Million flickering embers: A multidisciplinary analysis of child mortality in Uganda

Submitted in partial fulfilment of the requirements of the degree LLM (Human Rights and Democratisation in Africa)

By

Nkeiruka Adaobi Aduba

Prepared under the supervision of

Mr Samuel B. Tindifa

At the

Faculty of Law Makerere University, Uganda

31 October 2011

Plagiarism Declaration

I, _____**Nkeiruka Adaobi Aduba**_____ do hereby declare:

That I understand what plagiarism entails and am aware of the University's policy in this regard. That this dissertation is my own, original work. Where someone's work has been used (whether from a printed source, the internet or any other source) due acknowledgment has been given and reference made according to the requirements of the Faculty of Law. That I did not make use of another student's work and submit it as my own. That I did not allow anyone to copy my work with the aim of presenting it as his or her own work.

SIGNATURE: ____11368391_____

DATE **:** _____31 October 2011_____

Supervisor: Mr Samuel B. Tindifa

SIGNATURE:

DATE:

Dedication

In memory of the millions of children all over the world who have died from preventable diseases. And to give hope to those who confront death on a daily basis.

Acknowledgment

This dissertation would have been impossible without the support of my teachers, colleagues, friends and family. I am grateful to my supervisor Mr Samuel. B Tindifa of the Makerere University for his excellent guidance in writing this work. I would also like to thank the academic and administrative staff of the Makerere University.

I would like to thank Professor Michelo Hansungule for sharing his insight on the subject. I am also grateful to Professor Frans Viljoen and the Centre for Human Rights, University of Pretoria for the fantastic experience as a member of the LLM class of 2011.

To my colleagues and friends on the LLM Programme, it was wonderful learning with you and I am optimistic that our bonds of friendship will not be broken by distance and time.

I am immensely grateful to my family; my amazing Mum, Mrs Maureen Aduba whose prayers and constant encouragement kept me strong. My loving father, Professor Nnamdi Aduba for his constant support and my awesome brothers Chukwuemeka and Chike who made sure I felt their love from miles away. I would like to thank my wonderful god-mother, Mrs Kate Emuchay and my fabulous 'god-aunt' Emilia Onyema (PhD) for all your support. I love you all so much.

To my friends at home who encouraged me; Foluso, Chinwe, Gbolahan, Bukar, Chuka and all my lovely friends, 'You all rock!!' To my friends in Uganda, Godiva, Susan and Irene thanks so much.

Finally, I am eternally grateful to God for his boundless love and mercies. I am constantly overwhelmed by your love.

List of Abbreviations

ACHPR	African Charter on Human and Peoples' Rights
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti Retroviral Treatment
AUCPAIDP	African Union Convention for the Protection and Assistance of Internally Displaced Persons 2009
CEDAW	Convention for the Elimination of Discrimination Against Women
CRC	Convention on the Rights of the Child
DFID	Department for International Development
DPT-3	Diphtheria, Pertussis and Tetanus 3
FANTA-2	Food And Nutrition Assistance II Project
HIV	Human Immunodeficiency Virus
ICCPR	International Covenant on Civil and Political Rights 1966
ICESCR	International Covenant on Economic Social and Cultural Rights 1966
IDPs	Internally Displaced Persons
IHRL	International Human Rights Law
IMF	International Monetary Fund
MDG	Millennium Development Goal
NGO	Non-Governmental Organisation
NHP	National Health Policy
ORT	Oral Rehydration Therapy
ORS	Oral Rehydration Salts
SAPS	Structural Adjustment Programmes
UN	United Nations

UNDP United Nations Development Programme

UNICEF United Nations Children's Fund

UNMCHP Uganda National Minimum Health Care Package

USD United States Dollars

WHO World Health Organisation

Table of Contents

Chapter One

Introduction

1.1 Background of the study

The issue of child mortality is currently under international spotlight,[1] as the rates of neonatal and under five mortality are sobering. '[A]bout 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 one child in eight dies before age five.[3] As contained in the Millennium Development Goals (MDGs) 2010 report, in 2008, sub-Saharan Africa bore half of the 8.8 million deaths in children under five.[4]

The causes of child mortality have been attributed to four diseases, pneumonia, diarrhoea, malaria and AIDS which were responsible for 43% of all deaths in children under five.[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 analyses child mortality within sub-Saharan Africa. Its focus is specifically on the causes and rates of child mortality in Uganda. According to the United Nations Children's Fund (UNICEF),[7] in 2008, the leading causes of deaths in children under five in Uganda were malaria,[8] diarrhoea,[9] and pneumonia[10] with the deaths caused by HIV/AIDS and measles

[1]United Nations Millennium Development Goal 4: Reduce child mortality.
[2]United Nations Children's Fund (UNICEF) 'Millennium Development Goals 4. Reduce child mortality' http://www.unicef.org/mdg/childmortality.html (accessed 14 June 2011).
[3] United Nations Inter-agency Group for child mortality estimation 'Levels and trends in child mortality: Report 2010'(2010) 1: http://www.childinfo.org/files/Child_Mortality_Report_2010.pdf (accessed 14 June 2011).
[4]UN 'The Millennium Development Goals Report'(MDG Report 2010) (2010) 27.
[5] As above.
[6] As above.
[7] UNICEF 'Country profile Uganda: Maternal, newborn and child survival' http://www.unicef.org/esaro/ACSD_Profile_003UGA_Uganda_2011.pdf (accessed 14 August 2011).
[8] 22%.
[9] 16%.
[10] 12%.

constituting a smaller fraction. However it was also noted that neonatal mortality formed a huge part of child mortality as 24% of deaths in children under five were neonatal.

Another factor which plays a key role in child mortality in Uganda is the level of malnutrition affecting children under five 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 consequently leading to a rise in the rate of malnutrition.[12] Furthermore, Uganda is struggling with reducing its rates of malnutrition and decreasing the number of children under five years who are underweight.[13] According to the World Health Organisation (WHO), 38 % of children under five 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 global deaths in children under five 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, head of the Mwanamugimu Nutrition Unit; 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 five years'.[18] 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.[19] Additionally, the Mulago hospital is confronted by a shortage of drug supplies and staff which it is currently tackling.[20] Generally the health

[11] EK Matsamura 'Infant mortality: "Uganda's children are not feeding well" '*The Observer* 10 October 2010 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] FANTA-2 'The analysis of the nutrition situation in Uganda' (FANTA-2 Report)(2010)1.
[13] As above.
[14] UNICEF 'Uganda statistics' http://www.unicef.org/infobycountry/uganda_statistics.html (accessed 14 August 2011).
[15] UNICEF Maternal, newborn and child survival (n 7 above).
[16] E Lirri 'Mulago hospital struggles with malnourished children' *The Monitor* 24 April 2010 http://allafrica.com/stories/201004260894.html (accessed 14 August 2011).
[17] As above.
[18] As above.
[19] As above.
[20] As above.

system in Uganda is weighed down by lack of drugs, medical supplies and inadequate personnel.[21]

In order to reduce child mortality in Africa, immunisation must be extensively embarked on.[22] This is an issue for Uganda, in 2008 it was one of the ten countries in Africa where large numbers of infants were not given the diphtheria, pertussis and tetanus vaccine (DPT3).[23] Also in 2009, Uganda's measles immunisation rate of 81% fell below its national goal of 90%.[24] 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 five years and an infant mortality rate of 88 deaths per 1000 live births.[25] In 2009, Uganda's under five mortality rate dropped to 128, and its infant mortality rate was 79.[26] 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.[27] However child mortality 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.[28]

In Uganda certain regions have higher mortality rates, it was reported that the under five mortality rates in Northern Uganda in 2009 was 177 and its infant mortality rate 106 deaths in 1000 births, this is much higher than the collective nationwide statistics.[29] According to UNICEF there is 'an acute child survival crisis' in the sub region of Karamoja.[30]

---

[21] African Peer Review Mechanism 'Republic of Uganda: APRM country review report no.7' (2009) para 992.
[22] UNICEF 'Progress for children: Achieving the MDGs with equity' (2010) 24.
[23] As above.
[24] Ministry of Finance, Planning and Economic Development 'Millennium Development Goals Report for Uganda 2010'(MDGs Report for Uganda) (2010) 21.
[25] MDGs Report for Uganda (n 24 above) 20.
[26] UNICEF Uganda statistics (n 14 above).
[27]RE Black et al 'Where and why are 10 million children dying every year?'(2003) 361 *Lancet* 2227.
[28] As above.
[29] UNICEF Humanitarian action Uganda in 2009 http://www.unicef.org/har09/files/har09_Uganda_countrychapter.pdf (accessed 22 August 2011).
[30] As above.

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 Economic, Social and Cultural 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.

1.2 Statement of the problem

Uganda's international commitment[31] to dedicate 15% of its budget to the health sector has failed[32] and it is making very slow progress in reducing child mortality.[33] According to the National Development Plan, Uganda's health standards are poor even in comparison with sub-Saharan African standards.[34] The health sector continues to face challenges of inadequate staff.[35] In 2002, the ratio of doctors to patients was 1: 24,752, and for nurses 1: 1,634.[36] This has a detrimental effect on the health service delivery.[37] Thus despite the fact that more health facilities have been built by the government, health service delivery is still poor.[38]

According to Uganda's 2010 Health Profile there are variations in infant and under five 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%.[39]

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

[31] Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases 2001.
[32] The African Child Policy Forum 'Budgeting for children in Africa: Rhetoric, reality and the scorecard' (2011) 6.
[33] MDGs report for Uganda (n 25 above).
[34] The Republic of Uganda 'National Development Plan 2010/11– 2014/15' (National Development Plan) para 62.
[35] National Development Plan (n 34 above) para 100.
[36] As above.
[37] As above.
[38] National Development Plan (n 34 above) para 610.
[39] Globalhealth at MIT 'Country briefing: Uganda –health' http://globalhealth.mit.edu/home/uganda-health/ (accessed 27 August 2011).

serving only 12% of the Ugandan population'.[40] According to African Medical and Research Foundation (AMREF) Uganda '13% of people do not seek medical attention because they can't afford it or reach clinics.'[41] These facts paint a bleak picture for child survival in rural areas.

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 combines analysis of child mortality from a human rights lens as it relates to Uganda's international obligations to guarantee the right to health and life. And it also examines how the progress towards other MDGs, which is a development perspective, affects the attainment of MDG 4 reducing child mortality.

1.3 Scope of the study

This study is multi disciplinary in nature as most studies have not looked at the issue from the combined perspectives of medicine, demography, development and human rights. This is necessary to provide a holistic view and understanding of child mortality in Uganda and as such information on different districts in the country has been examined.

1.4 Objectives of the study

This study examines the factors that influence child mortality and challenges faced in sustaining child survival in Uganda. It also analyses the existing health services, laws and policies targeted at addressing child mortality.

1.5 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?

[40]A Kelly 'Healthcare a major challenge for Uganda' *The Guardian* 1 April 2009 http://www.guardian.co.uk/katine/2009/apr/01/healthcare-in-uganda (accessed 27 August 2011).
[41]AMREF 'Our work in Uganda' http://www.amref.org/where-we-work/our-work-in-uganda/ (accessed 27 August 2011).

- Does the failure to achieve other MDGs affect the attainment of MDG 4?
- How effective are national laws and policies on health in addressing the issue of child mortality?

1.6 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[42] 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 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.[43] Studies have also focused on infant and child morbidity rates in specific hospitals. Some researchers[44] have considered the prevalence of diseases among children under the age of five years at the Mulago hospital against their social backgrounds in order to proffer suggestions for the reduction of such illnesses. Nassali[45] 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[46], the UN analysed the issue of child mortality from the medical and development perspectives basically stating the causes of child mortality and the need to redirect efforts towards combating diseases like pneumonia,

[42] Unpublished: A Kabagenyi 'Household characteristics and child mortality in Uganda' unpublished master's thesis, Makerere University 2006.
[43] Unpublished: PI Hadoto 'An assessment of the factors contributing to child mortality in Northern Uganda (1997-2002)' unpublished master's thesis, Makerere University 2009.
[44] Unpublished: N Amuge 'Infant and child morbidity in Mulago hospital' unpublished undergraduate thesis, Makerere University 1997.
[45] Unpublished: HB Nassali 'The effect of malaria on child mortality rates: A case study of Naguru health centre in Nakawa division 2001-2006',unpublished undergraduate thesis, Makerere University, 2007.
[46] 2010.

diarrhoea, malaria and AIDS.[47] It has stressed the need to ensure proper nutrition in order to reduce the susceptibility to these life threatening diseases.[48] It examines the progress on the reduction of child mortality and has highlighted the regions which are lagging behind which includes sub–Saharan Africa.[49] Other reports[50] 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[51] have stressed the importance of equity in the reduction of child mortality strategies. The African Report on Child Wellbeing 2011[52] 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 the underlying human rights dimension of this important issue and also discover if the existing national laws are adequate, an area which has not received much attention.

1.7 Research methodology

The research methodology is comprised of library based research and depended to a great extent on internet based resources, as research on child mortality is an issue which requires the most recent facts. It also involved an in- depth analysis of statistics and reports.

1.8 Limitations of the study

In writing a thesis on child mortality, the challenges the researcher encountered relate to the fact that this topic is multi disciplinary in nature. It is based on medical, demographic and sociological research within a human rights context of enforcement, protection, promotion and monitoring of Uganda's obligations under

[47] UN MDG report 2010 (n 4 above) 27.
[48] As above.
[49] As above.
[50] United Nations Inter-agency Group for Child Mortality Estimation 'Levels and trends in child mortality report 2010'.
[51] Save the Children 'A fair chance at life: Why equity matters for child mortality'(2010).
[52] By the African Child Policy Forum.

children's right to health and life and other related human rights. As a result most of the information found is partly legal and mostly sociological.

This study also had time limitations and its focus areas were restricted to certain districts in Uganda. There were also challenges in obtaining information from the relevant government ministries.

1.9 Overview of chapters

This thesis consists of four chapters. Chapter one basically sets out the objectives, the research question, and methodology. Chapter two discusses 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 examines the national and international legal and policy framework under which the relevant human rights related to the issue will be examined. Chapter four discusses the challenges of reducing child mortality, concludes and makes recommendations on the subject.

Chapter Two

The reality of child mortality in Uganda

2 Introduction

This chapter discusses the major causes of child mortality in Uganda and examines the link between child mortality and the MDGS. In other words it assesses the interdependence of child survival on factors such as access to safe water and sanitary facilities, girl child education amongst others.

2.1 Causes of child mortality in Uganda

Prior to examining the causes of child mortality in Uganda, definitions of infant mortality rate, under five and neonatal mortality must be considered. According to 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.'[53] 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'.[54] Under five 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'.[55] 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.'[56] Child mortality in this thesis includes infant mortality rates, neonatal mortality and under five mortality rates.

According to WHO, the under five mortality rate for Uganda in 2008 was 135 deaths per 1000 live births falling from 158 in 2000 and 186 in 1990.[57] 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.[58] Some progress has been made in reducing

[53] World Health Organisation (WHO) 'Health status statistics: Mortality: Neonatal mortality rate (per 1000 live births)' http://www.who.int/healthinfo/statistics/indneonatalmortality/en/ (accessed 20 September 2011).
[54] As above.
[55] WHO 'Health status statistics: Mortality: Probability of dying (per 1000) under age five years (under-5 mortality rate)' http://www.who.int/healthinfo/statistics/indunder5mortality/en/ (accessed 20 September 2011).
[56] UNICEF 'Definitions: basic indicators' http://www.unicef.org/infobycountry/stats_popup1.html (accessed 20 September 2011).
[57] WHO 'World health statistics'(2010) 55.
[58] As above.

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.[59] However this progress is slow and intensive efforts must be made by Uganda to halve its present under five 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 %.[60] It has been shown that in order to attain MDG 4 Uganda's progress must be an 'average annual rate of reduction … between 2004 and 2015 [of] 8.6.'[61] The difference between the needed progress rate and the actual rate of reduction is wide which clearly reveals slim prospects for the attainment of MDG 4 and that current efforts must be escalated and fast if considerable progress is to be made.

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.[62] However it provides a detailed breakdown of the causes of mortality in children under five years in Uganda as follows ; HIV/AIDS - 5% Diarrhoea - 16% Measles - 2% Malaria - 22%, Pneumonia - 14% , prematurity - 7% , Birth asphyxia- 7%, Neonatal sepsis- 5%, Congenital abnormalities - 2%, injuries - 4% and other causes - 16%.[63]

A comparison of the major causes of child mortality in Uganda, malaria, diarrhoea and pneumonia reveals similarities in global[64] and regional causes of child mortality. It has been noted that the highest percentages of child deaths due to malaria are in Africa.[65] Also in 2008, malaria, diarrhoea and pneumonia constituted 52% of under five mortality in the African region.[66]

The levels of child mortality due to malaria, pneumonia and diarrhoea in Uganda can be directly linked to insufficient coverage of available health interventions.

[59] UNICEF Maternal, newborn and child survival (n 7 above).
[60] WHO and UNICEF 'Countdown to 2015 decade report (2000-2010) with country profiles: taking stock of maternal, newborn and child survival'(WHO and UNICEF countdown to 2015 decade Report) 9.
[61] J Bryce et al 'Countdown to 2015: tracking intervention coverage for child survival' (2006) 368 *Lancet* 1071.
[62] WHO Health statistics (n 57 above) 59.
[63] WHO Health statistics (n 57 above) 69.
[64] WHO and UNICEF Countdown to 2015 decade report (n 8 above) 11.
[65] Global health opportunities: Understanding child health http://www.globalhealth.org/images/pdf/gho/2009_ch_understanding.pdf (accessed 21 September 2011)
[66]United Nations Economic Commission for Africa (ECA),the African Union Commission (AUC), the African Development Bank (AfDB) and the United Nations Development Programme- Regional Bureau for Africa (UNDP-RBA) 'Assessing Progress in Africa toward the Millennium Development Goals' (2010) 30.

According to WHO, from 2000-2008, in Uganda only 9% of children under five years slept under insecticide treated nets and 61% of children in the same period received treatment with anti malarial drugs.[67] According to the Demographic Health Statistics 2006, the total level of antibiotic use for pneumonia was 47% and the total percentage of children receiving 'diarrhoeal treatment– ORT and continued feeding' was 39%.[68] 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 associated with nutrition. Poor nutrition increases 'the morbidity burden among children' although its impact is not uniform in all illnesses.[69] It has been shown that children who are undernourished are more prone to infectious diseases like pneumonia, diarrhoea and malaria.[70] Furthermore due to the connection between illness and malnutrition, children who are undernourished are at higher risk of dying from infectious diseases.[71] 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.'[72] According to the Uganda Child Survival Strategy, malnutrition forms the proximate and ancillary cause of about 60% of child mortality in Uganda.[73] It is evident that in order to improve child survival and attain MDG 4 the rates of malnutrition must be substantially lowered.[74]

More bleak statistics on malnutrition are revealed by Food and Nutrition Technical Assistance II Project (FANTA-2) which has shown that '[m]alnutrition starts before birth for children in Uganda'.[75] Estimates show that 11% of children are stunted at birth and 16% of children have low body weights for their heights at birth.[76] It must be noted here that the rates of stunting vary across the different regions in the country with the highest numbers in Karamoja and then in the Southwest and

[67]WHO Health statistics (n 57 above) 95.
[68] UNICEF Maternal, newborn and child survival (n 7 above).
[69] LE Caulfield et al; 'Undernutrition as an underlying cause of child deaths associated with diarrhoea, pneumonia, malaria and measles' (2004) 80 *American Journal of Clinical Nutrition* 197.
[70] As above.
[71] As above.
[72] FANTA-2 Report (n 12 above) 1.
[73] Ministry of Health 'Child Survival Strategy for Uganda – 2008-2015 Draft' (2009) quoted in FANTA-2 (n 12 above) 2.
[74] FANTA-2 Report (n 12 above) 2.
[75] FANTA-2 Report (n 12 above) 8.
[76]As above.

North regions.[77] 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 five years.[78] 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…'[79]

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. It should also be noted here that past Structural Adjustment Programmes (SAPs) of the International Monetary Fund (IMF) and the World Bank had a negative impact on the livelihoods of the population as general health indicators such as malnutrition rates in children did not reduce.[80] Also, the introduction of the policy of cost sharing, due to IMF requirements and debt payments 'where patients are expected to pay for a portion of their health care… led to less access for the poor to health care.'[81]

2.2 The link between child mortality and 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 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.

[77] FANTA-2 Report (n 12 above) 9.
[78] As above.
[79] As above.
[80] R Naiman & N Watkins 'A survey of the impacts of IMF structural adjustment in Africa: growth, social spending, and debt relief' (1999) http://www.cepr.net/index.php/a-survey-of-the-impacts-of-imf-structural-adjustment-in-africa/ (accessed 21 September 2011).
[81] As above.

2.2.1 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.'[82] 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.[83]

Uganda also produces adequate food for its needs, nevertheless its nationwide food supply is unequal and dependent on many factors including poverty and climate.[84] It must be noted that despite improvement in the national indicators on the number of people suffering from hunger,[85] there are still high levels of malnutrition among children under five years and the reduction in the percentage of underweight children under five years has been little, 'between 1995 and 2006, from 27 to 20 percent.'[86] According to FANTA-2, Uganda will not substantially reduce hunger and malnutrition by 2015 and its gains in poverty reduction have no direct effect on eliminating malnutrition.[87]

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.'[88]

2.2.2 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.[89] From 2000 - 2008, it was found

[82] B Gordon et al *Inheriting the world: The atlas of children's health and the environment* (2004) 10.
[83]MDGs Report for Uganda (n 24 above) 13-14.
[84]FANTA-2 Report (n 12 above) 1.
[85]MDGs Report for Uganda (n 24 above) 16.
[86] FANTA-2 Report (n 12 above) 1.
[87]As above.
[88] FANTA-2 Report (n 12 above) iv.
[89]United Nations 'The Millennium Development Goals Report' (2011) 26.

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.[90] Also '[a] child's chances of surviving increase even further if their mother has a secondary or higher education'.[91] 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.[92] 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.'[93] While the rates for children whose mothers were better educated with secondary school or more were '34 per 1,000 lower.'[94]

Uganda has made good progress in increasing enrolment in primary education 'from about 2.7 million in 1996 to 8.2 million in 2009'[95] 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.[96] It has been found that in Uganda a large number of girls failed to complete primary school and also that from 1997 to 2006, just 11% of the girls who completed primary school enrolled for secondary school.[97] 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. The estimates have been put at one death per 1,000 less for children whose mothers did not complete primary school.[98]

Generally, there is evidence that 'educated women tend to marry later and to have their first births later.'[99] 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

[90] As above.
[91] As above.
[92] S Ssewanyana SD Younger 'Infant mortality in Uganda: determinants, trends and the Millennium Development Goals' (2007) 17 *Journal of African Economies* 40.
[93] Ssewanyana & Younger (n 92 above) 46.
[94] As above.
[95] MDGs Report for Uganda (n 24 above) 17.
[96] MDGs Report for Uganda (as above).
[97] Unpublished: NL Okella 'The determinants of persistent child mortality trend in Uganda' unpublished master's thesis, Maastricht Graduate School of Governance, 2009 26.
[98] Ssewanyana & Younger (n 92 above) 53.
[99] J Hobcraft 'Women's education, child welfare and child survival: a review of the evidence' (1993) 3 *Health Transition Review* 161.

more vulnerable to 'excess mortality risks' related to early childbearing and also late childbearing.[100]

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.[101]

2.2.3 Child mortality and gender equality

The promotion of gender equality and the empowerment of women is MDG 3,[102] 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 Declaration and Platform for Action and also has national policies such as the Uganda Gender Policy to ensure equal participation of women in the different aspects of development.[103]

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.[104] Women still face challenges in accessing credit facilities in the agricultural sector and this is where their services are predominantly engaged.[105] 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.[106]

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

[100] Hobcraft (n 99 above) 162.
[101] United Nations Educational, Scientific and Cultural Organisation (UNESCO), UNICEF, The Government of Qatar & Save the Children International 'The central role of education in the Millennium Development Goals' (2010) 12- 13.
[102] UN Millennium Project: About the MDGs: What they are http://www.unmillenniumproject.org/goals/index.htm (accessed 21 September 2011).
[103] MDGs Report for Uganda (n 24 above) 19.
[104] As above.
[105] Ministry of Finance, Planning and Economic Development 'Gender inequality in Uganda: the status, causes and effects.' Discussion Paper (Gender inequality in Uganda)(2006) 16. See also the MDGs Report for Uganda , which states that women form approximately 70% of the workforce in the agricultural sector, 19.
[106] Gender inequality in Uganda (n 105 above) 19.

by society on male children, are in constant competition to produce male heirs.[107] 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.[108] 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.[109] 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', and the loss of a mother has been linked to reduced chances of child survival.[110]

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.[111] 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.[112]

2.2.4 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 five is related to poor maternal health and nutrition as well as the quality of care received at delivery and during the newborn period.'[113] In addition, the increased deaths in new born children have been connected to maternal health and survival.[114] 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

[107] Gender inequality in Uganda (n 105 above) 24.
[108] See Gender inequality in Uganda (n 105 above) 30. Here it was shown that 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.
[109] Gender inequality in Uganda (n 105 above) 31.
[110] As above.
[111] D Abu- Ghaida & S Klasen 'The costs of missing the Millennium Development Goal on gender equity' (2002) 7.
[112] As above.
[113] UNICEF 'Millennium Development Goals 5. Improve maternal health' http://www.unicef.org/mdg/maternal.html (accessed 8 October 2011).
[114] WHO and UNICEF countdown to 2015 decade Report (n 56 above) 7.

parents, and motherless children are likely to receive less health care and education as they grow up.'[115]

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.[116] Based on the above facts, Uganda's maternal mortality ratio hinders the reduction in child mortality rates. An improvement in maternal survival will be 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.[117] Advances must be made in maternal health in order to positively affect child survival in Uganda.

2.2.5 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.[118] 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.[119]

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.[120] 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.'[121] HIV/AIDS was identified as the cause of 5% of the under five deaths in 2008.[122]

---

[115] IM Kamrul & UG Gerdtham 'The costs of maternal-newborn illness and mortality' (2006) 14.
[116] MDGs Report for Uganda (n 24 above) 22.
[117] MDGs Report for Uganda (n 24 above) 23.
[118] Millennium Development Goals Goal 6: Combat HIV/AIDS, malaria and other diseases http://www.un.org/millenniumgoals/aids.shtml#mdgs (accessed 7 October 2011).
[119] As above.
[120] H Brahmbhatt et al 'Mortality in HIV- infected and uninfected children of HIV-infected and uninfected mothers in rural Uganda' (2006) 41 *Journal of Acquired Immune Deficiency Syndrome* 507.
[121] As above.
[122] UNICEF Maternal, newborn and child survival (n 7 above).

It is clear 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.'[123] On a positive note, gains are being made in improving access to Anti - Retroviral Therapy (ART) to people in need.[124] 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 one million people yearly and children under the age of five years are particularly affected with daily mortality rates of about 3,000.[125] Malaria also causes maternal mortality and low birth weight in infants in sub-Saharan Africa.[126] According to the World Malaria Report 2008, 'Uganda had an estimated 10.6 million malaria cases in 2006.'[127] 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.[128] 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.[129] 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.[130]

Nevertheless, more progress needs to be made in the execution of preventive interventions and access to anti malarial drugs increased to ensure that children who require treatment receive it. Statistics show that 'less than 30% of children who needed treatment in 2005/2006 received treatment with appropriate anti

[123] MDGs Report for Uganda (n 24 above) 25.
[124] As above.
[125] UNICEF 'Malaria a major cause of child death and poverty in Africa' (UNICEF: Malaria and child death) (2004) 1. See also J Sach & P Malaney 'The economic and social burden of malaria' (2002) 415 *Nature* 682.
[126] As above.
[127] WHO 'World Malaria report 2008' 120.
[128] DFID 'Malaria: country profiles version 1.1' (DFID profile version 1.1)(2011) 99.
[129] DFID profile version 1.1 (n 128 above) 102.
[130] MDGs Report for Uganda (n 24 above) 28.

malarial drugs.[131] It has been found that the use of insecticide treated nets can halve the transmission of malaria and cut down child mortality by 20%.[132] 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.

2.2.6 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 five years reduced globally in 2008 due to interventions such as oral rehydration salts (ORS) treatment and enhanced access to safe water and sanitation.[133] However, there is evidence to prove that diarrhoea is one of the major causes of child deaths in Africa'[134] and still remains one of the main causes of under five mortality in Uganda.[135]

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%.[136] 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 2008, the percentage of urban population using improved drinking water sources was 91% whereas the rural population was 64% and the combined percentage of population using safer water was 67%[137] On the other hand the population rates for the use of improved sanitation is lower on the whole at 38% with the rural population enjoying better sanitation at 49% than the urban population at 38%.[138] 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.[139] In Karamoja 'only 30 percent

[131] As above.
[132] UNICEF: Malaria and child death (n 125 above) 3.
[133] CLF Walker et al 'Scaling up diarrhea prevention and treatment interventions: a lives saved tool analysis' (2011) 8 *PLoS Medicine* 2.
[134]RE Black R et al 'Global, regional, and national causes of child mortality in 2008: a systematic analysis' (2010) 375 *Lancet* 7.
[135] WHO Health statistics (n 57 above) 69.
[136] WaterAid Biggest killer of children in Africa cannot be addressed without sanitation and water http://www.wateraid.org/documents/wa_african_union_2pp_proof_2.pdf (accessed 7 October 2011).
[137] WHO Health statistics (n 57 above) 108.
[138]As above.
[139] UNICEF Humanitarian action Uganda (n 29 above).

of Karamajong have access to safe water' and just 2% access to improved sanitation,[140] 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.[141] Improved sanitation has been shown to have a diminishing effect on other causes of child mortality such as pneumonia and under nutrition.[142] 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.[143] Furthermore, research has shown that there are even more public health gains to be made from improved sanitation than improved access to water.[144] 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 four 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.

[140] As above.
[141] I Gunther & G Fink 'Water, sanitation and children's health: Evidence from 172 DHS surveys' (2010), 30.
[142] WaterAid Biggest killer of children in Africa cannot be addressed without sanitation and water (n 135 above).
[143] Gordon et al (n 82 above) 20.
[144] Gunther & Fink (n 141 above) 30.

Chapter Three

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

3 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 discusses 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 looks at the existing rights to life and the right to the highest attainable standard of health at the international, regional and national levels. It also examines some key policies created to address the problem of child mortality.

3.1 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. It is also important to note that hampering or impeding 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 on Civil and Political Rights 1966 (ICCPR)[145] provides for the inalienable right to life existent in every person which cannot be divested

[145] Uganda acceded to the ICCPR on 21 June 1995. United Nations Treaty Collection International Covenant on Civil and Political Rights http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-4&chapter=4&lang=en (accessed 26 October 2011).See also General Comment No. 31 which emphasizes the importance of state parties fulfilling their obligations under the ICCPR.

and which must be protected by law.[146] 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.[147] 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.[148]

The word 'desirable' implies that this is the 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 international instruments.[149] 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)[150] is regarded as 'the central instrument of protection for the right to health'.[151] Article 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.

---

[146] Art 6. Also, the right to life is provided for alongside liberty and security of person in art 3 of the Universal Declaration of Human Rights 1948.
[147] Human Rights Committee, General Comment No 6, the right to life, art 6, 16th session 1982 , para 5.
[148] As above.
[149] See art 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination(1965), arts 28, 48(e) & 45(c) the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families(1990), art 25 of the Convention on the Rights of Persons with Disabilities (2006).
[150] Uganda acceded to the ICESCR on 21 January 1987. United Nations Treaty Collection International Covenant on Economic, Social and Cultural Rights http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en (accessed 26 October 2011).
[151] Office of the United Nations High Commissioner for Human Rights(OCHCR) & WHO 'The Right to Health: Fact sheet No.31'(2008) 9.

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.'[152]

The Convention on the Rights of the Child 1989 (CRC)[153] 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'.[154] Article 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'.[155]

It must be noted that while Article 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 genres of rights.[156] In other words, the fulfilment of children's rights should not be limited by the fact that they are economic and social rights. While economic and social rights are not justiciable in many 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 legal sanctions are not always available.'[157]

[152] Committee on Economic, Social and Cultural Rights, General Comment No 14, 22nd session 2000, para 14.
[153] Uganda ratified the CRC on 17 August 1990.
[154] Art 6(1).
[155] Art 24(1).
[156] A Eide & WB Eide *Article 24 the right to health* (2006) para 7.
[157] A Eide & WB Eide (n 156) para 9.See also art 26 of the Vienna Convention on Law of Treaties which obliges state parties to implement their duties in good faith.

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;[158] 'provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care.[159]

Article 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.[160] It recognises the importance of the provision of proper maternal health care[161] 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.[162]

Article 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'[163]. The state also has duties to ensure that it puts in place precautionary health care services for families.[164]

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.[165] The CRC also recognises the importance of international partnership in ensuring the achievement of the right to health especially for developing countries.[166]

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'.[167] The importance of equity in health

[158] Art 24(2)(a).
[159] Art 24(2)(b).
[160] Art 24(2)(c).
[161] Art 24(2)(d).
[162] A Eide & WB Eide (n 156 above).
[163] Art 24(2)(e).
[164] Art 24(2)(f).
[165] Art 24(3).
[166] Art 24(4).
[167] Para 22 General Comment No 14.

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.[168] In other words, equity in health services implies that every child irrespective of social background should have access to health care. The application of principles of equity, non discrimination and dignity are vital to the realisation of the right to health.[169]

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 fulfilment of states obligations under the CRC and its optional protocols.[170] State parties 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.[171] Uganda has submitted two state party reports[172] 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.[173]

A key instrument in the promotion of child survival is the United Nations Millennium Declaration which was adopted by all member states of the United Nations in 2000 to address global issues of poverty and inequality.[174] The Millennium Declaration sets out Millennium Development Goals (MDGs) that includes as one of its targets, the reduction of child mortality,[175] state parties report on their progress towards attaining these goals.[176] The MDGs have however been criticised by the former Special Rapporteur for the Right to the highest attainable

[168] Global Health Council 'Health equity for the world's children would save millions of lives' http://www.globalhealth.org/images/pdf/publications/child_health_equity.pdf
[169] A Eide & WB Eide (n 156 above) para 9.
[170] OCHCR 'Committee on the Rights of the Child: monitoring children's rights' http://www2.ohchr.org/english/bodies/crc/ (accessed 26 October 2011).
[171] As above.
[172] Uganda's initial report was due in 1992 however it was submitted in 1996. Its subsequent report was also a late submission in 2003.
[173] A Lloyd 'Evolution of the African Charter on the Rights and Welfare of the Child and the African Committee of Experts: raising the gauntlet' (2002) 10 *International Journal of Children's Rights* 182.
[174]United Nations Development Programme (UNDP) 'The Millennium Development Goals: Eight goals for 2015' http://www.beta.undp.org/undp/en/home/mdgoverview.html (accessed 26 October 2011).
[175]United Nations Millennium Declaration 2000 para 19.
[176] UNDP 'What are the Millennium Development Goals?' http://www.undp.org/mdg/basics.shtml (accessed 26 October 2011).

standard of health, Paul Hunt, as not taking into cognisance the connection between health, human rights and development.[177]

The General Assembly of the UN has since its Millennium Declaration resolved to create 'a world fit for children' recognising the challenges 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. [178]

3.2 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).[179] The Children's Charter is an innovative treaty and it has been described as 'the most progressive of the treaties on the rights of the child.'[180] Article 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'.[181]

Under the Children's Charter, every child has 'the right to enjoy the best attainable state of physical, mental and spiritual health'[182] It also includes state parties obligations to fulfil this right by taking steps to 'reduce the infant and child mortality rate;'[183] 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,[184] adequate nutrition,[185] and 'combat[ing] disease and malnutrition'[186] and other essential elements of health. Like the CRC, the Children's Charter also states the importance of catering for maternal health care as it is vital

[177] Human Rights Council, Report of the Special Rapporteur on the right to the highest attainable standard of health 'Promotion and protection of all human rights, civil, political, economic, social and cultural rights including the right to development (A/HRC/7/11/Add.2),11.
[178] UN General Assembly Resolution A/RES/S-27/2.
[179] Uganda ratified the Charter on 17 August 1994.
[180] 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.
[181] Art 5(2).
[182] Art 14(1).
[183] Art 14(2)(a).
[184] Art 14(2)(b).
[185] Art 14(2)(c).
[186] Art 14(2)(d).

to children's health.[187] It reiterates provisions of the CRC on the duty of states to provide relevant health information and support to communities and families.[188] The Children's Charter obliges state parties to involve other stakeholders in creating and running of 'basic services programmes for children'.[189] 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.[190]

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.[191] State parties are obliged to submit reports on the steps they have taken to implement the Children's Charter.[192] 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.[193] 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,[194] whose goal is 'to contribute to Africa's socio-economic 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.'[195] 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.[196] As regards child mortality, the

[187] Art 14(2(e).
[188] Art 14(h).
[189] Art 14(i)
[190] Art 14(j).
[191] Art 42(b) ACRWC.
[192] Art 43.
[193] Guidelines for the consideration of communications of the African Committee of Experts on the Rights and Welfare of the Child chapter 1 art 1(1) http://caselaw.ihrda.org/doc/acerwc_comm/view/ (accessed 26 September 2011).
[194] African Union 'Africa Health Strategy 2007-2015' http://www.africa-union.org/root/UA/Conferences/2007/avril/SA/9-13%20avr/doc/en/SA/AFRICA_HEALTH_STRATEGY.pdf (accessed 26 October 2011).
[195] Africa Health Strategy 2007-2015 (n 194 above) para 26.
[196] Africa Health Strategy 2007-2015 (n 194 above) para 6.

strategy states that due to the few causes of under five mortality, good progress may be made through targeted efforts.[197] It calls for integrated projects which will target more than one disease[198] 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.[199]

A principal regional commitment which is relevant to the right to health is the AU's Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases which acknowledges the devastating effect of these diseases on the continent and the role that socioeconomic factors like poverty, malnutrition and underdevelopment play in its spread.[200] Of great relevance is the commitment to allocate at least 15 % of a state party's total annual budget to the reformation of its health sector.[201] This shows the importance attached by the AU to the right to health and its implementation.

In addition, the AU has recognised that the fulfilment of the right to health includes access to essential medicines. It thus adopted the Resolution on Access to Health and needed Medicines in Africa which emphasizes that states have duties to ensure the availability, affordability and accessibility to essential medicines which are vital to living a 'healthy and dignified life'.[202] These declarations are important because by calling on states to increase allocations to the health sector and to provide access to essential medicines, the AU reemphasizes the states obligation to guarantee the realisation of the right to health for all its citizens.

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 2009 (AUCPAIDP). 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.[203] The AUCPAIDP places

[197] Africa Health Strategy 2007-2015 (n 194 above) para 98.
[198] As above.
[199] Africa Health Strategy 2007- 2015 (n194 above) para 108.
[200] Para 4.
[201] Abuja Declaration on HIV/AIDS, Tuberculosis and other related infectious diseases 2001, para 26.
[202] Adopted at the 44th Ordinary session 2008.
[203] Military: Uganda civil war http://www.globalsecurity.org/military/world/war/uganda.htm (accessed 12 October 2011).

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).[204] 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.[205] 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.

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

The constitution of Uganda[206] provides for the right to life in a negative sense, Article 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…

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…'[207]

Nevertheless Article 45 of the constitution provides that

> the rights, duties, declarations and guarantees relating to the fundamental and other human rights and freedoms specifically mentioned in this Chapter shall not be regarded as excluding others not specifically mentioned.

Considering the above provision, it can be said that the right to health relates to the explicitly provided right to life and can therefore be included in the guaranteed rights and is therefore justiciable. A counter argument may be raised for the non justiciability of the right to health despite Article 45 on the basis of the fact that aspects of the right to health have been captured in the National Objectives and Directive Principles of State Policy and thus cannot be construed as rights as

[204] Art 9(2)(b).
[205] Art 9(2)(c). See also the National Policy for Internally Displaced Persons 2004 which also refers to children as a vulnerable group who are entitled to protection.
[206] 1995.
[207] Art xiv.

contemplated by Article 45. In determining whether the right to health is justiciable under Article 45, the court should adopt a generous interpretation by giving a broad meaning to the right to life which is dependent on access to quality health care and health facilities. Therefore the right to health though not explicitly mentioned is one of the rights implicitly considered by Article 45. It is thus justiciable.

However under the rights of children,[208] 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[209] 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.[210] 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. According to the Children's Act;

(1) It shall be the duty of a parent, guardian or any person having custody of a child to maintain that child and, in particular, that duty gives a child the right to … immunisation … and medical attention.[211]

These provisions seem to shield the state from its responsibilities as the fulfilment of these rights are accessed through the parents firstly and the state as a secondary resort. These provisions are disappointing considering that Uganda had ratified the CRC and the Children's Charter prior to the enactment of 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.[212]

[208] Art 34.
[209] Chapter 59 (1997) Laws of Uganda.
[210] UNICEF & FIDA Uganda 'Collection of children laws: A simplified handbook on international and national laws and policies on children'(2011) 12.
[211] Sec 5.
[212] As above.

Another 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.[213] 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.[214] 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 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 imposes a duty on the state 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.[215] Cases concerning child care and protection are to be handled by the family and children's court.[216]

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 Article 34(3) of the constitution of Uganda which states that '[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.'

[213] A Eide & WB Eide(n 156 above) para 17.
[214] Sec 10 Children's Act (1997).
[215] Sec 11 Children's Act (1997).
[216] Sec 14(b).

While this provision makes up for the lack of a non discrimination clause in the Children's Act, it fails to include a very important factor which deprives children of medical treatment, the lack of money to pay for treatment. This raises the argument on whether health services for children should be made free of charge. It is one which was debated during the preparatory process of the CRC and is contained in the *travaux prepartoires*.[217] 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.'[218] 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.[219] 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.'[220]

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.[221] 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.

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 Article 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.[222] 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,[223] the realisation of the right to health of its citizens appears not to be a top priority of the state.

---

[217] S Detrick *The United Nations Convention on the Rights of the Child: A guide to the 'Travaux Preparatoires'* (1992) 343- 347.
[218] Art 24(1).
[219] A Eide & WB Eide (n 156 above) para 32.
[220] A Eide & WB Eide(n 156 above) para 33.
[221] General Comment No 14 para 12(b).
[222] A Eide & WB Eide (n156 above) para 45.
[223] UNICEF Maternal, newborn and child survival (n 7 above).

On the policy side, the National Health Policy 2010- 2020 (NHP) does not focus on children in particular but includes them in the general population as entitled to access to good health care services.[224] The NHP highlights the causes of child mortality[225] but importance may be said to be given to child health in general as a part of the Uganda National Minimum Health Care Package (UNMHCP) which shall consist of affordable health programmes.[226] In addition, importance is ascribed by the government to research to inform health programmes for children as one of the vulnerable groups.[227]

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. However, it must be noted that Uganda is currently implementing the regional child survival strategy[228] which consists of interventions aimed at reducing child mortality.[229] Also, children are incorporated into different specific disease interventions[230] and other health programmes in Uganda.

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.

It must be emphasised that here that the current laws on the right to the highest attainable standard of health under the Constitution of Uganda is not spelt out and should be included in the bill of rights. Furthermore, the Children's Law is inadequate and does not provide for a full fledged right to the highest attainable standard of health. These laws must be amended to enable children and the people of Uganda enjoy these rights.

---

[224] UNICEF & FIDA (n 210 above) 103.
[225] Ministry of Health 'The second National Health Policy'(The second National Health Policy) (2010) 3.
[226]The second National Health Policy (n 225 above) 16.
[227] The second National Health Policy (n 225 above) 19.
[228] Developed by WHO, UNICEF and World Bank.
[229]See generally P Habimana et al 'Progress in implementing the Child Survival Strategy in the African region' (2010) Issue 11 *The Africa Health Monitor*
[230] Uganda AIDS Commission 'National HIV & AIDS strategic plan 2007/8 -2011/12' (2007).

As regards existing policies, the challenge lies with their implementation. The current pace of implementation is too slow to notice any marked improvement in child survival. Therefore, the implementation process of these policies needs to be monitored. In addition, any existing impediments to policy implementation such as financing need to be addressed. Uganda needs to rapidly implement its national policies and also the regional child survival strategy for a substantial decrease in child mortality to be recorded.

Chapter Four

Challenges, conclusion and recommendations

4 Introduction

In this final chapter, the challenges confronting an accelerated attainment of child survival in Uganda are considered. The causes of child mortality and the interdependence of the reduction of child mortality on the achievement of other MDGs have been examined. In addition the existing legal and policy frameworks relating especially to children's rights to health and life have been analysed. Child mortality is scrutinised from the perspective of the existing obstacles which impede national progress on MDG 4.

On the path to the realisation of any human right lies a series of challenges. As regards the right to health, an aspect of which is child survival these challenges include; inadequacy of health personnel and facilities, insufficient budgetary allocation, inequity in the provision of health services and the lack of political will to implement international and regional obligations. These challenges are analysed as they affect the improvement of child survival in Uganda.

This chapter concludes on the subject of child mortality in Uganda in light of all the aspects of the issue previously examined and makes recommendations.

4.1 Challenges

4.1.1 Inadequacy of health personnel and facilities

According to WHO's map on the global distribution of the health workforce (per 10,000 population) from 2000-2009 the general estimates of physicians in Uganda is less than five.[231] Specifically, the number of physicians to population is recorded to be one doctor per 10,000 people and 13 nurses and midwifes per 10,000 people.[232] This falls below the WHO standards of one doctor to 600 patients.[233]

[231] WHO Health statistics (n 57 above) 114.
[232] WHO Health statistics (n 57 above) 122.
[233] 'Malaysia hopes to attain WHO doctor-patient ratio by 2015' *The star online* 23 April 2010 http://thestar.com.my/news/story.asp?file=/2010/4/23/nation/20100423145351&sec=nation (accessed 26 October 2011).

WHO also has set minimum standards of two physicians per 10,000 population,[234] which Uganda also fails to meet. In addition, Uganda's environment and public health workers are less than 0.5 per 10,000 people.[235] This is clearly inadequate to handle all the medical needs of the population and also implies that some segment of the population will not have access to professional care. This has been noted by the Uganda Human Rights Commission which carried out inspections of several hospitals in different districts[236] in 2010.[237] Commonalities which existed in these hospitals include; inadequate staffing and in some hospitals like the Butyaba Health Centre, there were no nursing or clinical officers.[238] There were also problems of overloading of the designed patient capacity, insufficient drug supply and drug stock outs, lack of equipment, inadequate supply of electricity and poor and sometimes no accommodation facilities for hospital staff.[239]

It has been stated that many district hospitals in Uganda are understaffed and have been neglected by the government.[240] The shortage of health personnel has been identified as the 'main constraint to mobilizing responses to health challenges'.[241] Also many districts in sub regions[242] in Northern Uganda suffer from inadequate staffing with the actual number of staff falling below national standards provided for in the second Health Sector Strategic Plan (2005/06- 2009/10).[243] Coupled with inadequate staffing is the problem of drug stock outs in many health facilities in Northern Uganda.[244]

The problem of inadequate health personnel, equipment and drugs is not restricted to Northern Uganda. Some hospitals like the Nyabushenyi health centre in South western Uganda despite the improvements in its physical structure lacks health

[234] S Naicker et al 'Shortage of healthcare workers in developing countries- Africa' (2009) 19 *Ethnicity and Disease* S1-62.
[235] WHO Health Statistics (n 57 above)122.
[236] Buliisa District, Tororo District, Kasese District, Amuru District, Busia District, Nebbi District and Abim District.
[237] Uganda Human Rights Commission 'The 13th Annual Report 2010 to the Parliament of the Republic of Uganda'(Uganda Human Rights Report) (2010) 114.
[238] As above.
[239] Uganda Human Rights Report (n 237 above) 114-116.
[240] R Lumu 'Health policy without resources a waste of time' *The Monitor* 2 February 2010 http://allafrica.com/stories/201002020329.html (accessed 26 October 2011).
[241] S Naicker et al (n 234 above) S1-62.
[242] Acholi, Lango and Karamoja Districts.
[243] WHO 'Emergency and humanitarian Action: Uganda: The humanitarian situation' 2 http://www.afro.who.int/en/clusters-a-programmes/ard/emergency-and-humanitarian-action/eha-country-profiles.html (accessed 26 October 2011).
[244] As above.

workers, it has only one nurse and insufficient equipment.[245] In Buliisa district in Western Uganda, it was found that there was no doctor in the entire district.[246] There was also no electricity in Buliisa Health Centre IV and there were drug stock-outs at the health centre and also at the Butyaba Health Centre.[247] Also hospitals like the Tororo hospital in Tororo district in Eastern Uganda suffer problems of insufficient personnel and equipment, it is supposed to have 57 nurses but it has only 30.[248]

Linked to the problem of inadequate health personnel is the fact that there is a disproportionate distribution of health personnel.[249] Studies have found that '73% of doctors are in central region alone.'[250] It can thus be implied that the problem of inadequacy of health personnel in other regions can also be attributed to the concentration of health staff in the central region.

All these factors clearly show that the right to health is being impeded especially with regards to its tenet of availability; health services are barely available to the population in these districts. And if health services are not available this means that in general more of the population will be unhealthy and in particular more children will be vulnerable to death from preventable diseases due to the lack of medical care and drugs. For example the Nutrition unit of the Nebbi Government hospital was found not to have nutritional supplements, while other health centres[251] did not particularly budget for such medicines.[252] This will not suffice if Uganda is to improve its child survival rates.

It is important to note here that apart from Uganda's international right to health obligations, Uganda as a state party to the AU has regional obligations under the Resolution on Access to Health and Needed Medicines in Africa 2008 to ensure the availability, accessibility and affordability of safe medicines to its people.

---

[245] 'Assessing maternal and reproductive health in Ntungamo District , South western Uganda' http://arhtogether.org/news/assessing-maternal-and-reproductive-health-in-ntungamo-district (accessed 26 October 2011)

[246] Uganda Human Rights Report (n 237 above).

[247] As above.

[248] As above.

[249] J Odaga & P Lochoro 'Budget ceilings and health in Uganda' (2006) 7 http://www.who.int/rpc/evipnet/uganda_report%20Budget%20ceiling%20and%20health.pdf (accessed 26 October 2011).

[250] As above.

[251] Kucwiny Health Centre III.

[252] Uganda Human Rights Report (n 237 above) 116.

4.1.2 Insufficient budgetary allocation to the health sector

The significance of a well funded health sector has great implications on the realisation of the right to health of the people. This has been recognised by the AU in its Abuja Declaration on HIV/AIDS, TB and Other Related Infectious Diseases adopted in 2001 to which all state parties agreed to dedicate 15% of their national budget to health.[253] In 2008, the percentage of the Uganda national budget dedicated to the health sector was a little above 10%.[254] This is an improvement from its previous year's health budget of 9.8%[255] and its 2010 budget of 10.2%[256] nevertheless these budgets are insufficient to support any tangible improvements.

According to WHO standards the least per capita cost for the provision of basic health care in low income countries is $34 per person.[257] However according to the Health Sector Strategic Plan III, Uganda's health sector 'needs an estimated USD 40 per capita per annum' to be able to cater for the minimum healthcare provision.[258] Uganda has consistently been spending far less, in 2007 it spent a dismal $7,[259] and in 2008/2009 this was slightly increased to $10.40.[260] It has been found that '[i]nadequate funding remains the primary constraint inhibiting development of the health sector in Uganda.'[261]

Specifically relating to budgetary allocation to children's health focusing on quota provided for immunisation of children, the government 'contributed only 15% to the budget for national EPI vaccine programme in 2007.'[262] While the African Child Policy Forum considers Uganda as a country which 'allocated a fair amount of resources to children'[263] a lot more needs to be done if there is to be great improvement in child survival. Therefore, there is a critical need for increasing the funding of the health sector and its efficiency. This would translate into the

[253] Para 26.
[254] The African Child Policy Forum 'The African Report on child wellbeing: Budgeting for children' (The African Report on child wellbeing) (2011) 7.
[255] WHO Health statistics (n 57 above) 136.
[256] S Koenig & B Atim 'Health Spending in Uganda: The impact of current aid structures and aid effectiveness' (2010) 6.
[257]The African Report on child wellbeing (n 254 above).
[258] S Koenig & B Atim (n 256 above).
[259] WHO Health statistics (n 57 above)138.
[260] S Koenig & B Atim (n 256 above).
[261] J Odaga & P Lochoro (n 249 above).
[262] The African Child Policy Forum 'The African report on child wellbeing 2011: Budgeting for children: Country brief Uganda' (The African child report Uganda) (2010) 1.
[263] The African child report Uganda (n 262 above) 3.

availability of drugs and medical equipment, improved conditions for health staff and consequently the retention of these staff in public health facilities.

A key factor in the health expenditure of Uganda like other African countries is its dependence on out of pocket expenditure for the utilisation of health services. In 2007, WHO estimated Uganda's out of pocket expenditure to be 51%.[264] This is particularly important in Uganda's situation considering that user fees at government health facilities were abolished in 2001, this is indicative of heavy reliance on private for profit health care facilities.[265] It has been stated that the substandard quality of care at the public health facilities is the basis for increased use of private health facilities.[266] Also studies have shown that the elimination of user fees has not cut down out of pocket expenses and patients still report making payments at public health facilities before drugs were given.[267] This clearly shows the existence of corruption amongst health staff working in public hospitals, which may be traced to poor staff conditions of service.[268]

It is deducible that inadequate budgetary allocation to the health sector impedes the realisation of children's right to health in terms of access to quality health facilities, health care and unavailability of drugs. On the whole, it makes quality health service economically inaccessible to families who must pay expensive bills to receive health care from other alternatives. Thus children from poor families suffer due to the government's failure to fulfil their right to health.

4.1.3 Inequity in the provision of health services

This challenge relates to the fact that the provision of health services and the coverage of health programmes for child survival and development are unequally enjoyed. It has been noted that

> [c]overage rates for effective newborn and child survival interventions are not only low in most developing countries – within every country, rates consistently reflect socioeconomic inequities, and

[264] WHO Statistics 2010(n 57 above) 137.
[265] V Govender et al 'Progress towards Abuja target for government spending on health care in East and Southern Africa'(2008) 57 *EQUINET Discussion Paper Series* 12.
[266] As above.
[267] M Ruhweza et al 'Financial risks associated with healthcare consumption in Jinja, Uganda' (2009) 9 *African Health Sciences* S88.
[268] See generally VSO International 'Ugandan Health Workers speak The Rewards and the Realities' (2010) for information on the poor conditions of service for health workers in Uganda.

often disparities by gender or across ethnic groups. Children born into poor families are much less likely to be given healthcare than those from richer families.[269]

In Uganda, WHO statistics on the coverage of immunisation programmes against measles for one year old children vary due to different factors. In rural areas the rate of coverage is 67% while that of urban is 77%, coverage is also higher amongst the population in the highest wealth quintile at 73% and the lowest group has 66% immunisation coverage.[270] Other differences in child health interventions exist for example the treatment for diarrhoea for male children was higher at 41% compared to the female children at 38%.[271] In terms of geographical distribution, more children living in urban areas were treated for diarrhoea, 48%, whereas only 39% in the rural areas were treated.[272] As regards treatment for the poorest population the extent of coverage was 39% while the richest population enjoyed 44% coverage.[273]

Another inequity which exists is that under five mortality rate is higher in the rural areas at 147 deaths per 1000 live births compared with urban rates of 115 deaths.[274] The rates of under five mortality are also higher amongst families in the lowest wealth quintile at 172 deaths and the rates for those in the highest wealth quintile is 108 deaths.[275] The highest inequities in under five mortality however exists between children whose mothers have the highest levels of education at 91 deaths and those with lowest education levels at 164 deaths.[276] Simply put a child is more likely to die if (s)he is born to an uneducated mother or to a poor family or lives in a rural area due to the fact that these socioeconomic factors interfere with his/her enjoyment of the right to health.

In addition, there are other barriers faced in accessing health care, studies have shown that poor families face barriers of 'cost, distance [and] lack of drugs,' in accessing child health services.[277] Also the inequalities in the usage of health services are caused by '[l]ack of knowledge/awareness, perceived poor quality of

[269] J Bryce et al (n 61 above) 1073.
[270] WHO Health statistics (n 57 above) 151.
[271] UNICEF Maternal, newborn and child survival (n 7 above).
[272] As above.
[273] As above.
[274] WHO Health statistics (n 57 above) 151.
[275] As above.
[276] As above.
[277] SN Kiwanua et al 'Access to and utilisation of health services for the poor in Uganda: a systematic review of available evidence' (2008) 102 *Transactions of the Royal Society of Tropical Medicine and Hygiene* 1070.

services, lack of confidentiality and especially perceived poor attitude of health workers were barriers to utilisation on the demand side.'[278] These barriers must be addressed by the government so as to promote equal access to health services.

These are unfair circumstances which are also discriminatory in nature and are contrary to the tenets of the right to health contained in Article 12 of the ICESCR.[279] Furthermore, it is incompatible with the states obligation under the CRC to respect and fulfil the rights of children and protect them from any form of discrimination.[280] The state also has the duty to ensure that its population is informed and access to child health information is given.[281]

4.1.4 Lack of political will

'For the notion of responsibility to be meaningful, it should ultimately reside in specific places and institutions, and with specific people. If everyone is responsible then no one is actually responsible.'[282]

This quote is apt in analysing political will or the lack thereof. In governance, responsibility is conferred on the political office holders to provide development, ensure peace and the fulfilment of fundamental human rights alongside other tasks. Where this responsibility is abdicated or treated with indifference progress is impeded and a myriad of problems arise.

It has been noted that the lack of political will is a major challenge to addressing the problem of child mortality globally.[283] While Uganda is party to all the applicable covenants and declarations which provide extensively for the right to health generally and children's rights specifically, its implementation of these treaties falls short of those standards. The lack of or the scant political will in tackling the reduction of child mortality is evident from the inadequate budgetary allocation to the health sector, the restrictive nature of children's right to health under the law in Uganda and the non-justiciability of the socioeconomic right to health. Uganda must match its ratifications with real action.

---

[278] SN Kiwanua et al (n 277 above) 1071.
[279] See para 18 of General Comment 14 which further explains the prohibition of discrimination in access to health care on grounds of property, birth, social status amongst other grounds.
[280] Arts 2 & 3.
[281] Art 24(2)(e) CRC.
[282] International Women's Health Program 'Political will: Women and children first: Or are they?' http://iwhp.sogc.org/index.php?page=political-will&hl=en_US (accessed 26 October 2011).
[283] As above.

4.2 Conclusion

The issue of child mortality in Uganda has been analysed from different angles; causes, its relationship with other MDGs, the legal and policy framework within which children's rights to life and health exists and finally the challenges to achieving the reduction in child mortality in Uganda. This analysis has shown that progress towards improving child survival while not impossible will require great effort and corresponding improvements in the MDGs. It will require partnerships with all stakeholders with the government playing a principal role. Major progress will demand thorough reforms of the health sector, the expansion and development of the law, the implementation of policy and participation of all stakeholders.

It is evident that the chances of Uganda attaining the targeted reduction in child mortality rates by 2015, slightly above four years time, are slim to none. Nevertheless advances must be made to ensure that even if Uganda does not attain MDG 4 by 2015, record progress is made and it is able to achieve the target in less than 10 years after the deadline. We must be optimistic that this is possible and match this optimism with concrete action.

4.3 Recommendations

- Firstly, all child survival interventions and programmes must be improved and scaled up drastically including a rapid expansion of coverage and efficient and sustainable implementation.

- Existing mechanisms which monitor the causes and rates of child mortality in Uganda must be enhanced in order to produce accurate results on the current scale of the problem. This in turn will show whether ongoing interventions are succeeding and inform new child survival programmes.

- Health programmes targeting the reduction of the three main causes of child mortality in Uganda; malaria, diarrhoea and pneumonia must be scaled up. The coverage of interventions which provide insecticide treated nets, oral rehydration therapy and pneumonia medicines must be rapidly improved. Also preventive interventions in this regard should also be made available and accessible to all.

- Programmes on malnutrition must be increased and must include community advocacy on the importance of improving maternal and child

nutrition and should show practical and simple ways in which this can be done. Drugs should be made available, nutrition staff should be increased and relevant information on malnutrition made accessible at all health centres.

- Interventions on malnutrition must also address underlying determinants such as inadequate access to food, infant feeding practices, and poor health, hygiene and sanitation practices.

- Steps to reduce hunger and malnutrition by 2015 must be accelerated as this will also have a positive impact on child survival in Uganda. These steps must be implemented equitably in order to remedy existing disparities in the different regions.

- Child survival is improved by maternal education. Therefore research must be conducted to find out the causes of non completion of primary school and strategies implemented to increase the graduation rates of children and encourage the pursuance of secondary and tertiary education.

- Empowering women is vital to increase child survival as most women are actively involved in taking care of their children. Improved access to credit services especially in the agricultural sector and also access to land will reduce poverty and enable women to make better health choices for themselves and their children. Thus the government must increase its efforts to empower women in the agricultural sector and other parts of the economy. The female legislators should also play an instrumental role in the struggle to promote gender equality and also influence the making of laws which are beneficial to increasing gender equality and child survival.

- Current interventions to improve maternal survival in Uganda are inadequate and this has a major effect on child survival rates. These interventions must be drastically scaled up and the health care system rapidly improved. In addition, the efficiency and coverage of current child protection services must be enhanced to investigate, monitor and ensure that the children's right to health is being fulfilled.

- Advances in combating HIV/AIDs, malaria and other diseases have a progressive effect on child survival. Efforts to prevent the spread of HIV/AIDS, malaria and other diseases and to treat and manage existing infections must be upgraded.

- The government should increase programmes aimed at improving access to safe water and sanitation and ensure that they are effective, sustainable and equitable.

- The government must realise that increased progress in the achievement of the other MDGs is crucial to a reduction in child mortality. It must therefore be committed and make serious efforts to guarantee progress in the MDGs. Existing policies incorporate aspects of the MDGs however their progress must be accelerated to meet MDGs timelines.

- The government must also initiate partnerships with other stakeholders such as community members, religious bodies, traditional rulers, nongovernmental organisations, intergovernmental organisations and the media on child survival strategies.

- The government should make concrete efforts to fulfil the right to highest attainable standard of health despite the fact that it is not a justiciable right under national law. However, the government has ratified several international and regional instruments which provide for this right and it has to respect and fulfil its obligations.

- Civil society, legislators, academia, members of the public, religious bodies and other stakeholders should solidify efforts for a constitutional amendment which will include the incorporation of economic and social rights such as the right to health in the bill of rights. Other amendments should include the broadening of the rights of the child especially expanding the right to health beyond just medical treatment.

- The Children's Act must be amended and fuller rights for the child included. The right to health must be broad and similar to the CRC's and the ACRWC's, filtered through national situations but this should not be an excuse to restrict children's rights.

- Prior to any future amendments of the Children's Act, it is important for the realisation of children's right to life and health that the court's interpretation of the existing rights are broad and in favour of full enjoyment of these rights.

- As part of the amendments, the right to health as well as other rights in the Children's Act must elaborate on state obligations to respect, protect, promote and fulfil. The state obligations must be clear and detailed. Further amendments to the existing right to health should include the vital link between underlying determinants of the right to health and the right to life, survival and development. Also, state obligations under a revised Children's Act should include the duty to initiate and implement programmes for children's survival, well being and development.

- The current state obligations in the Children's Act on protecting and promoting the welfare of children by local government councils must be revised and embellished. Also, the non discrimination principle relating to access to health care and the enjoyment of other rights must be included and must be definite.

- Of great importance is the need for the inclusion of state obligations to guarantee affordability, equity in access to health care and enjoyment of the right to health, in the amendments of the Children's Act. The obligation for the state to make rapid advances in child survival in Uganda must also be highlighted.

- Concrete efforts must be put into the implementation of existing policies and strategies on children's health and other factors which affect the fulfilment of their right to health, survival and development.

- The government needs to develop effective strategies to address the problems of inadequate staffing, unavailability of drugs, equipment, inadequate electricity supply and poor staff accommodation facilities amongst other issues. These can be remedied by increased budgetary allocation to the health sector and ensuring that the funds are efficiently managed. Furthermore development and other incentives in the rural areas will lead to greater attraction and retention of qualified personnel.

- In order to deal with the issue of child mortality and other health related problems, the government must comply with its international commitments to dedicate at least 15% of its total budget to health. Also there must be a corresponding increase in the per capita cost for the distribution of basic health care.

- The government must also ensure that the purpose behind the abolition of user fees at public health facilities which is improving access to health care is realised by addressing corruption in health facilities and its latent causes.

- Rapid progress must be made in improving access, availability and affordability of quality public health services so as to reduce out of pocket expenditure for the utilisation of health services. This will go a long way in improving equity in access to health services.

- Equity in the provision of health care must be emphasised in the implementation of programmes. In addition, socioeconomic factors such as education and income which affect access to health should be remedied by increasing the progress in the other MDGs.

- From the statistics discussed earlier, it is evident that certain regions of Uganda particularly the northern region is behind in the coverage and implementation of child survival interventions. Therefore special attention must be given to such areas if child survival rates are to substantially decrease.

- Data gathering on information relevant to children's health such as the impact of existing interventions, the number of children who require medical assistance, the effect of socioeconomic factors on the enjoyment of the right to health and the progress on the reduction of child mortality must be improved and updated. This information should then be used as a basis for the creation and implementation of nationwide interventions.

- The government should ensure that child survival reduction strategies are equitably administered in order to prevent unequal reduction in child mortality rates across all regions and ethnic groups. This should be done in

partnership with local communities, traditional rulers, NGOs, members of the civil society, academia, religious bodies and other stakeholders.

- The government should be amenable to soliciting and initiating international partnerships in order to achieve MDG 4 and all other MDGs.

- Civil society and community members should play an active role in the promotion, protection and realisation of children' right to health and other rights by reporting violations and instituting cases at the family and children's court.

Word count – 16,847, excluding table of contents and bibliography

Bibliography

Books

Gordon, B; Mackay, R & Rehfuess, R (2004) *Inheriting the world: The atlas of children's health and the environment* Geneva: WHO

Eide, A & Eide, WB (2006) *Article 24 the right to health* Leiden: Martinus Nijhoff Publishers

Detrick, S (1992) *The United Nations Convention on the Rights of the Child: A guide to the 'Travaux Preparatoires'* Dordrecht: Martinus Nijhoff Publishers

Journals

Black, RE; Morris, SS & Bryce, J 'Where and why are 10 million children dying every year?'(2003) 361 *Lancet* 2227

Bryce, J; Terreri, N, Victora, CG, Mason, N, Daelmans, B, Bhutta, ZA, Bustreo, F, Songane, F, Salama, P & Wardlaw, T 'Countdown to 2015: tracking intervention coverage for child survival' (2006) 368 *Lancet* 1071

Black, RE; Cousens, S, Johnson, HL, Lawn, JE, Rudan, I, Bassani, DG, Jha, P, Campbell, H, Walker CF, Cibulksis, R, Eisele, T, Liu, L & Mathers, C, 'Global, regional, and national causes of child mortality in 2008: a systematic analysis' (2010) 375 *Lancet* 7

Brahmbhatt, H; Kigozi, G, Wabwire-Mangen, F, Serwadda, D, Lutalo, T, Nalugado, F, Sewankambo, N, Kiduggavu, M, Wawer, M & Gray, R 'Mortality in HIV- infected and uninfected children of HIV-infected and uninfected mothers in rural Uganda' (2006) 41 *Journal of Acquired Immune Deficiency Syndrome* 507

Caulfield, LE ; De Onis, M, Blossner, M & Black, RE 'Undernutrition as an underlying cause of child deaths associated with diarrhoea, pneumonia, malaria and measles' (2004) 80 *American Journal of Clinical Nutrition* 197

Govender, V; McIntyre, D & Loewenson, R 'Progress towards Abuja target for government spending on health care in East and Southern Africa'(2008) 57 *EQUINET Discussion Paper Series* 12

Kiwanuka, SN; Ekirapa, EK, Peterson, S, Okui, O, Rahman, MH, Peters, D & Pariyo, GW 'Access to and utilisation of health services for the poor in Uganda: a systematic review of available evidence' (2008) 102 *Transactions of the Royal Society of Tropical Medicine and Hygiene* 1070

Habimana, P; Mwinga, K, Sagoe-Moses, C & Ketsela, T 'Progress in Implementing the Child Survival Strategy in the African region' (2010) Issue 11 *The Africa Health Monitor*

Hobcraft, J 'Women's education, child welfare and child survival: a review of the evidence' (1993) 3 *Health Transition Review* 161

Kiwanua, SN; Ekirapa, EK, Peterson, S, Okui, O, Rahman, MH, Peters, D & Pariyo, Ruhweza, M; Baine, SO, Onama, V, Basaza, V & Pariyo, G 'Financial risks associated with healthcare consumption in Jinja, Uganda' (2009) 9 *African Health Sciences* S88

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

Naicker, S; Plange-Rhule, J, Tutt, RC & Eastwood, JB 'Shortage of healthcare workers in developing countries- Africa' (2009) 19 *Ethnicity and Disease* S1-62

Olowu, D '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

Sach, J & Malaney, P 'The economic and social burden of malaria' (2002) 415 *Nature* 682

Ssewanyana, S & Younger, SD 'Infant mortality in Uganda: determinants, trends and the Millennium Development Goals' (2007) 17 *Journal of African Economies* 40

Walker, CLF; Friberg, IK, Binkin, N, Young, N, Walker, N, Fontaine, O, Weissman, E, Gupta, A & Black, RE 'Scaling up diarrhea prevention and treatment interventions: A lives saved tool analysis' (2011) 8 *PLoS Medicine* 2

International instruments

Beijing Declaration and Platform for Action (1995)

The Convention on the Rights of the Child (1989)

The Convention on the Rights of Persons with Disabilities (2006)

The International Covenant on Civil and Political Rights (1966)

The International Covenant on Economic Social and Cultural Rights (1966)

The International Convention on the Elimination of All Forms of Racial Discrimination (1965)

The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (1990)

The Vienna Convention Law on Treaties (1969)

Universal Declaration of Human Rights (1948)

United Nations Millennium Declaration A/RES/S-27/2 (2000)

General Comments and Resolutions

Committee on Economic, Social and Cultural Rights, General Comment No 14, (2000)

Human Rights Committee, General Comment No 6, art 6, (1982)

Human Rights Committee, General Comment No 31 (2004)

Resolution adopted by the General Assembly S-27/2 A world fit for children (2002)

Regional instruments

Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001)

African Charter on Human and Peoples' Rights (1981)

African Charter on the Rights and Welfare of the Child (1990)

African Union Convention for the Protection and Assistance of Internally Displaced Persons (2009)

African Union 'Africa Health Strategy 2007-2015'

Guidelines for the consideration of communications of the African Committee of Experts on the Rights and Welfare of the Child <http://caselaw.ihrda.org/doc/acerwc_comm/view/> (accessed 26 September 2011)

Resolution on Access to Health and needed Medicines in Africa (2008)

National laws

Constitution of the Republic of Uganda 1995

The Children Act 1997 Chapter 59 Laws of Uganda

Policies

Ministry of Health 'Child Survival Strategy for Uganda – 2008-2015 Draft' (2009)

Ministry of Health, Health Sector Strategic & Investment Plan 2010/11 -2014/15 (2010)

Ministry of Health 'National Health Policy 2010-2020' (2010)

The Republic of Uganda Ministry of Health 'The second National Health Policy' (2010)
The Republic of Uganda 'National Development Plan 2010/11– 2014/15' (2010)

The Republic of Uganda 'National Policy for Internally Displaced Persons' (2004)

Uganda AIDS Commission 'National HIV & AIDS strategic plan 2007/8 -2011/12' (2007)

Newspapers

Lirri, E 'Mulago hospital struggles with malnourished children' *The Monitor* 24 April 2010 <http://allafrica.com/stories/201004260894.html> (accessed 14 August 2011)
Lumu, R 'Health policy without resources a waste of time' *The Monitor* 2 February 2010 <http://allafrica.com/stories/201002020329.html> (accessed 26 October 2011)
Matsamura, EK 'Infant mortality: "Uganda's children are not feeding well" '*The Observer* 10 October 2010 <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)
'Malaysia hopes to attain WHO doctor-patient ratio by 2015' *The star online* 23 April 2010 <http://thestar.com.my/news/story.asp?file=/2010/4/23/nation/20100423145351&sec=nation> (accessed 26 October 2011)

Papers

Abu- Ghaida, D & Klasen, S 'The costs of missing the Millennium Development Goal on gender equity' (2002)

Gunther, I & Fink, G 'Water, sanitation and children's health: Evidence from 172 DHS surveys' (2010)

Kamrul, IM & Gerdtham, UG 'The costs of maternal-newborn illness and mortality' (2006)

Ministry of Finance, Planning and Economic Development 'Gender inequality in Uganda: the status, causes and effects' Discussion Paper (2006)

Office of the United Nations High Commissioner for Human Rights and WHO 'The Right to Health: Fact sheet No.31' (2008)

Reports

African Peer Review Mechanism 'Republic of Uganda: APRM country review report no.7' (2009)

DFID 'Malaria: country profiles version 1.1' (2011)

FANTA-2 'The analysis of the nutrition situation in Uganda' (2010)

Human Rights Council, Report of the Special Rapporteur on the right to the highest attainable standard of health 'Promotion and protection of all human rights, civil, political, economic, social and cultural rights including the right to development (A/HRC/7/11/Add.2)

Koenig, S & Atim, B 'Health Spending in Uganda: The impact of current aid structures and aid effectiveness' (2010)

Ministry of Finance, Planning and Economic Development 'Millennium Development Goals Report for Uganda 2010' (2010)

Odaga, J & Lochoro, P 'Budget ceilings and health in Uganda' (2006) <http://www.who.int/rpc/evipnet/uganda_report%20Budget%20ceiling%20and%20health.pdf> (accessed 26 October 2011)

Save the Children 'A fair chance at life: Why equity matters for child mortality' (2010)

The African Child Policy Forum 'Budgeting for children in Africa: Rhetoric, reality and the scorecard' (2011)

The African Child Policy Forum 'The African Report on child wellbeing: Budgeting for children' (2011)

The African Child Policy Forum 'The African report on child wellbeing 2011: Budgeting for children: Country brief Uganda' (2010)

UN 'The Millennium Development Goals Report' (2010)

UN 'The Millennium Development Goals Report' (2011)

United Nations Economic Commission for Africa, the African Union Commission, the African Development Bank and the United Nations Development Programme-Regional Bureau for Africa 'Assessing Progress in Africa toward the Millennium Development Goals' (2010)

United Nations Educational, Scientific and Cultural Organisation, UNICEF, The Government of Qatar & Save the Children International 'The central role of education in the Millennium Development Goals' (2010)

UNICEF 'Malaria a major cause of child death and poverty in Africa' (2004)

UNICEF 'Progress for children: Achieving the MDGs with equity' (2010)

UNICEF & FIDA Uganda 'Collection of children laws: A simplified handbook on international and national laws and policies on children' (2011)

United Nations Inter-agency Group for Child Mortality Estimation 'Levels and trends in child mortality report 2010'

United Nations Inter-agency Group for child mortality estimation 'Levels and trends in child mortality: Report 2010' http://www.childinfo.org/files/Child_Mortality_Report_2010.pdf (accessed 14 June 2011)

Uganda Human Rights Commission 'The 13th Annual Report 2010 to the Parliament of the Republic of Uganda' (2010)

WHO 'World health statistics' (2010)

WHO 'World Malaria report 2008'

WHO and UNICEF 'Countdown to 2015 decade report (2000-2010) with country profiles: taking stock of maternal, newborn and child survival'
VSO International 'Ugandan Health Workers speak The Rewards and the Realities' (2010) for information on the poor conditions of service for health workers in Uganda

Unpublished thesis

Amuge, N 'Infant and child morbidity in Mulago hospital' unpublished undergraduate thesis, Makerere University 1997

Hadoto, PI 'An assessment of the factors contributing to child mortality in Northern Uganda (1997-2002)' unpublished master's thesis, Makerere University 2009

Kabagenyi, A 'Household characteristics and child mortality in Uganda' unpublished master's thesis, Makerere University 2006

Nassali, HB 'The effect of malaria on child mortality rates: A case study of Naguru health centre in Nakawa division 2001-2006', unpublished undergraduate thesis, Makerere University, 2007

Okella, NL 'The determinants of persistent child mortality trend in Uganda' unpublished master's thesis, Maastricht Graduate School of Governance, 2009

Websites

A Kelly 'Healthcare a major challenge for Uganda' *The Guardian* 1 April 2009 <http://www.guardian.co.uk/katine/2009/apr/01/healthcare-in-uganda> (accessed 27 August 2011)

AMREF 'Our work in Uganda' http://www.amref.org/where-we-work/our-work-in-uganda/ (accessed 27 August 2011).

'Assessing maternal and reproductive health in Ntungamo District , South western Uganda' <http://arhtogether.org/news/assessing-maternal-and-reproductive-health-in-ntungamo-district> (accessed 26 October 2011)

Centre for Economic and Policy Research 'A survey of the impacts of IMF structural adjustment in Africa: growth, social spending, and debt relief' (1999) <http://www.cepr.net/index.php/a-survey-of-the-impacts-of-imf-structural-adjustment-in-africa/> (accessed 21 September 2011)

Globalhealth at MIT 'Country briefing: Uganda –health' <http://globalhealth.mit.edu/home/uganda-health/> (accessed 27 August 2011)

Global health opportunities: Understanding child health <http://www.globalhealth.org/images/pdf/gho/2009_ch_understanding.pdf> (accessed 21 September 2011)

Global Health Council 'Health equity for the world's children would save millions of lives' <http://www.globalhealth.org/images/pdf/publications/child_health_equity.pdf> (accessed 12 October 2011)

International Women's Health Program 'Political will: Women and children first: Or are they?' <http://iwhp.sogc.org/index.php?page=political-will&hl=en_US> (accessed 26 October 2011)

Millennium Development Goals Goal 6: combat HIV/AIDS, malaria and other diseases <http://www.un.org/millenniumgoals/aids.shtml#mdgs> (accessed 7 October 2011)

Military: Uganda civil war
<http://www.globalsecurity.org/military/world/war/uganda.htm> (accessed 12 October 2011)

OCHCR 'Committee on the Rights of the Child : monitoring children's rights'
<http://www2.ohchr.org/english/bodies/crc/> (accessed 26 October 2011)

R Naiman & N Watkins 'A survey of the impacts of IMF Structural Adjustment in
UN 'Millennium Project: About the MDGs: What they are'
<http://www.unmillenniumproject.org/goals/index.htm> (accessed 21 September 2011)

UNICEF 'Country profile Uganda: Maternal, newborn and child survival'
<http://www.unicef.org/esaro/ACSD_Profile_003UGA_Uganda_2011.pdf> (accessed 14 August 2011)
UNICEF 'Definitions: basic indicators'
<http://www.unicef.org/infobycountry/stats_popup1.html> (accessed 20 September 2011)

UNICEF 'Humanitarian action Uganda in 2009'
<http://www.unicef.org/har09/files/har09_Uganda_countrychapter.pdf> (accessed 22 August 2011)

UNICEF 'Millennium Development Goals 4: Reduce child mortality'
<http://www.unicef.org/mdg/childmortality.html> (accessed 14 June 2011).

UNICEF 'Millennium Development Goals 5: Improve maternal health'
<http://www.unicef.org/mdg/maternal.html> (accessed 8 October 2011).

UNICEF 'Uganda statistics'
<http://www.unicef.org/infobycountry/uganda_statistics.html> (accessed 14 August 2011)

United Nations Development Programme (UNDP) 'The Millennium Development Goals: Eight goals for 2015'

<http://www.beta.undp.org/undp/en/home/mdgoverview.html> (accessed 26 October 2011)

UNDP 'What are the Millennium Development Goals?' <http://www.undp.org/mdg/basics.shtml> (accessed 26 October 2011)

United Nations Treaty Collection International Covenant on Civil and Political Rights <http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-4&chapter=4&lang=en> (accessed 26 October 2011)

United Nations Treaty Collection International Covenant on Economic, Social and Cultural Rights <http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en> (accessed 26 October 2011)

WaterAid Biggest killer of children in Africa cannot be addressed without sanitation and water <http://www.wateraid.org/documents/wa_african_union_2pp_proof_2.pdf> (accessed 7 October 2011)

WHO 'Emergency and Humanitarian Action: Uganda: The humanitarian situation' <http://www.afro.who.int/en/clusters-a-programmes/ard/emergency-and-humanitarian-action/eha-country-profiles.html> (accessed 26 October 2011)

WHO 'Health status statistics: Mortality: Neonatal mortality rate (per 1000 live births)' <http://www.who.int/healthinfo/statistics/indneonatalmortality/en/> (accessed 20 September 2011)

WHO 'Health status statistics: mortality: probability of dying (per 1000) under age five years (under-5 mortality rate)' <http://www.who.int/healthinfo/statistics/indunder5mortality/en/>(accessed 20 September 2011)