nshimye; and Honorable Justice Remmy Kasule (*CEHURD v. Attorney General*, 2011, p. 1).
- 8 The justices serving on the Supreme Court were Honorable Lady Justice Esther Kisaakye; Honorable Lady Justice C.N.B. Kitumba; Honorable Justice G.M. Okello; Honorable Justice J.W.N. Tsekooko; Honorable Justice B.J. Odoki (former Chief Justice); Honorable Justice Jotham Tumwesigye; and Honorable Justice Bart M. Katureebe (current Chief Justice) (*CEHURD v. Attorney General*, 2013, p.1).
- 9 A lead judgment is the opinion of the court on a particular matter before it. There are three ways in which a judge may author a lead judgment: (i) they can nominate themselves; (ii) they can be nominated by the head of the court, especially when they have expertise in the area of law relevant to the case; and (iii) through normal scheduling, where each judge gets an equal share of work load before the court (L. Tibatemwa Ekirikubanza, personal communication, October 19, 2020).
- 10 Justice Barishaki Cheborion (lead judge), Justice Alfonse Owiny Dollo (Chief Justice), Justice Kenneth Kakuru, Justice F.M.S. Egonda Ntende, and Justice Christopher Madrama (*CEHURD v. Attorney General*, 2011).
- 11 The judge has an LLM in Human Rights and Intellectual Property Rights Law from Lund University, Raoul Wallenberg Institute, Sweden, together with the World Intellectual Property Organisation (WIPO) and another LLM in Human Rights and Democratization in Africa from the University of Pretoria Centre for Human Rights, South Africa.
- 12 Judge David Batema has a Master of Laws in Women's Law from University of Zimbabwe; Justice Esther Kisaakye, the lead judge in the appeal of *CEHURD v. Attorney General*, has a Master of Arts in Women's Rights from Georgetown University, United States; and a Doctor of Juridical Science from American University, United States.

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