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LEGAL AND POLICY DIMENSIONS OF PERSON-CENTERED PERINATAL HEALTHCARE IN UGANDA

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ABSTRACT

Statement of the Problem: Uganda has made notable legal, policy, and institutional efforts to improve maternal and newborn healthcare, including constitutional protection of the rights to life, dignity, equality, and women's rights. However, many women continue to experience neglect, verbal abuse, denial of information, lack of informed consent, poor participation in decision-making, and other forms of disrespect during pregnancy, childbirth, and the postnatal period.

Purpose of the Study: The purpose of this article was to examine how Uganda's legal and policy framework safeguards respectful, dignified, informed, and participatory perinatal healthcare. The article specifically focused on constitutional provisions, judicial decisions, international and regional human rights obligations, national health policies, and institutional arrangements governing maternal and newborn healthcare.

Research Methodology: The study adopted a qualitative doctrinal research methodology supported by policy and institutional analysis. It reviewed legal instruments, judicial decisions, international human rights frameworks, national health policies, government reports, and scholarly literature on maternal healthcare rights, respectful maternity care, reproductive dignity, and health system accountability.

Findings: The findings revealed that Uganda has a strong normative foundation for person-centered perinatal healthcare through the Constitution, international commitments, judicial interpretation, and national health policies. Nonetheless, these protections remain weakly operationalized at the facility level due to limited enforceability, inadequate accountability systems, resource constraints, workforce shortages, fragmented grievance mechanisms, and persistent social inequalities. The study further found that maternal healthcare policies still place stronger emphasis on mortality reduction and service coverage than on dignity, informed consent, privacy, respectful treatment, and women's participation in care decisions.

Conclusion: The study concludes that Uganda's challenge lies not in the absence of legal and policy recognition, but in the weak translation of these commitments into respectful and rights-based maternal healthcare practice. Person-centered perinatal healthcare, therefore, remains both a public health concern and a legal-governance issue requiring stronger accountability, institutional responsiveness, and enforceable standards.

Recommendations: The article recommends the development of enforceable respectful maternity care standards, stronger grievance redress systems, mandatory rights-based maternal care training for healthcare workers, improved facility oversight, and better integration of dignity, informed consent, privacy, confidentiality, and women's participation into maternal health monitoring systems.

Keywords*: Legal, Policy Dimensions, Person-Centered, Perinatal Healthcare, Uganda*

INTRODUCTION

Maternal and newborn healthcare in Uganda has increasingly shifted from a narrow focus on mortality reduction to a broader legal and policy discourse centered on dignity, quality, and women's rights. Although Uganda has recorded significant progress in reducing maternal mortality from 336 deaths per 100,000 live births in 2016 to about 189 in 2022, alongside increased skilled birth attendance and facility deliveries (UDHS, 2022), these gains have exposed a critical governance gap: improved access to services does not necessarily ensure respectful, dignified, or participatory care during pregnancy, childbirth, and the postnatal period. The central concern has therefore moved beyond access to whether women's rights, autonomy, and dignity are effectively protected within maternal healthcare systems. This concern is captured in the concept of person-centered perinatal healthcare, which emphasizes women as rights-bearing individuals entitled to respect, informed consent, privacy, non-discrimination, and active participation in care decisions. Its realization depends on the effectiveness of Uganda's legal, policy, and institutional frameworks, including constitutional protections, judicial enforcement, and health system accountability structures.

Uganda's legal framework provides a strong normative foundation through the Constitution of the Republic of Uganda, 1995, particularly Articles 22, 24, and 33, which guarantee the right to life, dignity, and women's rights. These provisions have been reinforced by judicial developments, especially CEHURD & Others v Attorney General (Constitutional Petition No. 16 of 2011; Supreme Court Appeal, 2020), which elevated maternal health failures into constitutional accountability discourse. At the international level, Uganda is bound by instruments such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the International Convention on Economic, Social, and Cultural Rights (ICESCR), the Convention on the Rights of the Child (CRC), and the Maputo Protocol, which require states to ensure accessible, acceptable, and dignified maternal healthcare. These commitments are reflected in national policy frameworks such as the Reproductive, Maternal, Newborn, Child Health and Adolescents (RMNCAH) Sharpened Plan II (2022/23–2026/27), which increasingly incorporates quality of care, respectful maternity care, and rights-based approaches. Despite this strong normative and policy alignment, evidence from the Uganda Harmonized Health Facility Assessment (2023) and related studies reveals persistent gaps between legal commitments and women's lived experiences.

This disconnect highlights a broader governance problem in Uganda's maternal healthcare system: while maternal health is increasingly recognized as a constitutional and human rights issue, the translation of these rights into effective, respectful, and dignified care remains inconsistent. This article, therefore, examines the extent to which Uganda's constitutional provisions, judicial decisions, international obligations, national policies, and institutional arrangements collectively shape the realization of person-centered perinatal healthcare. It argues that despite strong formal commitments, significant implementation gaps persist, and addressing these requires stronger legal enforceability, policy coherence, and institutional accountability to fully embed a rights-based approach to maternal healthcare.

PROBLEM STATEMENT

Uganda has made significant constitutional, legal, and policy progress in recognising maternal and newborn healthcare as a rights-based public priority. The 1995 Constitution guarantees rights to life, dignity, equality, and women's protection under Articles 21, 22, 24, and 33, reinforced by Uganda's obligations under CEDAW, ICESCR, and the Maputo Protocol, while the RMNCAH Sharpened Plan II (2022/23–2026/27) commits to quality, accountability, and the reduction of preventable maternal deaths. These reforms have contributed to notable public health gains, including a decline in maternal mortality from 438 deaths per 100,000 live births in 2011 to 189 in 2022, alongside skilled birth attendance rising to approximately 91% (UDHS, 2022).

However, despite this expanding legal and policy framework, a critical implementation gap persists between formal rights recognition and the practical realisation of person-centered perinatal healthcare. Contemporary evidence demonstrates that despite Uganda's progressive legal and policy commitments to maternal healthcare, significant rights-practice gaps persist within maternity care settings. While 85.9% of Ugandan women delivered in health facilities in 2022, only 14% received all essential recommended maternal and newborn interventions, and just 47.8% delivered in facilities assessed as adequately ready to provide quality maternal care, revealing substantial deficits in effective, respectful, and rights-compliant service delivery (Uganda DHS 2022; Uganda Harmonised Health Facility Assessment, 2023). Facility readiness was particularly weak in lower-level public health centers, where readiness stood at only 46.4%, disproportionately affecting poor and rural women. Complementary findings from CEHURD (2023) and the Ministry of Health quality reviews further indicate persistent reports of neglect during labour, verbal abuse,

denial of informed consent, breaches of confidentiality, and exclusion from maternal healthcare decision-making.

These realities expose a profound disconnect between Uganda's constitutional guarantees of dignity, equality, and freedom from degrading treatment under Articles 21, 24, and 33, and women's lived experiences in maternity settings. Consequently, Uganda's maternal healthcare challenge increasingly lies not merely in expanding access or reducing mortality, but in strengthening the legal, policy, and institutional effectiveness necessary to translate formal rights into genuinely respectful, dignified, and participatory perinatal healthcare. This study addresses the central problem of the gap between Uganda's formal legal and policy commitments to maternal healthcare and the practical realization of person-centered perinatal healthcare. The primary purpose of this article is to critically examine the extent to which Uganda's legal, policy, and institutional framework safeguards and operationalizes person-centered perinatal healthcare.

THEORETICAL FRAMEWORK

This paper used a Human Rights-based approach to shift the focus from mere medical survival to addressing systemic injustices, unequal power dynamics, and the root social causes of maternal mortality and morbidity regarding prenatal healthcare. A human rights-based approach to development programming (HRBA) is one which systematically applies the values, principles and standards contained in international and national human rights law to all aspects, both substantive and procedural, of the development process, namely to: Situational analysis and assessment, Priority and target-setting, Policy and strategy development, Programming and project formulation, Project implementation and service delivery, Monitoring and evaluation (UNDP, 2006). This approach aims to increase the capacity of both the duty-bearers and the rights-holders (UNDP 2006; UNFPA 2014). This approach applies the AAAQ framework (availability, accessibility, acceptability, and quality), which depends on the conditions prevailing in a particular state party.

LITERATURE REVIEW

The relationship between maternal healthcare and women's rights has increasingly evolved from a narrow focus on survival to a broader concern with dignity, autonomy, and reproductive justice. Globally, maternal health scholarship has traditionally prioritised reducing maternal and neonatal

mortality through improved service access, skilled birth attendance, and emergency obstetric care (World Health Organisation [WHO], 2023). This biomedical orientation has significantly shaped health reforms in many developing countries, including Uganda, where maternal health interventions have historically focused on increasing facility-based deliveries and reducing preventable deaths. While these interventions remain essential, emerging literature increasingly argues that maternal survival alone is an insufficient measure of healthcare justice unless accompanied by respectful, dignified, and participatory care (Kruk et al., 2018).

The concept of person-centered perinatal healthcare has therefore emerged as a critical framework for evaluating maternal healthcare quality. Drawing from WHO standards on quality maternal and newborn care, person-centered care emphasizes that women should not only survive childbirth but should also experience healthcare that respects their dignity, autonomy, privacy, informed consent, and meaningful participation in decisions affecting their bodies and newborns (WHO, 2023). This framework is closely linked to the respectful maternity care movement, which identifies mistreatment during childbirth, including neglect, verbal abuse, discrimination, non-consented care, and breaches of confidentiality as violations of fundamental human rights rather than merely poor service delivery (White Ribbon Alliance, 2019).

In Sub-Saharan Africa, and particularly Uganda, literature increasingly documents persistent gaps between maternal healthcare access and maternal healthcare experience. Studies on Uganda's maternity care systems indicate that although facility deliveries and skilled attendance have improved substantially, women, particularly poor, rural, and vulnerable mothers, continue to face disrespectful and abusive treatment during childbirth (CEHURD, 2023; Uganda Harmonised Health Facility Assessment, 2023). Sarkar et al (2018) reviewed the perinatal period and indicated that interpersonal aspects of quality of perinatal care and service delivery are largely lacking in this low-resource setting. It was further showed three interrelated process aspects of quality of perinatal care are negative reported patient-provider interactions, the perceptions shaping patient-provider interactions, and emergent consequences arising out of these processes of care (Sarkar et al, 2018). Research also highlighted shortages of resources and staff, high workloads, disrespect and abuse during care, lack of privacy and dignity, and poor-quality care as some of the reasons for dissatisfaction with perinatal care in sub-Saharan Africa (Mannava et al, 2015; Dantas et al, 2020). These challenges are driven by weak accountability systems, resource constraints,

workforce shortages, and uneven implementation of standards, all of which undermine the practical realisation of person-centered perinatal healthcare.

Similarly, research on respectful maternity care in Kampala revealed a disconnect between midwives' understanding of respectful care and their actual practices within strained healthcare environments (Andru et al, 2020). Thus, person-centered maternal healthcare cannot be reduced to individual provider behaviour alone; it is deeply connected to broader structural and institutional conditions. Notably, such findings suggest that expanding healthcare coverage without addressing governance, accountability, and rights-based service quality may fail to achieve genuine maternal justice.

Legal scholarship on maternal healthcare in Uganda has similarly expanded, particularly through constitutional litigation and rights-based advocacy. The Constitution of Uganda, 1995, alongside judicial decisions such as CEHURD v Attorney General, has increasingly framed maternal healthcare as a constitutional matter involving rights to life, dignity, equality, and state accountability. International human rights scholarship further reinforces this perspective by highlighting the obligations imposed by CEDAW, ICESCR, and the Maputo Protocol to ensure maternal healthcare that is accessible, acceptable, equitable, and dignity-protective (United Nations Human Rights Council, 2022). However, much of this scholarship tends to focus either on legal recognition or healthcare policy independently, with limited integrated analysis of how constitutional law, judicial interpretation, policy frameworks, and institutional structures collectively influence women's perinatal experiences.

The governance and accountability literature offers additional insight through the concept of implementation gaps. Scholars such as Bovens (2007) and Brinkerhoff (2004) argue that formal legal recognition alone does not guarantee effective rights realisation unless supported by institutional accountability, enforceability, and responsive governance systems. Applied to maternal healthcare, this suggests that constitutional rights and policy commitments may remain largely symbolic if healthcare institutions lack sufficient resources, accountability mechanisms, and operational standards to protect women's dignity in practice. Uganda's maternal health context reflects this challenge, where legal and policy commitments coexist with persistent reports of disrespectful care, weak grievance systems, and uneven institutional responsiveness.

Despite these important contributions, three significant gaps remain in the literature. First, there is insufficient legal-policy scholarship specifically examining person-centered perinatal healthcare as a governance issue within Uganda's constitutional and policy framework. Second, existing maternal health research often prioritizes mortality and service access over legal enforceability, dignity, and accountability. Third, there is limited integrated analysis connecting constitutional provisions, judicial decisions, international obligations, national policies, and institutional arrangements to women's actual maternal healthcare experiences. This study addresses these gaps by providing a comprehensive legal and policy analysis of person-centered perinatal healthcare in Uganda, thereby contributing to scholarship on maternal health law, reproductive rights, and governance.

METHODOLOGY

This study adopts a qualitative doctrinal research design supported by policy and institutional analysis. This study primarily examines the legal and policy dimensions governing person-centred perinatal healthcare in Uganda, with particular emphasis on constitutional provisions, statutory frameworks, judicial decisions, international human rights commitments, national health policies, and institutional governance structures. Through doctrinal legal analysis, the study evaluates how Uganda's legal order conceptualizes, protects, and operationalizes women's rights to respectful, dignified, informed, and participatory maternal healthcare.

The study relies primarily on secondary data sources purposively selected for their relevance, authority, and contemporary significance. These sources include the Constitution of the Republic of Uganda, judicial decisions relating to maternal healthcare and state accountability, international and regional human rights instruments such as CEDAW, ICESCR, and the Maputo Protocol, national health policies including the RMNCAH Sharpened Plan II (2022/23–2026/27), Ministry of Health reports, Uganda Demographic and Health Survey (UDHS 2022), Uganda Harmonized Health Facility Assessment (2023), CEHURD reports, and scholarly literature on maternal healthcare, reproductive rights, and public governance published between 2010 and 2026.

Data are analyzed thematically through a legal-policy governance framework, focusing on five key analytical domains: constitutional protections, judicial interpretation, international human rights obligations, national policy adequacy, and institutional implementation effectiveness.

Particular attention is given to identifying gaps between normative legal commitments and practical maternal healthcare realities, especially regarding respectful maternity care, accountability, and reproductive dignity.

CONSTITUTIONAL PROVISIONS AND STATUTORY LEGAL FRAMEWORKS ON THE PROTECTION OF PERSON-CENTERED PERINATAL HEALTHCARE

The findings reveal that Uganda's Constitution provides a substantial normative foundation for person-centered perinatal healthcare under Article 33(3), which affirms that the state shall protect women and their rights, taking into account their unique status and natural maternal functions in society. This protection is largely implicit rather than expressly articulated in the language of maternal healthcare. Article 22 guarantees the right to life, which extends to maternal survival and state obligations to prevent avoidable maternal deaths. Article 24 protects women from cruel, inhuman, or degrading treatment, thereby providing a constitutional basis for challenging disrespectful maternity practices such as verbal abuse, neglect, denial of pain relief, or humiliating treatment during childbirth. Article 21 guarantees equality and non-discrimination, while Article 33 specifically mandates state protection of women's rights and recognizes their unique status and maternal functions. The National objectives XIV & XX mandate the State to provide basic health services to the population. Similarly, the Public Health Act Cap 310 provides for the State's responsibility in public health and maternal services. Collectively, these provisions establish constitutional grounds for respectful, dignified, and rights-based maternal healthcare. However, the study finds that constitutional and statutory legal framework protection remains predominantly broad and interpretive, with limited explicit constitutional operationalization of informed consent, reproductive autonomy, privacy, and participatory maternal care standards. Consequently, while Uganda's Constitution and statutory legal framework provide important rights architecture, its practical effectiveness in directly guaranteeing person-centered perinatal healthcare remains dependent on interpretation, policy translation, and institutional enforcement.

JUDICIAL DECISIONS AND CONSTITUTIONAL JURISPRUDENCE

The findings indicate that Uganda's judiciary has progressively contributed to maternal healthcare rights discourse, particularly through constitutional litigation that frames maternal health as a governance and accountability issue. The landmark Centre for Health, Human Rights and

Development (CEHURD) & Others v Attorney General significantly advanced the constitutionalizing of maternal healthcare by affirming that systemic failures in maternal health service delivery may implicate state accountability under constitutional rights frameworks. This marked a critical jurisprudential shift from viewing maternal healthcare solely as administrative policy to recognizing it as a constitutional matter involving life, dignity, and state obligation. However, despite this progress, judicial jurisprudence remains relatively limited in directly addressing respectful maternity care dimensions such as informed consent, confidentiality, participatory care, and everyday abuses in maternity wards. Thus, while constitutional litigation has expanded reproductive justice discourse, Uganda's jurisprudence on person-centred perinatal healthcare remains emergent rather than fully developed.

INTERNATIONAL AND REGIONAL HUMAN RIGHTS COMMITMENTS

Uganda's international and regional human rights obligations significantly strengthen its normative commitments to person-centered perinatal healthcare. Instruments such as CEDAW, ICESCR, the Convention on the Rights of the Child, and the Maputo Protocol collectively impose obligations to ensure maternal healthcare that is accessible, acceptable, dignified, equitable, and rights-compliant. The findings show that these frameworks provide strong normative standards for reproductive autonomy, informed participation, and respectful maternity care. However, despite Uganda's formal ratification of these instruments, domestic implementation remains uneven. International commitments are more visible in policy discourse than in enforceable facility-level protections, resulting in partial integration of global human rights principles into practical maternal healthcare governance.

NATIONAL HEALTH POLICIES AND OPERATIONALIZATION

The findings demonstrate that Uganda's national health policies have increasingly evolved to incorporate quality-of-care principles beyond mortality reduction. The RMNCAH Sharpened Plan II (2022/23–2026/27), reproductive health strategies, and safe motherhood frameworks recognize quality, accountability, and service responsiveness. Nevertheless, policy emphasis remains heavily focused on biomedical outcomes such as mortality reduction, service coverage, and facility utilization, with comparatively weaker operationalization of person-centered dimensions including dignity, autonomy, informed consent, and protection from mistreatment. Policy standards on

respectful maternity care are often advisory rather than enforceable, and monitoring systems priorities service access over experiential quality indicators. This creates a policy-practice gap in which maternal healthcare quality is formally recognized but inconsistently implemented.

INSTITUTIONAL ARRANGEMENTS AND PRACTICAL EFFECTIVENESS

The study finds that Uganda's institutional arrangements remain the most significant barrier to the practical realization of person-centered perinatal healthcare. Although the Ministry of Health, professional councils, healthcare facilities, and grievance systems collectively constitute the institutional governance framework, implementation is undermined by weak accountability structures, underfunded maternity wards, workforce shortages, inadequate provider training, fragmented complaints systems, and socio-economic inequalities. Recent evidence from the Uganda Harmonised Health Facility Assessment (2023) indicates that only 47.8% of women delivered in facilities adequately prepared to provide quality maternal care, while lower-level facilities remain especially under-resourced. These weaknesses disproportionately affect poor, rural, and vulnerable women, transforming formal maternal rights into inconsistent healthcare experiences dependent on institutional capacity rather than enforceable legal entitlement.

DISCUSSION

Constitutional and Statutory Legal Framework and Person-Centered Perinatal Healthcare

The findings demonstrate that Uganda's constitutional and legal framework provides a strong normative basis for person-centered perinatal healthcare, particularly through Articles 21, 22, 24, 33, and National Objectives XIV& XX of the Constitution of the Republic of Uganda (1995), which collectively guarantee equality, life, dignity, and protection from cruel, inhuman, and degrading treatment. This aligns with global human rights interpretations that situate maternal healthcare within the broader right to health and dignity (WHO, 2023; Kruk et al., 2018). However, despite this strong alignment at the level of principles, there remains a clear contradiction in operationalization, as the Constitution does not explicitly define enforceable standards for respectful maternity care, informed consent, or reproductive autonomy, thereby limiting its direct translation into facility-level accountability and leaving implementation dependent on interpretation and institutional commitment.

Judicial Jurisprudence and Maternal Healthcare Rights Development

Ugandan judicial decisions, particularly CEHURD & Others v Attorney General (2011; Supreme Court Appeal 2020), demonstrate a progressive shift toward recognizing maternal healthcare as a constitutional and state accountability issue, especially where systemic failures contribute to preventable maternal deaths. This position is consistent with international reproductive rights jurisprudence and the WHO (2023) standards that frame maternal mortality as a human rights concern rather than only a clinical outcome. However, while courts have advanced the constitutionalizing of maternal health, there remains limited jurisprudential development on everyday respectful maternity care issues such as dignity violations, informed consent, and discriminatory treatment, reflecting a partial rather than comprehensive integration of reproductive justice into judicial reasoning.

International and Regional Human Rights Commitments

Uganda's obligations under instruments such as CEDAW (1979), ICESCR (1966), the CRC, and the Maputo Protocol establish a coherent and robust international legal framework requiring states to ensure maternal healthcare that is accessible, acceptable, equitable, and dignity-centered. These standards are strongly aligned with the WHO (2023) quality-of-care frameworks and the Respectful Maternity Care Charter (White Ribbon Alliance, 2019), both of which emphasize autonomy, respect, and non-discrimination. Nevertheless, the findings reveal a contradiction between normative commitment and domestic implementation, as these international obligations are insufficiently domesticated into enforceable national standards, resulting in weak translation into facility-level accountability and inconsistent protection.

National Health Policies and Operationalization of Rights-Based Care

The study findings indicate that Uganda's national health policies, particularly the Reproductive, Maternal, Newborn, Child Health and Adolescents (RMNCAH) Sharpened Plan II (2022/23–2026/27), reflect an increasing policy shift toward integrating quality of care, accountability, and respectful maternity care principles. This aligns partially with WHO (2023) and global health systems literature advocating for patient-centered and experience-based quality indicators. However, a critical contradiction persists in that policy implementation continues to prioritise biomedical outcomes such as mortality reduction, service coverage, and facility delivery rates,

while respectful maternity care indicators remain weakly defined, poorly measured, and largely non-enforceable, resulting in a persistent gap between policy intent and operational reality.

Notably, the International Human Rights standard shows that applying a rights-based approach to the reduction of maternal mortality and morbidity depends upon a just, as well as effective, health system. Health systems are more than a delivery apparatus for interventions and commodities. A society in which rich and poor women alike, irrespective of race, ethnicity, caste, disability, or other characteristics, can rely on the health system to meet their sexual and reproductive health needs fairly is a more just society. In turn, claims for sexual and reproductive health goods, services, and information should be understood by health system users, providers, and policymakers as fundamental rights, not as commodities to be allocated by the market or matters of charity (Lynn, 2005; OHCHR, 2011).

Institutional Arrangements and Implementation Gaps

The findings show that institutional arrangements within Uganda's maternal healthcare system constitute the most significant barrier to realising person-centered perinatal care, despite the existence of governance structures under the Ministry of Health and related regulatory bodies. Evidence from the Uganda Harmonised Health Facility Assessment (2023) and CEHURD (2023) highlights persistent weaknesses in facility readiness, workforce capacity, grievance mechanisms, and accountability systems, particularly in lower-level and rural facilities. This reflects a structural implementation gap consistent with Bovens' (2007) accountability theory, where formal rights and policies fail to produce substantive outcomes due to weak enforcement mechanisms, resource constraints, and systemic inequalities that disproportionately affect vulnerable women.

Across constitutional, judicial, international, policy, and institutional dimensions, the findings reveal a consistent pattern of strong normative alignment but weak implementation coherence. While Uganda demonstrates substantial agreement with global standards on maternal dignity and respectful care (WHO, 2023; CEDAW, 1979), there remains a persistent contradiction between formal legal commitments and lived maternal healthcare experiences. This disconnect indicates that maternal healthcare reform in Uganda is not primarily constrained by the absence of legal or policy frameworks, but rather by insufficient institutional translation, weak accountability

mechanisms, and limited integration of dignity-based indicators into health system performance monitoring.

Contribution of the Study

This study contributes to existing scholarship by repositioning maternal and newborn healthcare in Uganda from a predominantly biomedical and public health concern toward a broader legal, policy, and governance question centered on the practical realization of person-centered perinatal healthcare. While existing literature has largely focused on maternal mortality reduction, healthcare utilization, service delivery, and reproductive health outcomes, comparatively limited scholarly attention has been directed toward interrogating how Uganda's constitutional provisions, judicial decisions, international human rights obligations, national health policies, and institutional governance structures collectively shape women's experiences of respectful, dignified, informed, and participatory maternal healthcare. This article bridges the important analytical gap by shifting the focus from healthcare access alone to the effectiveness of legal and policy frameworks in operationalizing reproductive dignity and maternal justice.

The study further contributes by conceptualizing person-centered perinatal healthcare not merely as a clinical quality standard, but as a constitutional and human rights governance issue. In doing so, it expands the discourse on maternal healthcare beyond mortality prevention to include dignity, autonomy, informed consent, Human Rights-based approach principles of participation, equality, accountability, and institutional responsiveness. This reframing is significant because it highlights that failures to observe the Human Rights-based approach and the international standards on respectful maternity care may constitute not only health system inefficiencies, but also legal and governance deficiencies that undermine constitutional rights and state obligations at the international level. In addition, the article contributes to policy and legal reform discourse by critically examining the disconnect between Uganda's formal legal and policy commitments and the lived realities of women in maternity care settings. Through this integrated constitutional, policy, and institutional analysis, the study provides a more comprehensive understanding of how weak implementation, fragmented accountability, and systemic inequalities compromise person-centered perinatal healthcare. Ultimately, the study offers evidence-based legal and policy recommendations for strengthening accountability, institutional responsiveness, and rights-based

maternal healthcare governance, thereby contributing to broader debates on reproductive justice, health law, and public governance in Uganda and similar developing contexts.

CONCLUSION

This study concludes that Uganda has developed a progressively expanding constitutional, judicial, international, and policy framework capable of supporting person-centered perinatal healthcare. However, despite this formal recognition, substantial implementation gaps persist between legal commitments and women's lived maternal healthcare experiences. Constitutional protections remain broad, judicial advances remain partial, international obligations are incompletely domesticated, policies remain more biomedical than rights-operational, and institutional systems remain constrained by weak accountability and resource limitations. As a result, Uganda's maternal healthcare challenge increasingly lies not in the absence of rights, but in the insufficiency of legal enforceability, policy operationalization, and institutional responsiveness necessary to transform formal protections into respectful, dignified, and participatory maternal healthcare. Person-centred perinatal healthcare in Uganda, therefore, remains a legal and governance project as much as a public health one.

RECOMMENDATIONS

Uganda should develop explicit statutory frameworks or regulatory standards specifically recognising respectful maternity care, informed consent, reproductive autonomy, confidentiality, and dignity as enforceable maternal healthcare rights.

Strategic litigation and judicial interpretation should further expand constitutional jurisprudence on respectful maternity care beyond mortality and emergency obstetric failures to include dignity-based violations within maternity settings.

Uganda should strengthen the domestic incorporation of CEDAW, ICESCR, and Maputo Protocol obligations into enforceable maternal healthcare standards and facility governance protocols.

National maternal health policies should move beyond mortality-focused metrics to include measurable person-centred care indicators such as informed consent, patient dignity, respectful treatment, and women's participation.

The Ministry of Health and related institutions should strengthen grievance redress systems, maternal rights monitoring, provider accountability, and facility oversight mechanisms while addressing workforce shortages and infrastructural deficits. Healthcare workers should receive mandatory rights-based maternal care training, while women should be empowered through legal literacy on maternal healthcare rights.

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