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THE STATUS OF INTEGRATION OF HUMAN RIGHTS-BASED APPROACH IN HEALTH CARE DELIVERY IN UGANDA: CASE STUDY OF SELECTED NORTHERN AND CENTRAL REGIONS' HEALTH SERVICE POINTS.

December 2016

Assessment of the Integration of Human Rights Based Approach in Health Care Delivery in Selected Facilities in Uganda

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List of Acronyms

AAAQ- Availability, Accessibility, Acceptability and Quality
CCA: Common Country Assessment
CSOs: Civil Society Organizations
CEHURD: Center for Health, Human Rights and Development
CRC: Convention on the Rights of the Child
HRBA: Human Rights-Based Approaches
HUMCs: Health Unit Management Committees
HCIII: Health Centre III
HCIV: Health Centre IV
ICESCR: International Covenant on Economic, Social and Cultural Rights
PFP: Private for Profit
PNFP Private-not-for profit
UNATCOM: Uganda National Commission for UNESCO
UNDAF: United Nations Development Assistance Framework
UNCESCR: United Nations Committee on Economic, Social and Cultural Rights
UNESCO: United Nations Educational, Scientific and Cultural Organization
WHO: World Health Organization

STRUCTURE OF THE REPORT

The Assessment of the Application of Human Rights-Based Approach in Healthcare Delivery Report is structured into eight (8) main segments viz-the Executive Summary; Chapters 1, 2, 3, 4, & 5; Bibliography; and, Annexes.

The Foreword provides an overall introduction and commissions the report

The Executive Summary provides a synopsis of the HRBA report.

Chapter One, Presents the background information on HRBA focusing on its purpose and objectives.

Chapter Two provides the Analytical Framework of the HRBA. It also highlights the application of HRBA to healthcare in Uganda's context, looking at the policy and legal framework.

Chapter Three presents a comprehensive assessment of the Application of Human Rights Based Approach in Healthcare Delivery in Uganda. The assessment focuses on key thematic areas, including the scope and linkages of the AAAQ framework with the Rights Based Approach; main achievements and challenges; as well as implementation gaps.

Chapter Five comprises the summary, conclusion and recommendations arising from the assessment.

Bibliography: Provides a list of documents that provided the main source of information for the HRBA.

Annexes: Provide in-depth information on some areas of the report to facilitate cross-referencing.

FOREWORD FROM THE SECRETARY GENERAL

A human rights-based approach (HRBA) aims to support better and more sustainable development outcomes by analyzing and addressing the inequalities, discriminatory practices (de jure and de facto) and unjust power relations which are often at the heart of development problems. Under a human rights-based approach, development efforts are anchored in a system of rights and corresponding State obligations established by international law. A HRBA also appreciates the importance of capacity development and is one of the key programming principles guiding UN common country programmes like Common Country Assessment (CCA) and United Nations Development Assistance Framework (UNDAF). HRBA as applied to health specifically aims at realizing the right to health and other health-related human rights. It underlines the fact that Health policy making and programming are to be guided by human rights standards and principles and aim at developing capacity of duty bearers to meet their obligations and empowering rights-holders to effectively claim their health rights.

One key Strategic objective of UNESCO under its Social and Human Sciences programme for 2015/16 biennium was to support inclusive social development, foster intercultural dialogue and promote ethical principles through leading initiatives based on a human rights-based approach in education, the sciences, culture, communication and information that support social transformations for the emergence of more inclusive societies and greater intercultural dialogue. This also entailed coordinating the application of a human rights-based approach across all programmes and activities of the Organization and coordinating input to United Nations human rights mechanisms.

It was against the above background that the Uganda National Commission for UNESCO (UNATCOM) undertook this study to understand the increased outcries about the declining health care system and the apparent gaps in accessibility to health care especially by the poor, disabled, women and other marginalized groups in the Country. The study was to specifically assess the Public Health Programmes in the Country to identify whether their designs are by use of rights-based principles, document some case studies of public health programs employing rights based approaches and based on the findings, to ultimately develop and adapt a model that could be published online for use by medical practitioners. This project was also in line with the Sustainable Development Goal (SDG) 3 of ensuring healthy lives and promoting well-being for all at all ages. Although the objective of developing an online model for use by the medical practitioners could not be achieved, the findings and recommendations in this report go a long way in answering some of the concerns raised and thus lays a foundation for more work in the area of HRBA.

I therefore recommend this report to all concerned stakeholders in the field of human rights and specifically those interested in the "right to health" as spelled out in the World Health Organisation's Constitution.

Rosie Agoi

SECRETARY GENERAL (a.i)

A WORD FROM THE DIRECTOR GENERAL OF HEALTH SERVICES

In July 2016, when the Ministry of Health was requested for collaboration in this study, it notified the heads of the targeted health facilities through their Chief Administrative Officers to cooperate in making the exercise a success. This was in consideration of the importance to build evidence on some best practices in human rights-based approaches (HRBA) in our health service delivery which had not been previously well documented. It was to track our performance in HRBA following the launch of a comprehensive National Patient's Charter in October 2009 that provided for the rights and responsibilities for both the patients and the health service providers and the second National Health Policy (2010) that puts the client and community at the forefront and adopted a client-centered approach in healthcare.

Some positive findings include satisfaction by 90.99% of the exit clients with the respectful handling at time of receiving health care, provision of continuous professional development sessions to staff in most of the facilities and one exemplary case of practices of HRBA integration in care provision. However, gaps exist in some of the old legal and policy guidelines , staff knowledge in rights-based approaches , the functionality of some Health Management Committees , the stock outs of essential medicines, the weak ambulance and referral system, non-provisions for the physically-impaired patients and others with special need in over 92.5 % of the surveyed units, problem of economic access affecting about 52.6% of health facility clients in private wings and the longtime of access of services by over 50% of the clients. I have also taken note of the findings that some facilities have un-used equipment either due to lack of skilled personnel to operate them or because of non- repair. The case of 40% of the units lacking clean water and 22.5% lacking alternative sources of power are of concern. The recommendations call for a comprehensive country-wide assessment for a strong basis to apply HRBA models in the health care service delivery in the Country. These raise the need for increased support in resources to the heath sector including the need for more qualified personnel and their facilitation.

I wish to thank the Uganda National Commission for UNESCO (UNATCOM) for the initiative to undertake the study as a stock-taking on the application of HRBA in our health sector and I urge that our cooperation in this area be strengthened further. I also thank all the District Health Officers and the Officers in charge of the health facilities for their cooperation with the consultant team. Finally, I recommend this report for reading by health service providers for improvement in the health care service delivery in our Country.

Prof. Olaro Charles

Director health services (Clinical services)

Acknowledgement

The Uganda National Commission for UNESCO (UNATCOM) wishes to acknowledge the efforts of the Centre for Health, Human Rights and Development (CEHURD) for the collaboration in undertaking this study not only as a consultancy firm but also as a partner through committing some additional resources to make this study a success.

UNATCOM also thanks the Ministry of Health especially the Office of the Director General for Health Services for getting the targeted Health Units to cooperate in the study and delegating a commissioner to officially open the validation workshop. All the personnel in charge of the targeted health units who provided information to the Consultants and those who later participated in the validation workshop made the study realize its objectives.

UNATCOM further acknowledges the efforts of the Ag. Secretary General Ms. Rosie Agoi for the overall supervision. Dr. Dominic Venture Mundrugo-Ogo Lali who formulated and Provided the technical leadership to the project while the interns Mr. Emmanuel Odimbe, Mr. Vincent Ogal, Ms Lara Berens, and Ms. Veronika Seemann did the secretarial work. Finally, the staff in both the secretariat and the accounting department are appreciated for the various support without which the project would not have got the results here presented. All other efforts are greatly appreciated and are hereby duly acknowledged.

EXECUTIVE SUMMARY

The major objective of this study was to collate evidence regarding the integration of human rights-based approach in health care delivery in Uganda. The study is part of larger ongoing efforts at developing an online Human Rights-Based Approach (HRBA) model for medical professionals. The entire process will contribute towards building evidence-based practices for rights-based approaches to health service delivery.

The specific objectives of the study were; To review the literature on International, regional and national human rights standards for a Human Rights-Based Approach for health care delivery; To assess compliance with the Human Rights Based Principles at selected health facilities; To document case studies regarding the use of HRBA to health care delivery; and, To recommend strategies for integrating the Human Rights Based Approach in health service delivery.

An extensive legal and policy review, included documentation of some of the strategic litigation involving violations of the right to health. A cross – sectional survey employing interviews and observations was used to assess 40 health facilities for integration of the HRBA and documentation of case studies that apply the approach. The facilities included public, private-for-profit and private-not-for-profit health facilities in Acholi, Lango and Central Region. The selected facilities included Regional Referral Hospitals, General Hospitals, Health Centre IVs (HCIVs) and Health Centre III (HCIII). The survey was conducted between July and August 2016.

Findings from the legal and policy review show that several International and regional human rights instruments provide guidance for the integration of Human Rights Based approaches to health care delivery. The instruments have informed Uganda's legal and health policy frameworks such as the Patient Charter developed by the Ministry of Health as to guide health care delivery.

The study, however, noted gaps in the implementation of HRBA in the sampled health facilities. Some guidelines such as the Public Health Act and the Venereal Disease Act which lack Human Rights Principles, still guide the operations of health facilities in Uganda. Only 55% (22 out of 40) of the facilities reported knowledge of the patient charter. In the validation meeting health workers acknowledged lack of knowledge of the legal environment within which they operate. Rights holders lack spaces to engage duty bearers on framing of human rights in the delivery of health care services. The Health Unit Management Committees (HUMCS), which are government structures for promoting community participation in the delivery of health

care, are largely non-functional except one supported by civil society organizations (CSOs). Hence, the accountability of duty bearers is minimal.

While essential medicines were available, major stock outs were found even in hospitals. 75% of the facilities do not have the hepatitis B vaccine for a disease that is endemic in the country and kills faster than HIV. In terms of accessibility, Over 92.5% (37 out of the 40 facilities) lacked ramps for access by people with physical impairment. Similarly 92.5% of the facilities also lacked sign language interpreters for those with hearing impairments. Only 2 (5%) had clinics for commercial sex workers and 3 (7.5%) out of 40 could respond to the specific needs of albinos. Ambulance services are still a major challenge in many facilities. Specifically, 40% lacked clean water and 22.5% (9 out of the 40 facilities) lacked alternative sources of power. In a few facilities, patients had to pay to use the toilets. Economic access is also a problem as 52.6% of health facility clients who were asked to pay, expressed hardship to meet the costs. Over 50% of the clients spend over 30 minutes before they reach the facility. Some facilities have un-used equipment either due to lack of skilled personnel to operate them or the need for repair.

Nevertheless, 90.99% of the exit clients felt that they had been respectfully treated while receiving health care. Most of the facilities provide continuous professional development sessions to their staff. Lacor hospital in particular provides annual training programs for the staff. In fact, this hospital attempts to integrate the HRBA in care provision through client satisfaction surveys, suggestion boxes, and radio talk shows. Other good practices were treatment and consultation rooms to enhance privacy, and special clinics for the mentally impaired in two facilities.

This study recommends that a national level assessment be done to generalize results countrywide for legal and policy reforms integration of the HRBA in medical training and involvement of human rights and legal fraternities in health care. At the district level, we recommend the local government to use their authority to apply the HRBA. Facility level recommendations include operationalisation of the patient's charter and the HUMCs, and inclusion of the HRBA in continuous professional development. Finally, it is recommended that providers take initiative to self-educate on the HRBA, make reference to clinical guidelines to provide accurate and acceptable care, and document all care processes as evidence in case of litigation when accused of negligence.

CHAPTER ONE

BACKGROUND

1.1 Introduction and Rationale

The right to the highest attainable standard of health (referred to in short as "the right to health") was first reflected in (WHO) Constitution and has been firmly endorsed in a wide range of international and regional human rights instruments. A human rights-based approach (HRBA) aims to support better and more sustainable development outcomes by analyzing and addressing the inequalities, discriminatory practices (de jure and de facto) and unjust power relations which are often at the heart of development problems. Under a human rights-based approach, development efforts are anchored in a system of rights and corresponding State obligations established by international law. A HRBA also appreciates the importance of capacity development and is one of the key programming principles guiding UN common country programmes like Common Country Assessment (CCA) and United Nations Development Assistance Framework (UNDAF). HRBA as applied to health specifically aims at realizing the right to health and other health-related human rights. It underlines the fact that Health policy making and programming are to be guided by human rights standards and principles and aim at developing capacity of duty bearers to meet their obligations and empowering rights-holders to effectively claim their health rights. It entails integrating human rights norms and principles in the design, implementation, monitoring, and evaluation of health-related policies and programmes. These include human dignity, attention to the needs and rights of vulnerable groups, and an emphasis on ensuring that health systems are made accessible to all. The principle of equality and freedom from discrimination is central, including discrimination on the basis of sex and gender roles. Integrating human rights into development also means empowering poor people, ensuring their participation in decision-making processes which concern them and incorporating accountability mechanisms which they can access.

This study is premised on the universal understanding of the human rights-based approach (HRBA). It draws from the further guidance provided by the Office of High Commissioner for Human Rights on the application the HRBA principles.[1] The HRBA identifies three critical aspects including who has rights ("rights-holders" i.e. patients, as well as providers); what rights they have and the obligations that are owed to them (by "duty-bearers" e.g. government, hospitals).[2] Applying the HRBA therefore helps rights-holders like patients and

[1] Office of the United Nations High Commissioner for Human Rights (2016), 'Health Workers Summary Reflection Guide on a Human Rights-Based Approach to Health', United Nations, Geneva

[2] Harvard University FXB Center for Health and Human Rights (undated). Health service providers guide for providers on applying Human Rights-Based Approach to Health. In the context of maternal, sexual and reproductive health in East Africa

providers claim their rights, and encourage duty-bearers to meet their obligations. This means that duty-bearers become accountable to rights-holders. Through this, policies and programs are responsive to the needs of patients and practitioners.

It is further emphasized that Accountability must occur at every level in HRBA – from the practitioner level, right up to the national government.[3] As both duty-bearers and rights-holders, health service providers have a particularly important role in upholding human rights. For example, practitioners should deliver services that meet HRBA standards (as duty-bearers) but also demand adequate facilities and supplies, as well as conditions, to perform their work (as rights-holders). Further to accountability, the United Nations guides that the HRBA also analyzes a policy cycle through a framework of human rights principles of equality and non-discrimination, participation, indivisibility, and the rule of law[4], as well as the "AAAQ" framework, which identifies availability, accessibility, acceptability and quality of health-care facilities, goods and services as essential components of the right to health. It is pertinent to highlight that applying an HRBA is complementary to adhering to standards of medical ethics.[5]
Uganda's legal and policy environment provides a great basis for engaging with the government on HRBA because in many of its laws and policies the government undertakes to observe human rights in the provisions of health services. The National Health Policy II, for instance, explicitly identifies equity and human rights as some of the key social values guiding health sector processes and notes that: "*Government shall endeavor to achieve equal treatment for equal need and for equal access to health care according to need.*" One of the equity-related interventions cited in the Health sector strategic and investment plan is to improve access to equitable and quality clinical services at all levels in both the public and private sectors and institutions.[6]

In addition, Uganda is signatory to a number of international human rights instruments that speak to the right to health and spell out the government obligations. These include the International Covenant on Economic and Social rights (1987), the Convention on the rights of the Child (1986) and the African Charter on the rights and Welfare of the Child (1990), among other international and regional conventions. Many of the provisions in these Conventions have been adopted in Uganda's National laws. For instance, Objective XIV(b) the Constitution of Uganda sets out the state's duty to ensure that all Ugandans enjoy access to health services. Under Article 33(3), the state is required to protect women and their rights, taking into account their unique status and natural maternal functions. Children are protected under Article 34(3) which provides that no child should be deprived of

[3]Alicia Ely Yamin, Toward Transformative Accountability: A Proposal for Rights-based Approaches to Fulfilling Maternal Health Obligations, *Sur: An International Journal* 7(12): 95-122 (2010);
[4]United Nations Development Group, *The Human Rights Based Approach to Development Cooperation: Towards a Common Understanding Among UN Agencies* (2003).
[5] Supra, Note 1.

medical treatment, while article 34(4) provides that children should not be employed in or required to do work that is likely to be harmful to their health.

The government has, in addition, set up structures which provide spaces for communities to engage at various levels of the health sector. For instance, the Ugandan Government promoted the decentralizing of its health system as a way of empowering its citizens to participate in the process of development to improve their livelihood in critical sectors such as health. This saw the creation of structure such as the Health Unit Management Committees (HUMCs) and the Hospital Boards which are the first point of interaction between the communities and the health system. Indeed the Ministry of Health also developed the patient's charter which was intended to raise the standard of Health care by empowering the clients and patients to responsibly demand good quality health care from government facilities.[7] As a core focus of this charter, it intended to bring about the awareness of patients' rights and responsibilities that had been lacking among the population of Uganda and to motivate the community to participate in the management of their health by promoting disease prevention, timely referral of patients to health facilities for immediate attention of their health problems and concerns.

There are also structures such as the Uganda Human Rights Commission, the Equal Opportunities Commission which give audience to citizens when their rights have been violated. Other spaces include provisional bodies for health professionals where citizens can complain of health violations, the courts of law and Parliament.

Despite the existence of all these frameworks, there are persistent complaints on the quality of health care provision in any health facilities. Findings from a recent community consultation for instance indicated a sense of community marginalization in some Ugandan community groups.[8] These groups reported experiencing political sidelining, discrimination and inequitable access to health services which is seen as the key reason for their poor health. Clinical services were found to be of low quality with little or no access to facilities, trained personnel, and drugs and there are no rehabilitative or mental health services available. This combined with the growing trends of court judgments condemning human rights abuses in the provision of health care in Uganda call for the need to assess the potential value of application of HRBA principles in the health care setting in Uganda.

1.2 Objectives of the Study

The major objective of this assignment was to collate evidence about the application of HBRA in health care delivery. This will be used to develop HRBA model for medical professionals for online use which will contribute towards

[7] Government of Uganda (2009), 'Patients' Charter' Ministry of Health, Kampala.

[8] Mulumba et al. (2014) Perceptions and experiences of access to public healthcare by people with disabilities and older people in Uganda; International Journal for Equity in Health 2014, 13:76 http://www.equityhealthj.com/content/13/1/76

building evidence-based best practices for rights-based approaches to health service delivery which has not been sufficiently documented until now.

1.3 Specific Objectives

The specific objectives were;

- To review the literature on International, Regional and National Human Rights standards for a HBRA for health care delivery;
- To assess the selected health facilities' service delivery standards to identify their levels of compliance with the Human Rights Based Principles;
- To document any case studies as evidence of use of the HBRA to health care delivery
- To recommend some model approaches for integrating the HBRA in health service delivery.

CHAPTER TWO

ANALYTICAL FRAMEWORK

2.1 Legal Basis and Normative Content

This study is built on the human rights framework and more specifically the right to the highest attainable standard of physical and mental health (here in after called 'the right to health). This framework can serve as both an end and means in the provision of health care. The framework is capable of acting as a source of legal standards and obligations as well as one of principles and practical methods that determine how those standards and obligations are to be achieved in the provision of health care. The right to health was first articulated in 1948 under Article 25 (1) of the Universal Declaration of Human Rights which affirmed everyone's right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing, medical care and the necessary social services.

This right was later articulated in a more comprehensive manner under article 12 of the International Covenant on Economic, Social and Cultural Rights.[9] Under this, States parties recognized the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Article 12 (2) enumerates, by way of illustration, a number of steps to be taken by the States parties to achieve the full realization of this right. This has also been recognized in several other international human rights Conventions including under Article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination;[10] under Articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979[11]; Article 24 of the Convention on the Rights of the Child of 1989; Article 25 of the Convention on the Rights of Persons with Disabilities.[12]

At the regional level, the right to health is articulated under Article 16 of the African Charter on Human and Peoples' Rights;[13] Article 14 of the Charter on

[9] UN General Assembly, International Covenant on Economic, Social, and Cultural Rights (ICESCR) (Dec 16, 1966, entered into force Jan 3, 1976). http:// www.refworld.org/cgi-bin/texis/vtx/rwmain?docid=3ae6b36c0

[10] UN General Assembly, *International Convention on the Elimination of All Forms of Racial Discrimination*, 21 December 1965, United Nations, Treaty Series, vol. 660, p. 195, available at: http://www.refworld.org/docid/3ae6b3940.html [accessed 3 October 2016]

[11] UN General Assembly, *Convention on the Elimination of All Forms of Discrimination against Women*, 18 December 1979, A/RES/34/180, available at: http://www.refworld.org/docid/3b00f2244.html [accessed 3 October 2016]

[12] UN General Assembly, *Convention on the Rights of Persons with Disabilities*, 13 December 2006, A/RES/61/106, Annex I, available at: http://www.refworld.org/docid/4680cd212.html [accessed 3 October 2016]

[13] Organization of African Unity (OAU), *African Charter on Human and Peoples' Rights ("Banjul Charter")*, 27 June 1981, CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), available at: http://www.refworld.org/docid/3ae6b3630.html [accessed 3 October 2016]

the Rights and Welfare of Child[14], and also under Article 14 of the Protocol to the African Charter on the Rights of Women in Africa.[15]

2.1.1 The Normative Content of the Right to Health

The Committee on Economic, Social and Cultural Rights (CESCR) as the United Nations body authorized to monitor compliance with the ICESCR issued a general comment on the right to health – famously referred to as General Comment No. 14 (UNCESCR) of 2000.[16]General Comment No. 14 must however be considered together with the earlier General Comment No. 3 on the Nature of States Parties' Obligations.[17]Under this General Comment No. 14, the Committee interprets the right to health, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. The Comment also emphasizes the important aspect of is the participation of the population in all health-related decision making at the community, national and international levels.

Article 12 (2) (d), specifically requires states to take steps for the creation of conditions which would assure to all medical service and medical attention in the event of sickness. This article means that Health services/ health care are an integral part of realizing the highest attainable standard of physical and mental health. As such, delivery of healthcare must conform to the standards of the right to health framework in order to contribute to the realization of the right to health.

The text of General Comment 14 provides for the normative content of the right to health and interprets article 12 (2) (d) to connote the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education. According to the comment, this also calls for; regular screening programs; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care. The Comment also highlights a further important aspect as being the improvement and furtherance of participation of the population in the provision of preventive and curative health services. It is clear from the Comment that the right to health must be understood as a right to the

[14] Organization of African Unity (OAU), *African Charter on the Rights and Welfare of the Child*, 11 July 1990, CAB/LEG/24.9/49 (1990), available at: http://www.refworld.org/docid/3ae6b38c18.html [accessed 3 October 2016]
[15] African Union, *Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa*, 11 July 2003, available at: http://www.refworld.org/docid/3f4b139d4.html [accessed 3 October 2016]
[16] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4, available at: http://www.refworld.org/docid/4538838d0.html [accessed 3 October 2016]
[17] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant)*, 14 December 1990, E/1991/23, available at: http://www.refworld.org/docid/4538838e10.html [accessed 4 October 2016]

enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health. These aspects must however be interpreted as part of the broader normative content of the right to health which includes the social determinants of health.

As part of the normative content of the right to health, the General Comment further stipulates among others that governments have an obligation to ensure that health care information, services and commodities are Available, Affordable, Acceptable and of Quality (AAAQ framework).[18] Each of these components contributes to how "health" should be understood and the obligations of the State (duty bearers) and responsibilities of the right holders. Although the AAAQ framework covers various components of the right to health (including social determinants of health), this review focuses on the right to health with focus on health service delivery. Within the AAAQ framework, government has the obligation to ensure;

- That health services are made ***available*** by ensuring that health care facilities are functional and available in sufficient quantity;
- That health services are ***accessible*** and accessibility covers four dimensions; physical accessibility, economic accessibility, non-discrimination access and access to information for all sections on the population.
- That service is **acceptable** and thus considers individual culture, medical ethics and is also gender sensitive.
- That health services should be of **quality** and as such require both scientific and medically appropriate services as well as regular control mechanisms and training of health professionals and health service providers.

2.1.2 The Nature of Obligations

Part II of the General Comment provides for the States Parties' Obligations which are also provided for under Article 2 (2) of the International Covenant on Economic, Social and Cultural Rights. The Comment highlights that the right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to *respect*, *protect* and *fulfill*. Respect: this obligation calls upon the States to refrain from interfering with the enjoyment of the right to health. From an access to health care perspective, the State has to refrain from denying or limiting equal access for all persons to preventive, curative and palliative health services and abstain from enforcing discriminatory practices in the delivery of health care as a State policy among other issues; Protect: this obligation calls upon States to take measures to prevent third parties from interfering with the enjoyment of the right to health. In the perspective of access to health care, States should for instance adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties

[18] General Comment 14, f the Committee on Economic, Social and Cultural Rights, http://www.ohchr.org/english/bodies/cescr/comments.htm.

and also ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct among other aspects; Fulfill: This contains obligations to facilitate, provide and promote. States must adopt legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health. From the perspective of access to health care, under obligation, a State must ensure provision of health care, including immunization programs against the major infectious diseases; ensuring the appropriate training of doctors and other medical personnel; the provision of a sufficient number of hospitals, clinics and other health-related facilities and ensuring that health services are culturally appropriate among other things.

Like with other economic, social and cultural rights, the Covenant and the General Comment provides for progressive realization and acknowledges the constraints due to the limits of available resources. As such, the obligations of the State in the provision of health care are clustered under immediate obligations and obligations that can be progressively realized in light of the available resources. The General Comment however introduces what it terms as the Core obligations and the obligations of comparable priority.

The immediate obligations in relation to the right to health, as illuminated under General Comment 14 (UNCESCR) include the States parties 'obligations to guarantee that the right to health will be exercised without discrimination of any kind and the obligation to steps towards the full realization of the Article 12. Under this obligation, the steps taken must be deliberate, concrete and targeted towards the full realization of the right to health. This therefore calls for policies and practices that are not discriminatory in the provision of health care.

On the other hand, while the General Comment recognizes progressive realization of the right to health, this should not be interpreted as depriving States parties' obligations of all meaningful content. It has to be considered as meaning that States parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of article 12. To this effect the General Comment presents a strong presumption that retrogressive measures taken in relation to the right to health are not permissible. Even in cases in which of deliberate retrogressive measures are taken, the State party has the burden of proving that they have been introduced after the most careful consideration of all alternatives and that they are duly justified. As such, the provision of health care, the state must avoid any measure that can be interpreted as being retrogressive.

The Committee also made reference to General Comment No. 3, (UNCESCR) under which it had earlier confirmed that States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Therefore, while States must progressively realize the right to health, they must at the same time begin by at least providing and

realizing the minimum essentials. The General Comment thus provides a list of 6 core obligations States must realize:

a) Non-discriminatory access to health facilities, goods and services;
b) Access to the minimum, nutritionally adequate and safe food;
c) Access to basic shelter, housing and sanitation, and safe and potable water;
d) Provision of essential drugs (as defined by the WHO);
e) Equitable distribution of all health facilities, goods and services;
f) Adoption and implementation of a national public health strategy and plan of action.

Further to the core obligations, the General Comment provides for obligations it refers to as obligations of comparable priority. There are five and they include:

a) Ensure reproductive, maternal and child health care;
b) Provide immunization against major infectious diseases in the community;
c) Take measures to prevent, treat and control epidemic and endemic diseases;
d) Provide education and access to information on the main health problems;
e) Provide appropriate training for health personnel, including education on health and human rights.

2.2 The Human Rights-Based Approach

A human rights-based approach to health specifically aims at realizing the right to health and other health-related human rights. Health policy making and programming are to be guided by human rights standards and principles and aim at developing capacity of duty bearers to meet their obligations and empowering rights-holders to effectively claim their health rights. A HRBA emphasizes that the ultimate goal of all health policies, strategies and programs is to further advance the realization of the right to health and other health-related human rights as laid down in national and international human rights legislation. Human rights standards provide guidance in defining the precise elements of a health objective. If the right to health and other health-related human rights are to be fully realized, policies and plans need to systematically integrate and further these rights.

This assessment is anchored in the HBRA. This is a conceptual framework anchored in international human rights law that is increasingly being integrated into a broad range of program areas, including health. While there is no one definition or model of HRBA, the United Nations has articulated several common principles to guide the mainstreaming of human rights into program work:

- The integration of human rights law and principles should be visible in all work, and the aim of all programs and activities should be to contribute directly to the realization of one or more human rights

- Human rights principles – universality and inalienability, indivisibility, interdependence and interrelatedness, non-discrimination and equality, participation and inclusion, accountability and the rule of law – should inform all stages of programming, including assessment, design and planning, implementation, monitoring and evaluation
- Participation and transparency should be incorporated into all stages and all actors must be accountable for their participation

The use of the human rights approach has been endorsed by the United Nations (UN) and other international agencies and organizations.[19] A rights approach emanates from the 1948 Universal Declaration of Human rights and the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR) and has also been recognized in regional instruments such as the 1981 African Charter in Human and People's rights.[20] In 2003, the UN recognized the need for coherence of approaches for UN inter-agency and thus developed and agreed upon a UN Common Understanding on Human Rights-based Approach.[21] This common understanding has been used as a guiding framework for partners, agencies, governments and non-governmental organizations.[22] The UN Common Understanding stipulates that:

a) "**GOAL**: All programs of development cooperation, policies and technical assistance should further the realization of human rights as laid down in the Universal Declaration of Human Rights and other international human rights instruments."
b) "**PROCESS**: Human rights standards and principles guide all development cooperation and programming in all sectors and phases of the programming process."
c) "**OUTCOME**: Development cooperation contributes to the development of the capacities of 'duty bearers' to meet their obligations and/or of 'rights holders' to claim their rights."

The World Health Organization (WHO) has recognized and made commitment to mainstreaming human rights into health care programs and policies at both national and regional levels.[23] The purpose of utilizing a human rights based approach is to ensure that all designed health policies,

[19] Mickey Chopra &Neil Ford, Scaling up health promotion interventions in the era of HIV/AIDS: Challenges for a Rights Based Approach, 20 Oxford journals Health Promotion international, 383-390,available at http://heapro.oxfordjournals.org/content/20/4/383.short
[20] Mickey Chopra &Neil Ford, *Scaling up health promotion interventions in the era of HIV/AIDS: Challenges for a Rights Based Approach*, 20 Oxford journals Health Promotion international, 383-390
[21] WHO,UNOHCHR, Department of Ethics, Equity, Trade and Human rights (ETH), Information, Evidence AND Research(IER), available at http://www.ohchr.org/Documents/Issues/ESCR/Health/HRBA_HealthInformationSheet.pdf
[22] WHO,UNOHCHR, Department of Ethics, Equity, Trade and Human rights (ETH), Information, Evidence AND Research(IER), available at http://www.ohchr.org/Documents/Issues/ESCR/Health/HRBA_HealthInformationSheet.pdf
[23] WHO, Health and Human rights, Fact sheet No. 323, available at http://www.who.int/mediacentre/factsheets/fs323/en/

strategies and programs contribute to progressively realizing and improving the enjoyment of the right to health.[24]

2.3 Key Elements of a Human-Rights-Based-Approach

For the purpose of this study, we will consider six elements as critical for the realization of the HRBA to health. These provide a basis for human rights based interventions and evaluations of such interventions.[25] These five elements known include: Participation, Accountability, Non-discrimination (Equality), indivisibility, Rule of law and the AAAQ Framework.[26] For children, as guided by UN Committee on the Rights of the Child (CRC), the HRBA also requires that "best interests of the child" is a primary consideration in the design and implementation of policies which will affect children.[27] The elements of the HRBA are complementary in adhering to standards of medical ethics which is considered under rule of law. These principles will be considered within the confines of health care and health service delivery in private and public hospitals.

1. Participation

"Participation is both a means and a goal."[28]It is important that health service seekers participate effectively and meaningfully engage in making decisions that affect their lives including the methods and process by which they obtain health services from both public and private health facilities. Participation not only involves a mere interaction with the health system while seeking health services, but extends to ensuring that the communities served participate at various stages of health service programming, priority setting, monitoring and evaluation.[29]

2. Accountability

Duty bearers including government agents (health service providers) should be answerable to rights holders. This requires that the necessary measures and mechanisms required to ensure accountability within a health facility are put in place and adhered to. In addition, it is also important that rights holders are equipped and empowered so that they can exercise their right to obtain accurate information including that relating to their health and are able to demand accountability.

3. Non-discrimination

[24] WHO, Health and Human rights, Factsheet No. 323, available at http://www.who.int/mediacentre/factsheets/fs323/en/
[25] UNICEF, The Human Rights Based Approach: Statement of Common Understanding, available at http://www.unicef.org/sowc04/files/AnnexB.pdf
[26] Office of the United Nations High Commissioner for Human Rights (2016), 'Health Workers Summary Reflection Guide on a Human Rights-Based Approach to Health', United Nations, Geneva
[27] UN Committee on the Rights of the Child (CRC), *General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, 17 April 2013, CRC/C/GC/15, available at: http://www.refworld.org/docid/51ef9e134.html [accessed 4 October 2016]
[28] UNICEF, The Human Rights Based Approach: Statement of Common Understanding, available at http://www.unicef.org/sowc04/files/AnnexB.pdf
[29] UNICEF, The Human Rights Based Approach: Statement of Common Understanding, available at http://www.unicef.org/sowc04/files/AnnexB.pdf

All individuals are entitled to the same human rights and should not be subjected to any form of discrimination (based on sex, race or age) while seeking health care. There should also be measures to ensure that vulnerable and marginalized groups such as people living with HIV, people living with disabilities do not suffer any form of discrimination while seeking health services.

4. Indivisibility

Human rights are indivisible as such, all human rights have equal status, and cannot be positioned in a hierarchical order. Denial of one right invariably impedes enjoyment of other rights. Thus, the right of everyone to the highest attainable standard of physical and mental health cannot be compromised at the expense of other rights, such as the right to food or the right to education. This principle also emphasizes the issue of the social determinates which are critical for the right to health framework.

5. Rule of law

This requires that the approaches and measures utilized in health service delivery are no contrary to the legal framework and are grounded as legal rights set out in either domestic or international law. The principle also recognizes the Common Law and ethical principles which have shaped the practice of medicine for a long time.

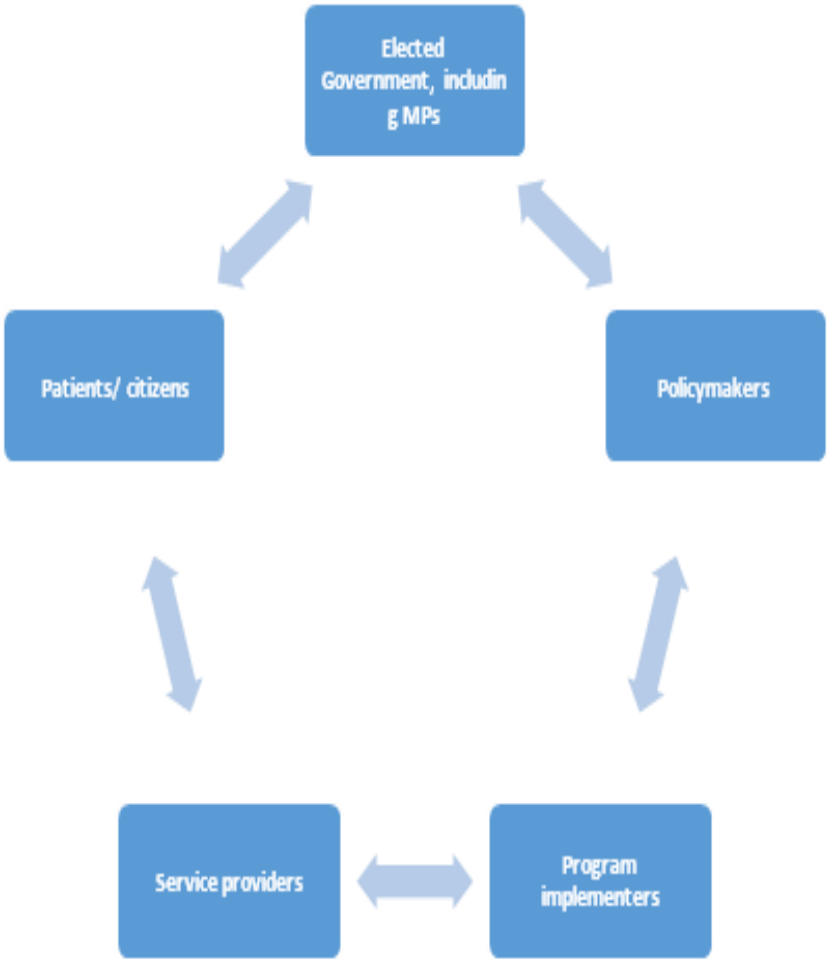
6. The "AAAQ" framework

This framework is provided for under general comment 14 as discussed above. It emphasizes the aspects of availability, accessibility, acceptability and quality of health care facilities, goods and services as essential components of the right to health, and should be provided by the health system

Further to the key elements, theHRBAidentifies"rights-holders" (patients, health service providers), and what rights and obligations "duty-bearers" (government, health facilities) owe them.[30]Human rights guide relationships between rights-holders and duty-bearers.HRBA compliant programming requires identification of human rights claims of rights-holders and the corresponding human rights provisions of duty-bearers; as well as the immediate, underlying, and structural causes of the non-realization of rights."[31] As such, Applying HRBA helps rights-holders like patients and providers claim their rights, and encourages duty-bearers to meet their obligations. This means that duty-bearers become accountable to rights-holders. Through this, policies and programs are responsive to the needs of beneficiaries.

[30]Harvard University FXB Center for Health and Human Rights (undated). Health service providers guide for providers on applying Human Rights-Based Approach to Health. In the context of maternal, sexual and reproductive health in East Africa

[31] For a brief explanation of these principles, see UN Development Group (UNDG), *The Human Rights Based Approach to Development Cooperation Towards a Common Understanding Among UN Agencies* (May 2003), available at: www.undg.org/archive_docs/6959-The_Human_Rights_Based_Approach_to_ Development_Cooperation_Towards_a_Common_Understanding_among_UN.pdf

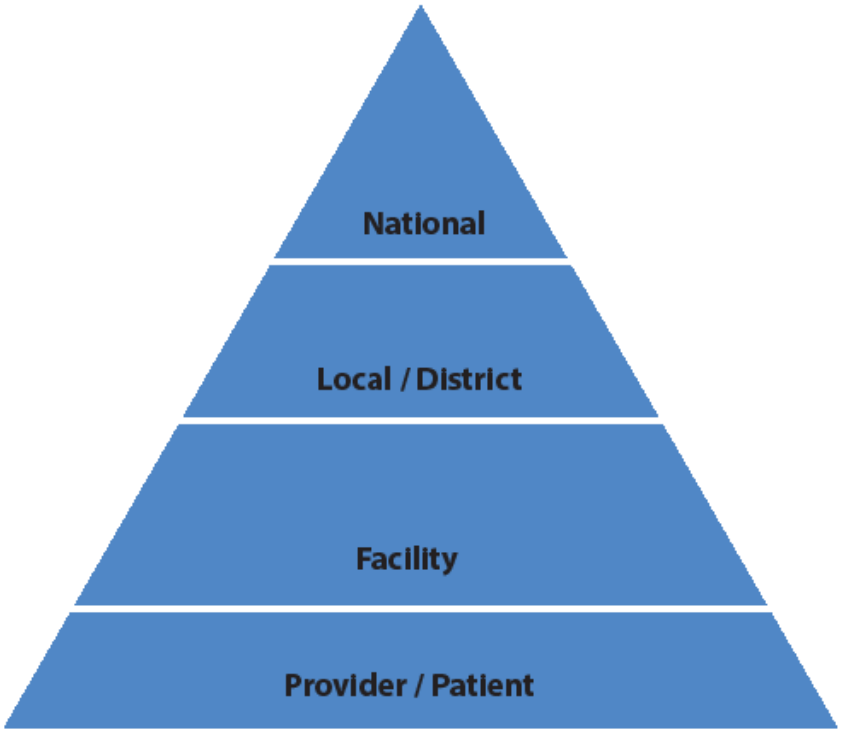


Circle of accountability[32]

Accountability is expected at each level, from the service access point to the national level. And as both duty-bearers and rights-holders, health service providers have a particularly important role in upholding human rights. They are expected to deliver services that meet HRBA standards (as duty-bearers) but also demand facilities, supplies and conditions they need to perform their work (as rights-holders).

In the provision of health care, the HRBA could be applied to health at four levels as indicated in the illustration below[33]:

[32]Yamin, AE and Cantor, R. Between Insurrectional Discourse and Operational Guidance (2014): Challenges and Dilemmas in Implementing Human Rights-based Approaches to Health. *Journal of Human Rights Practice*.
[33]A Yamin (2014) Health Service Providers Guide for Providers on Applying a Human Rights-Based Approach to Health In the Context of Maternal, Sexual and Reproductive Health in East Africa; FXB Center for Health and Human Rights, Harvard School of Public Health.



1) *Provider/patient level* – your direct interactions with patients and their families
2) *Facility level* – how your facility applies and respects human rights
3) *Local/district level* – implementation of national policies, and budgeting for health service delivery
4) *National level* – laws, policies and guidelines, and plans of action, that support or impede human rights

CHAPTER THREE:

METHODOLOGY

3.1 Legal and policy Review

- This was carried out to address objective 1 - To review the literature on International, Regional and National Human Rights standards for a Human Rights Based Approach for health care delivery. The documents were reviewed on how they provide for application of the HRBA in provision of health care. They included;
  - The International Covenant for Economic, Social and Cultural Rights
  - The Uganda Vision 2040
  - The Second National Development Plan
  - The National Health Policy 2010
  - The National Health Sector Development Plan
  - Constitution of the Republic of Uganda of 1995
  - The Public Health Act of 1935
  - Venereal Diseases Act of 1977
  - The Mental Treatment Act
  - The Anti-Homosexuality Act of 2014
  - HIV/AIDS Prevention and Control Act 2014
  - Laws for Professional Regulations
  - Health Service Commission Act of 2001
  - The Patients Charter
- The review further included a highlight on some court decisions in which CEHURD has litigated on violations of human rights in delivery of health care.

3.2 Cross – sectional Survey

This was carried out to address objectives 2, 3 and 4. We assessed health facilities using the five principles of the Human Rights based Approach, that is, Accountability, Participation, Non-discrimination, Indivisibility and Rule of Law

- Participation – How is the community involved in decision making for the facility? We specifically explored functionality of Health Unit Management Committees, involvement in budget processes

- Accountability – We explored platforms that allow duty bearers to account to rights holders. This was at two levels; 1) how are health workers accountable to patients, and 2) how is local government accountable to the health workers

- Non-discrimination – We explored mechanisms that ensure inclusion of minority groups

- Indivisibility – This focused on the elements of the right to health, including accessibility, availability, acceptability and quality of resources, goods and services

- Rule of law – We explored the legal framework that guides the delivery of health services within the districts

3.2.1 Sampling Strategy and Techniques

3.2.1.1 Districts and Health Facilities

A two-stage cluster random sampling was used at region and district level. First, the country was clustered into the 4 four traditional regions of Central, Northern, Eastern and Western out of which the two (2) Northern and Central Regions were selected at first level. Four (4) districts from each of were selected making a sample total of 8 districts. The lottery method was used to select the districts

Furthermore, 5 health facilities that included 3 public facilities (these included referral hospitals, HCIVs and HCIIIs), 1 Private Not for Profit (PNFP) facility and 1 Private for Profit (PFP) facility were purposively sampled from each of the districts, making a total of 40 health facilities. The highest levels of care (tertiary institutions or HCIVs) were sampled considering that each district has one or two. The private facilities were sampled depending to legal status and proximity to the local government structures. The HCIIIs had to be close to the local government structures. These facilities were sampled with guidance from Ministry of Health Officials that were well conversant with these health facilities. Table 4.1 below shows the type of health facilities by region and District.

Table 4.1: Targeted health facility and type

Region	District	Facility	Facility Type
Northern	Amuru	Lacor HCIII	Public
		Atiak HC IV	Public
		Pabbo Lacor HC III	PNFP
		Pawell, HC III	Public
		OT YAT Medical Centre	PFP
	Gulu	Gulu RRH	Public
		St Mary's Hospital Lacor	PNFP
		Awachi HCIV	Public
		Laroo HC III	Public
		Mola Clinic Gulu	PFP
	Lira	Lira RRH	Public
		PAG HCIV	PNFP
		Ogur HC IV	Public
		Ongica HC III	Public

Region	District	Facility	Facility Type
		Gift Life Care Clinic	PFP
	Apac	Apac Hospital	Public
		Aduku HC IV	Public
		Abongomola HC III	Public
		Abedober HC III	PNFP
		Apac Medical Centre	PFP
Central	Mubende	Mubende RR Hospital	Public
		Kassanda HC IV	Public
		Madudu St. Joseph III	Public
		Kitenga HC III	PNFP
		True vine hospital	PFP
	Mityana	Mityana Hospital	Public
		Mwera HC IV	Public
		Magala HC III	Public
		Mityana HC III	PNFP
		Santa Maria Medicare	PFP
	Nakaseke	Nakaseke Hospital	Public
		Kiwoko Hospital	PNFP
		Kapeka HC III	Public
		Ngoma HC IV	Public
		St. Cyprian Ngoma	PFP
	Butambala	Gombe Hospital	Public
		Kyabadaza HC III	Public
		Bulo HC III	Public
		Assumpta HC III	PNFP
		Kawonawo Domiciliary Clinic	PFP

3.2.1.2 Respondents

Respondents included 234 out-patients who were sampled on the day of data collection. The others who were purposively sampled considering their leadership position in provision of care included; 40 facility in-charges, 40-Health Unit Management Committee chairpersons, 8 District Health Officers. Table 3.2 below shows the number of respondents in each category.

Table 4.2: Number of respondents by category:

Category	Number Per district/Health center	Sampling Strategy	Number of Participants
District Health Officers	1	Purposive	8
Facility In-Charge	1	Purposive	40
Health Unit Management Committee chairpersons	1	Purposive	40
Exit -Patients	6	systematic	234
CSO Representatives	N/A	Purposive	2
Total			**284**

3.2.2 Methods and tools of data collection

3.2.2.1 Objective 2: Assessment of the Public Health Facilities' service delivery standards in the country to identify whether their designs align with rights to health principles

- **Interviews**

a) 40 semi structured interviews were held with facility in-charges on how the HRBA is applied in the facilities. We explored the elements described above.
   - Participation and accountability mainly explored the functionality of Health Unit Management Structures and any other facility level platforms
   - Under non-discrimination, we explored provisions for the physically and mentally impaired and minorities such as LGBTI and sex workers.
   - The AAAQ framework explored different goods and services including maternity wards, waiting rooms consultation rooms, laboratories, ambulances, equipment, medicines and vaccines in relation to the WHO essential list, sources of power, portable and drinking water, and waste management.
   - The element of the rule of law explored knowledge and application of the patients' charter, and the ethical code of conduct.

b) 232 exit interviews were held with hospital patients on acceptability of services

- ***Observations:*** *a* checklist was used to triangulate the information about goods and services mentioned above

3.2.2.2 Objective 3: Document Some Case Studies as Evidence of the Public Health Programs Employing Rights Based Approaches

- 8 key informant interviews were held with 8 district level leaders 40 health facility in-charges, 2 civil society representatives, on the level of community participation in planning for health services and accountability
- 234 Patient exit interviews included questions on accountability
- Exemplary health facilities applying the HRBA in the delivery of care were identified, as well as good and bad practices from different health facilities

3.2.3 Data Quality and Trustworthiness

A number of quality control and assurance procedures were instituted to control both sampling and non-sampling errors, and to control both data quality and trustworthiness among which included the following:

3.2.3.1 Selection and training of field officers

Selection and re-orientation of all field officers on data collection techniques, procedures and ethical considerations was done before dispatching the teams to the field. The selection process was spearheaded by a team that consisted of a the Consultant guided by criteria such as research experience, ability to articulate health issues, motivation of the candidate, confidence, creativity and interest

3.2.3.2 Pre-testing of tools

Pre-testing of all instruments was done with computation of the Content Validity Index (CVI) and reliability of the tools done after the pre-test. Improvements were made on items in the tools, until they were considered sufficiently valid to be used in the study.

3.2.3.3 Information exchange meetings

Information exchange and consultative meetings with strategic officers from MoH and UHRC was done. A strategic meeting with MoH was organized and the course of action and lines of engagement agreed. This was to ensure that MoH would have trust in the findings of the study.

3.2.3.4 Validation meeting

The draft report was subjected to a validation that included a meeting with different constituents including academia, human rights advocates, experts in human rights and representatives from constituents that provided the data. The process provided critical inputs and insights on recommendations.

3.2.4 Data analysis and synthesis

All interviews with key informants and patients were recorded and transcribed into English and analyzed by content and themes (Berg, 2004; Ulin et al, 2004) guided by the HRBA model to determine the inclusion and exclusion of human rights in health facilities. Complete transcripts and interview field notes from each interview were coded for a prior themes of common responses from service users in health service delivery regarding integration of rights based approaches to health service delivery. These were further subdivided into more detailed codes, including the emergent themes related to availability, accessibility, legal provisions and quality mechanisms to effective health service delivery in the study areas. All qualitative data (for example, the transcripts and field notes) and quantitative data (for example, descriptive statistics developed from our interviews) were stored and analyzed using NVIVO software. Information from the quantitative analysis was presented using graphs and tables.

3.2.5 Ethical considerations

Written permission was sought from Ministry of Health and a copy of the letter written from the Ministry of Health was sent to the In-Charge of the participating health facilities.

The research study protocol and consent documents was submitted for approval to the Uganda National Council of Science and Technology as part of CEHURD's research process on public health laws review and health equity. In addition assent was obtained from the communities involved. Informed consent form will be designed for each aspect of the study as appropriate. The informed consent form explained in full the nature of the study, role of the participants and benefits related to their participation in the study. All consent forms were pilot-tested for comprehensibility and modified, if necessary, prior to the start of the study. The written consent forms will be translated into the local languages before use.

All data collected was kept confidential and participants assured of confidentiality in the research and amongst any group will be stated as a requirement in the consent form. To protect the identities of the participants, no names were recorded. Participants were not required to discuss any topics with which they do not feel comfortable.

3.2.6 Limitations of the study

The primary cluster units are from only northern and central Uganda and hence may not offer an inference on the other regions for instance western and eastern Uganda. However the study is informative and provides an opportunity and basis for a large sample study. It also provides maiden findings on the integration of human rights based approaches in health facilities and provides an opportunity to interrogate HRBA in health systems in Uganda.

The selected sampling elements are not sampled through a proportionate probability sampling method and the sample lacks the merits of proportionate probability sampling. Hence some primary cluster units are underrepresented. However the sample provides an interaction with data from the regional referral hospitals, HCIVs, HCIIIs from the primary cluster units.

3.3 Review of findings from objective 1, 2 and 3

Recommendations were made based on findings from the legal and policy review and the cross sectional survey. This was done to address objective 4 (to recommend some model approaches for integrating the Human Rights Based Approach in health service delivery). The recommendations were made at National, District, Health Facility and Provider/Patient Levels.

CHAPTER FOUR:

KEY STUDY FINDINGS

4.1 THE HRBA TO HEALTH CARE IN UGANDA'S CONTEXT

Access to health care in Uganda remains one of the areas that needs attention of the government. Despite a number of promising policy statements and interventions by government, a number of bottlenecks continue to affect the delivery and utilization of health services. These in turn impede successes in achieving the population's right to access health care. The report of the working Group on the Universal Periodic[34]made the following observations and recommendations on Uganda's obligations towards its citizens on the right to health a need to continue working with the WHO and other relevant international agencies to further reduce the prevalence rate of HIV/AIDS and enhance access to quality health services for its people; a need to put in place a functioning health information system with disaggregated data from facilities, administrative sources and surveys, to enable effective monitoring of progress; a need to consolidate on-going actions to reduce maternal mortality; and a need to create a health insurance scheme for the poor.

According to General Comment 14, the most appropriate feasible measures to implement the right to health vary significantly from one State to another. Every State therefore, has a margin of discretion in assessing which measures are most suitable to meet its specific circumstances. The State however, should take whatever steps are necessary to ensure that everyone has access to quality health care in the shortest possible time. Countries should formulate and implement national health strategies and plans of action. These should among other things respect the principles of non-discrimination and people's participation. Countries should further consider adopting a framework law to operationalize their right to health national strategy. With this guidance, we review the steps Uganda has taken to operationalize the provisions of General Comment No. 14.

4.1.1 The Policy and Legal Framework

Uganda has put in place several strategies, policies and laws which are critical in implementing its obligations towards achieving the right to health and adopting the HRBA in health sector. It is clear from these frameworks

[34] Unite Nations (2011) 'Report of the Working Group on the Universal Periodic Review – Uganda' Human Rights Council, Nineteenth session Agenda N0.6, A/HRC/19/16, 14th meeting on 11 October 2011

that the formation of the current Constitutional order and economic structuring in the early 1980's following the World Bank and International Monitory Fund policy on liberalization highly influenced the health policy environment. These are presented below:

4.1.1.1 Strategies and Policies

a. The Uganda Vision 2040

The Uganda Vision 2040 is the overall guiding development framework for Uganda and provides the national direction for provision of health care. Vision 2040 acknowledges the obligation of Uganda to respect and promote human rights and commits to the respect for human rights in the process of development planning. The government in the Vision commits to ensure that human rights based approach to development is integrated in policies, legislation, plans and programs in order to strengthen the capacity of the duty bearers to respect, fulfil and protect human rights and of the rights holders to know, claim and realize their rights.

Vision 2040 notes that good health is instrumental in facilitating socio-economic transformation of the country. It specifically singles out that the slow progress on Uganda's health indicators is mainly attributed to the current health service delivery system which is facility-based. As such, its calls for a paradigm shift from facility-based to a household based health delivery system. This shift aims at the empowerment of households and communities to take greater control of their health by promoting healthy practices and lifestyles. The Vision is implemented through ten-year development plans and Uganda is currently implementing the Second National Development Plan which runs from 2010 to 2020.

b. The Second National Development Plan

The National Development Plan aims at achieving the aspirations of Vision 2040 by ensuring accessibility of quality health care to all people in Uganda and set several targets for the achievement of such access. The Plan for example proposes measures to increase deliveries in health facilities from 41% to 64%, reduce in-facility maternal deaths from 148/100,000 to 119/100,000 and reduce under 5 deaths in health facilities from 18/1000 to 16/1000 among others by 2020. This plan builds on the earlier achievements of the first National Development Plan which focused on poverty eradication plans and it mirrors the participation discourse of the earlier plans but what is unique is its emphasis on the role of public-private partnerships which speaks to the role of private health facilities.

The plan highlights that meeting good governance principles will be important for creating the required legal and socio-political environment to accelerate economic and social transformation. As such, its mentions constitutional democracy; protection of human rights; rule of law; free and fair political and electoral processes; transparency and accountability; government effectiveness and regulatory quality among the other principles

of good governance. Paragraph 614 provides that the Governance under this Plan goes beyond the public sector and focuses on articulating how government and other stakeholders will participate in the promotion of good governance in the operationalisation of the Plan. While the plan does well to provide for and set targets towards the realization of health rights as part of the good governance principles, its key omission remains in the failure to mainstream health rights into the planning framework that it proposes.

c. The National Health Policy 2010

So far, Uganda has had two national health policies which have both been shaped by prevailing circumstances at the time of their formulation. The first policy came into place in 1999 as the National Health Policy.[35] Just like the strategic plans at the time, this policy was also informed by the development agenda at the time. The background to the policy indeed affirms that health is an essential prerequisite as well as an outcome of sound development policies. Unlike the first policy, this policy expressly states that the government was to place emphasis on investing in the promotion of people's health and nutrition which constitute a fundamental human right for all people. The language of human rights is vivid through a number of sections of this policy.

The National Health Policy has its own development framework through which it seeks to implement its human rights commitments and this can be traced back from the Health Sector Strategic Plan which was the first plan set out under the national health planning framework. The Health Sector Strategic Plan put forth Uganda's first attempt to provide for the universal realization of the right to health for everyone by proposing a Uganda national minimum health care package that ought to be available to all Ugandans. Indeed Uganda has remained true to the goal achieving the universal minimum health care package as is demonstrated in the latest National Health Sector Development Plan which was launched in 2015.

d. The National Health Sector Development Plan

The National Health Sector Development Plan provides the strategic focus of the sector in the medium term, highlighting how it will contribute, within the constitutional and legal framework, to the second National Development Plan (NDP II), and to the second National Health Policy (NHP II) imperatives of the country, and so to the overall Vision 2040"[36].

The plan recognizes that alongside national commitments, the state has global commitments including commitments under the Sustainable Development Goals and Human rights treaties and instruments whose realization the National Health Sector Development Plan should provide strategic focus for. It also argues that progress has been made in ensuring that key sector policies, strategies and guidelines recognize gender orientations and address health in in the context of its human rights definition

[35]Government of Uganda, '*The National Health Policy'* (1999), Ministry of Health, Kampala
[36] Ministry of Health (2015), The National Health Sector Development Plan (2015-2020)

for which progressive realization is key. Indeed the ministry has put in place a gender and human rights desk, developed a male involvement strategy, developed guidelines for managing gender based violence and developed a human rights and gender manual for service providers and policy makers among others.

These efforts demonstrate positive progress towards mainstreaming the human rights based approach in the provision of health care but the challenge, which actually is recognized by the plan, remains operationalising these efforts and translating them into real change in the actual provision of health care services. This has largely been alluded to disparities between the commitments made towards implementing the strategies and the allocation of financial and human resources to the implementation of the strategies[37]. The implementation of the human rights based approach in planning and provision of health care has strong financial implications and efforts have to be made by the state to ensure that adequate human and financial resources are made available to support policy strategies and commitments to implement the approach in the health sector.

The plan is structured in terms of objectives that the Ministry deems to be of priority to the health sector for the purposes of strategic focus including the production of a healthy human capital through equitable safe and sustainable health services, addressing the key determinants of health, increasing financial risk protection for households and enhancing health sector competitiveness through health systems strengthening and governance. While these objectives from the outset can be interpreted to provide for the various aspects of the human rights based approach including participation, accountability and equality and non-discrimination in addition to the availability, accessibility, acceptability and quality frameworks of the right to health, the non-explicit provision for the same means that the realization of the human rights based approach would only be a pleasant coincidence in the implementation of the other objectives of the plan.

It is therefore imperative that to fulfil its commitment towards the realization of the human rights based approach in health care provision; the government has to make a deliberate effort towards mainstreaming the approach within its policy instruments and needs to commit finances and resources towards the implementation of the approach.

4.1.1.2 The Constitution and other Laws

a. Constitution of the Republic of Uganda of 1995

Uganda is a constitutional democracy and all of its laws and policies flow naturally from the Constitution of the Republic of Uganda of 1995 in which various concepts of the human rights based approach are highlighted.

[37] Ministry of Health (2015), The National Health Sector Development Plan (2015-2020)

The constitution of the Republic of Uganda founds itself on accountability and provides that all authority for which it prescribes is drawn from the people and requires that people be governed according to the constitution through their will and consent[38]. This foundation lays way for a cross section of provisions that reflect a strong constitutional commitment towards the mainstreaming of human rights in the implementation of the provisions of the Constitution.

The National Objectives and Directive Principles of State Policy require the state to guarantee and respect institutions that are responsible for protecting and promoting human rights by providing them with adequate resources to function effectively[39]. The Constitution further requires the state to endeavor to fulfil the fundamental rights of all Ugandans to social justice and economic development and, in particular, to ensure that all Ugandans enjoy rights and opportunities and access to education, health services, clean and safe water, work, decent shelter, adequate clothing, food security and pension and retirement benefits[40]. The importance of these objectives and principles is reiterated by the Article 8A of the Constitution that requires that Uganda be governed basing on the principles of national interest and common good enshrined in the national objectives and directive principles of state policy[41]. In the context of health care, the state is obliged to take all practical measures to ensure the provision of basic medical services to the population.

The Constitution under Chapter four makes further provision for Uganda's obligation to recognize and respect human rights and freedoms by prescribing that fundamental rights and freedoms of the individual are inherent and not granted by the State and that the rights and freedoms should be respected, upheld and promoted by all organs and agencies of Government and by all persons[42].

The Constitution recognizes a cross-section of rights essential to the implementation of the human rights based approach including the right to equality and freedom from discrimination when it provides that all persons are equal before and under the law in all spheres of political, economic, social and cultural life and in every other respect and shall enjoy equal protection of the law[43], the right to participate in decision making individually or through elected representatives in accordance with the law[44], the freedom of speech and expression including the freedom of press and other media[45], the right to access information in the possession of the state or any organ or agency of the state[46] and the right to just and fair treatment in respect to administrative decisions including the right to appeal from such

[38] Article 1, Constitution of Republic of Uganda
[39] Objective V, Constitution of Republic of Uganda
[40] Objective XIV
[41] Article 8A, Ibid
[42] Article 20, Ibid
[43] Article 21
[44] Article 38
[45] Article 29 (1a)
[46] Article 41

decisions[47] among other rights. It should be noted that though the Constitution is not exhaustive it is inclusive in nature as far as human rights are concerned.

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. By interpretation, other rights that are provided for in international instruments which Uganda has adopted and ratified and like the right to the highest attainable standard of health, the right to food, the right to housing among others should be given as much constitutional impetus as any right that is explicitly provided for in the constitution.

b. Other relevant legislations

Despite the progressive disposition of the Constitution, the legislative function of the state has not developed appropriately to provide for the Uganda obligation to mainstream human rights in the provision of health care.

The Public Health Act of 1935: The Public Health Act of 1935 remains the oldest and probably most obsolete piece of legislation for health in Uganda even where it provides for the prevention, control and management of public health in Uganda[48]. While a few parts of the Act remain relevant to the protection of public health like provision relating to prevention and suppression of infectious diseases, the Act does not have any provisions that recognize the need to use a human rights based approach in the management of public health.

Venereal Diseases Act of 1977: This Act provides for the examination and treatment of persons infected with venereal diseases and several other matters relating to treatment of venereal diseases. In addition to empowering medical health inspector to examine a person suspected to be suffering from any venereal disease and giving them treatment, the Act also prescribes offences for refusing treatment and failures to comply with orders of the medical officer.

The Mental Treatment Act: The Mental Treatment Act is similarly quite obsolete having commenced in 1938 and having gone through very little change since then[49]. Due to the limited revisions it has had since its commencement, it has not taken the benefit of contemporary human rights standards for treatment and protection of people with mental disabilities like the Convention on the Rights of Persons with Disabilities. Most of the provisions in the act only provide for the 'management' of people with mental disabilities but do not provide for the protection of their rights. The provisions are not even compatible with international standards for provision of mental health treatment.

[47] Article 42
[48] Chapter 281, Laws of Uganda
[49] Chapter 279, Laws of Uganda

The Anti-Homosexuality Act of 2014: This Act was challenged and annulled by the constitutional court for the faults of parliamentary procedure in its enactment. The substance of the legislation however has several provisions that could be encroaching on the space for protection and fulfillment of health rights of sexual minorities to access medical treatment

HIV/AIDS Prevention and Control Act 2014: This Act provides for the prevention and control of HIV and AIDS including protection, counseling, testing, care of persons living and affected by HIV and Rights including rights and obligations of persons living and affected by HIV and AIDS. Under its provisions, the Act creates obligations on government to devise measure to ensure the right of access to equitable distribution of health facilities, goods and services including essential medicines on a non-discriminatory basis. Its calls for provision of universal HIV treatment to all and several other rights. The Act has however been criticized for its provisions of privacy, compulsory testing and disclosure requirements and a constitutional case is before the Courts of Law for determination.

Laws for Professional Regulation*s:* Health workers are at the very end of the delivery chain as regards the implementation of the human rights approach in health care delivery and it is imperative that they understand and appreciate their obligations. Accordingly, the Uganda Medical and Dental Practitioners Council which regulates the conduct of all medical and dental practitioners in Uganda through the Medical and Dental Practitioners Act has a code of ethics which prescribes the obligations that health workers have in the protection of human rights[50]. The Nurses and Midwives Council similarly has a Code of Ethics which prescribes the obligations of nurses and midwives in the protection of human rights. While the language of these codes is phrased in the context of ethical codes, they take a human rights approach by prescribing standards through which human rights can be protected[51]. The Code of Ethics for medical and dental practitioners for example under Rule 4 requires medical and dental practitioners to respect and protect human rights but phrases their respective obligations as ethical responsibilities.

Health Service Commission Act of 2001: Health workers in the public sector are collectively regulated by the Health Service Commission created under the Health Service Commission Act of 2001 which similarly recognizes the duty of health workers in relation to rights of patients by phrasing them as responsibilities. The Act recognizes the duty of health workers to act in the best interest of patients at all times, to ensure informed consent, respect the privacy and confidentiality of a patient, avoid conduct detrimental to the community and abide by all laws and regulations governing their professions[52]. While these responsibilities can be interpreted as human rights obligations, the Act could have done well to phrase these responsibilities in a human rights language.

[50] The Medical and Dental Practitioners Act, Chapter 272, Laws of Uganda
[51] The Nurses and Midwives Act, Chapter 274, Laws of Uganda
[52] Part 4, The Health Service Commission Act, 2001

c: It is instead in the Patients Charter that the rights of patients are provided for including the right to emergency medical care, the freedom from discrimination, the right to a clean and healthy environment, the right to participate in decision-making and the right to medical information among others. The provisions of the Patients Charter are however limited in effect by the fact that they do not have the binding force of the law and can only be equated to guidelines which health workers can discretionarily apply.

4.1.2 Court Decisions on access to health care in Uganda

Court decisions are critical in framing the country's approach towards the application of HRBA principles in the provision of health care. In Uganda, Courts of law have also made pronouncements that shape the framework for observance of the adopted the human rights based approach for the adjudication of matters of significant public interest especially in a legal environment in which the protection of public interest is strongly taking root. A number of cases have been filed before the different levels of Courts and principles.

a. CEHURD & Ors v the Attorney General (political Question)

The Supreme Court of Uganda in the Center for Health Human Rights and Development &Ors v the Attorney General ruled that where there is an allegation that a policy violates a constitutional right of an individual, the Constitutional Court has a duty to hear the matter and determine whether the rights of the individual have been violated or not.[53]In effect, the state has a constitutional obligation to respect protect and fulfil human rights and where it is alleged that this obligation has been violated, the Constitutional Court has to hear the allegation and make an appropriate determination on it. The Court emphasized that it was important to hear a matter that questioned the constitutionality of the right to health in Uganda's context.

b. CEHURD and Daniel Yiga vs the Attorney General

The Constitutional Court of Uganda in Center for Health, Human Rights and Development and Christopher Yiga v Attorney General relied on the provisions of the Universal Declaration of Human Rights and the African Charter for Human and Peoples Rights to declare unconstitutional pieces of legislation that were inhuman and degrading and the powers of the minister to unjustifiably maintain victims of mental illness in detention.[54] This judgment gives specific recognition to the fact that the rights and freedoms in the constitution of Uganda are not exhaustive and rights and freedoms included in international instruments to which Uganda has committed are similarly applicable in Uganda. It specifically highlights the need for access to care for mental health victims that get tramped into the criminal justice system.

[53] Supreme Court Civil Appeal No 1 of 2013
[54] Constitutional Petition No. 64 of 2011

c. CEHURD & Ors v Nakaseke District Local Government

The High Court of Uganda in Center for Health Human Rights and Development &Ors v Nakaseke District Local Government held the district administration liable for the failure to administer over their health workers in what led to the death of a mother who had gone to give birth after her health rights were violated[55]. Due to the decentralized system of the health sector in Uganda, the obligations of the state to respect human rights extend to the decentralized units of administration which can actually be held responsible in case such rights are violated in their area of jurisdiction. In this case, the Court also declared access to emergency obstetric care as a human rights in Uganda.

d. CEHURD & Others v. Executive Director of Mulago Hospital and Attorney General

The case involves a woman who delivered twins at the hospital, but was given only one live child at the time of discharge. The hospital claimed that the second baby had died shortly after birth, but they could not produce the dead body. The mother was discharged without any medical records or a death certificate for the child. Following pressure from the couple and their supporters, the hospital produced a dead body whose DNA was later found not to be a match with either of the supposed parents. Prior to filing this suit, the lawyers made several attempts to access information to support the case, with limited success. Upon a request by the plaintiffs, the High Court judge ordered the hospital to release all the requested documents, including the patient's file, mortuary record, list of health workers on duty, registry of infants delivered, antenatal and delivery records, and a copy of the DNA results. The hospital complied and this case had continued on its merits. The key point here is the emphasis on the important of access to patient information which is part of the rights-based approach.

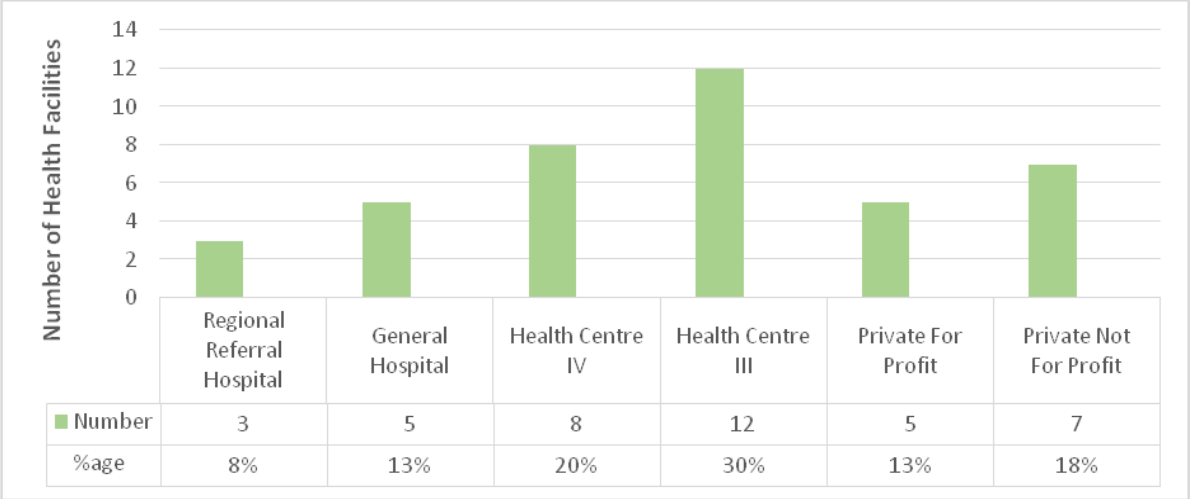
4.2 Cross – sectional survey findings

4.2.1 Type of Health facilities visited

Facility in-charges were asked to clarify on the type of their facility and the findings are presented as indicated in Figure 5.1 below;

Figure 5.1: Type of Health facilities visited

[55] High Court Civil Suit No 111 of 2012



The Figure 5.1 above indicates that out of the 40 health facilities visited, 3 (8%) were Regional Referral Hospitals, 5 (13%) were General Hospitals, 8 (20%) were Health Center IVs, 12 (30%) were HCIII, 5 (12.5%) were Private For Profit and 7 (17.5%) were Private Not For Profit. This implies that data was collected from various health center types giving a greater picture of how HRBA is being implemented at the different health centers types.
This section presents findings basing on the Human Rights Based Approach principles of Participation; Accountability Non-Discrimination; Indivisibility; Rule of Law.

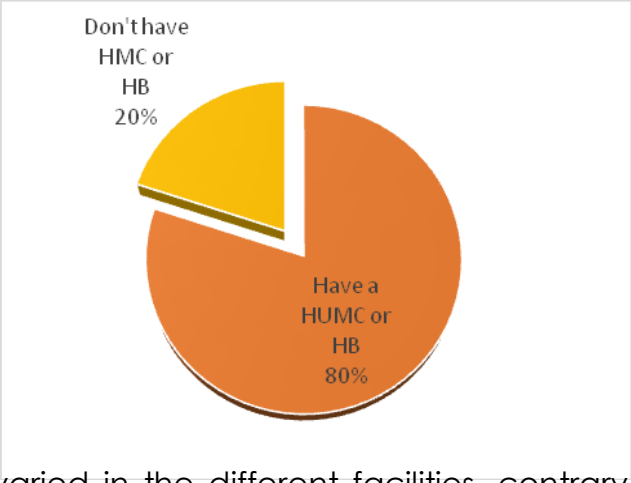
4.2.2 Participation in Health Care Services

- Health management Unit Committees (HUMCs), also known as facility management boards: These are governance structures that were designed by the Ministry of Health to link health facility governance with community needs. HUMCs are expected to participate in designing, organization, implementation and evaluation of health services. The MoH designed guidelines to support establishment and management of the HUMCs at the different decentralized levels of care.

*"Each facility has a management committee and community is represented. VHTs are also members of the community and these work with health facilities and the district. We also hold community dialogues with support from partner's e.g UNFPA, UNICEF, we now hold them quarterly (*District Health Officer)

All district leaders reported that they utilized this bottom-up approach in planning for health services in their districts. Of the 40 health facilities studied 32 (80%) had health unit management committees and or hospital boards as compared to 08 (20%) that lacked health unit management committees to govern facilities as presented in Figure 5.2 below. They explained that communities were always given an opportunity to be actively involved in the planning process and this was done by Health Unit Management Committee (HUMC), which directly interfaced with the community and articulated their concerns and problems to the sub county level.

Figure 5.2: Facilities with Management Committees



Despite the affirmation on engagement with HUMCs by the district health leaders, we found that most of the HUMCs were no longer functional. Clients are afraid of questioning clinical practice or to participate in treatment decisions. Where HUMCs were functioning, they seldom met and were generally ineffective. Non functionality is attributed to a lack to funds to convene the meetings. The composition of HUMCs also varied in the different facilities, contrary to the guidelines. Considering that the guidelines highlight funding and composition of HUMCs, it is likely that they are not followed. This would hinder implementation of these structures especially in Public Health facilities where supervision is constrained. As such, the community barely participates in budget meetings or health committees.

Nevertheless, a functional board was found at St Mary's Lacor Gulu hospital.

1. *"The HUMC is no longer functional; I solve problems as they come. We gather them together and especially in the outpatient department and make an effort to address the problems of the clients"* (HCIII health worker).
2. *"The health unit management committee is under- funded and it is hard to convene a meeting with the members when you lack seating allowances for them." (Facility In-Charge)*
3. *"We fear to question health workers because when they get annoyed they can harass you and it will be your fault" (exit patient)*

The board is headed by the ArchBishop. It constitutes of three directors from the respective directorates and schools, the hospital executive secretary and the hospital secretary, CORDI representative and the Senior Principal Nursing Officer. The hospital board sits every quarter and minutes are taken, filed and shared with the stake holders. Board resolutions and plans are communicated to the community through the general stake holders meeting that happens twice every year. Clients are informed of the board resolutions and plans and stake holder meetings are used to communicate hospital board resolutions and policies to clients. The meetings are also platforms for the community to raise their issues and contribute to decision making. The board also placed six suggestion boxes at different places and the health workers do encourage the clients to use them. The suggestion boxes are opened after every two days and any disciplinary or ethical concerns are forwarded to the disciplinary committee for immediate redress. Other issues, suggestions or concerns are compiled for discussion in the board meeting.

The hospital board further participates at community radio talk shows to further engage the communities they serve.

- Barazas: These are platforms supported by civil society where the community interfaces with duty bearers to address issues concerning them. They were found extensively in Lira and Apac, supported by Lira NGO forum and Apac Anti-Corruption Coalition respectively. They are mostly held at health centers and we learnt in this study that the first phase of budget planning happens at this level then continues to the parish committees. Committees are also active in operations of the facility as strong accountability platforms. They are illustrated further under accountability

4.2.3 Accountability in health services

Accountability is a vital part of the HRBA and it takes many dimensions including social, political, administrative, professional and legal accountability. General Comment 14 guides that the national health strategy and plan of action should be based on the principles of accountability as such, the national implementation has to ensure that any person or group which is a victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels. All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition. Some of the other accountability aspects to consider include ensuring that the community served have the capability to work with facility staff to help improve outcomes for health system users, and ensure services maintain a certain standard of performance. There should be mechanisms for users to advocate when performance falls short, such that facility and local leaders are held to account and remedy shortcomings and very critically there should be unfettered access to public information such as budget allocation and expenditure.

Redress mechanisms

"We engaged stakeholders and district authorities in a process that enabled the district to obtain an ambulance" (KII, TAAC,

a) Barazas: As described under participation, these are supported by CSOs. Barazas work at two levels: 1) The health workers are accountable to the clients; 2) The local district leaders are accountable to the health workers. For example, in Ogur HCIV, the Doctor refused to carry out any operation in a theatre with an un-tiled floor to avoid the risk of infection to his clients. He was supported by the community and the local district authorities took action – the floor is currently under repair. In Ongica HCIII, the one health worker that was there was not treating clients well. They complained about her and the district sent three new staff to that health facility and transferred that health worker to another facility where she would be closely supervised.

b) Patient initiative: In Gulu hospital, clients sued health workers over cases of negligence. This means that some clients are aware of their right to hold health workers accountable. However, most clients (82%)did not know where to report any grievances or seek redress on issues concerning the health facility. Those that knew where to report, mentioned police and Civil Society Organizations.

c) Suggestion boxes: Table 5.1 shows that 22 (55%) of the facilities visited had a suggestion box as a mechanism through which clients would communicate with the health facility administration. Unfortunately, they are not used. Some facility in -charges are not even aware of the presence of suggestion boxes in health facilities. Some don't even know whether they are responsible for the suggestion boxes and others were not clear on who had the keys to the suggestion boxes.
Suggestion boxes are instruments that should be reinforced by HUMCs. If the latter are non-functional, then it is only logical that the suggestion boxes are not used. One facility in-charge specifically disregarded clients' complaints, suggestions and recommendations. He is convinced that clients will always complain and are never appreciative and familiar of their work environment and the challenges they encounter to deliver care.

1. *"We have never opened a suggestion box in the last two years and I really don't know who is responsible for the suggestion box", facility in charge at district hospital.*
2. *"I don't know and I am not sure on who has the keys to the suggestion box. I have been here for the last three years and I have seen anyone open the suggestion box. I was told that they lost the keys. You have reminded me, I will make it a point to open the suggestion box", facility in charge Kasanda HCIV. The suggestion box was not functional and clients were clearly aware that the facility administration doesn't open it.*

In some facilities that had functional HUMCs, facility in charges engaged the concerned health workers and appropriate redress was given. However in facilities where the facilities in charges were not regularly present, the open door policy could not work and clients had no platforms to engage duty bearers. Clients resorted to radio talk shows through which they communicated their grievances to the duty bearers.

Never the less, as seen under participation, Lacor was exemplary. The board emphasizes the use of suggestion boxes which they closely monitor every two days.

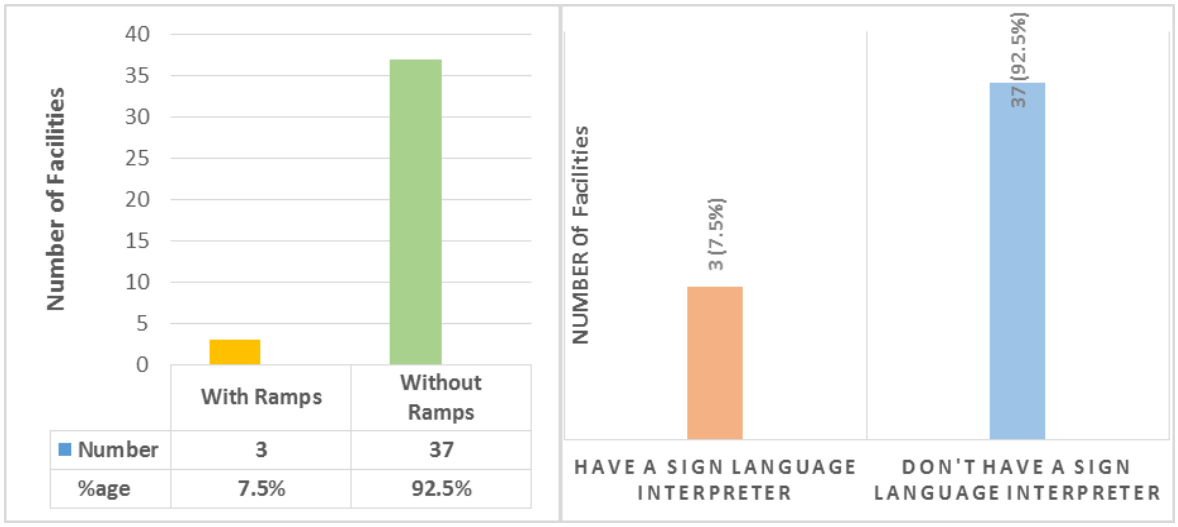
Table 4.3 Methods of accountability

Response	Yes	No	Total
Had suggestion boxes	22 (55%)	18 (45%)	40 (100%)
Have HUMC	32 (80%)	8 (20%)	40 (100%)
Clients with knowledge on where to seek redress	42 (18%)	190 (81.9%)	232 (100%)

4.2.4 Non - discrimination

General Comment 14 indicates that measures should be pursued in strategies and programs designed to eliminate health-related discrimination. As such health facilities, goods and services must be accessible to all, especially by the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds. The HRBA framework aims at highlighting on who is excluded, and draws attention to removing obstacles to equal access to health care. In this assessment we explored provisions for vulnerable groups such as those with physical and hearing impairments. We further explored services for marginalized groups such as commercial sex workers.

Figure 5.3: Facilities with ramps and sign language interpreters



The findings in figure 5.3 show thatof the 40 health facilities surveyed, only 7.5% had ramps and another 7.5% had sign language interpreters. Users with hearing impairment had to find interpreters at their cost, a situation that breaches the right to confidentiality, as one health worker commented. Those that could not afford interpreters have to seek care from other facilities that provide the service. Similarly, clients with physical impairment have to find facilities with ramps in order to access care. In some cases, health providers reported that although they had well established rehabilitation centers for persons with physical impairment, they lacked the requisite personnel to handle the clients.

Seeking appropriate care from distant facilities increases the cost of care, hence denying such clients the right to care. This further contravenes the Convention on the Rights of Persons with Disabilities CRPD (Article 8) and the

guiding principles that highlights respect for difference and acceptance of persons with disabilities as part of human diversity and humanity. In addition, parties to the Convention must raise awareness of the human rights of persons with disabilities (Article 8), and ensure access to roads, buildings, and

"We have no sign language interpreters and deaf clients have to come with sign language interpreters to enhance communication with health workers, we have no health worker trained in sign language"

"These people (persons with disabilities) usually come to health facilities with people to interpret for them because these services are not available at the health facility and this breaches their right to confidentiality"(Medical Superintendent of a regional referral hospital)

"We prioritize and serve them first. We also have a ramp we do not have a wheel chair but the clients come with their wheel chairs or clutches. The blind and deaf are usually escorted by their relatives (KII, Laroo, HCIII)

"We have a well-established rehabilitation center for needs of people with disabilities. Ten years ago the physiotherapist left and has never been replaced. Almost a year ago, the occupational therapist also left we are only left with the orthopaedic technician. We have recently requested the remaining cadres in the unit to come up with a submission on health workers needed in the unit so that we can lobby for support"

information (Article 9).

The district level key informants were concerned that discrimination and equality issues for vulnerable groups still exists. Medical/ clinical training does not include sign language and therefore Health workers are ill-equipped to cater for persons with special needs and disabilities. Never the less, health workers acknowledged giving them priority when they visit the facility.

4.2.4.1 Special clinics

Table 4.4 Type of special clinics

Type of special clinics	*Present*	*Absent*	*Total*
Commercial sex workers clinic	*2 (5%)*	*38 (95%)*	*40 (100%)*
Albinism Clinic	*3 (7.5%)*	*37 (92.5%)*	*40 (100%)*
Mental health Clinics	*2 (5%)*	*38 (95%)*	

Table 4.4above indicates that only 2 health facilities, Laroo HCIII and Gulu regional referral hospital, both in Gulu district had special clinics for commercial sex workers. They mainly provide condoms to encourage safe sex, and selective HIV care and sexual and reproductive health services. In Uganda, sex work is a crime, punishable by seven years in jail. Both the Ugandan penal code and the 2014 anti-pornography act provide legal ground to arrest, detain, and harass sex workers. However, the prevalence of HIV among this group is at 35% and this burden is almost five fold above the average prevalence (8.3%) among women within the reproductive age group. Considering this disease burden, government has made provisions for sex workers to access HIV care and treatment in the Uganda National HIV

strategic plan, although it has not acknowledged that criminalizing sex work undermines efforts to prevent HIV. The illegal environment exposes sex workers to many human rights violations including lack of access to comprehensive sexual and reproductive health care services due to stigma and discrimination.

In both facilities that provide the services however, the clinics operate on specific days and services are not integrated with other services in facilities. These clients are never asked to take their spouses to the facilities to access health services, because they are assumed not to have spouses or families - a characteristic of discrimination and a risk factor for spread of HIV and non-adherence to medical regimens. The facilities also do not provide post exposure prophylaxis for sex workers who practice unsafe sex for one reason or another.

4.2.4.2 Mental Health

Apac hospital and Lira regional referral were the only two facilities found to provide mental health services. Both facilities have specialized personnel to cater for such clients. Most of the other facilities refer to these two for mental health services

> *"If we receive a patient with a mental disability we refer him/her to Lira Regional Referral hospital. Since sex workers also have a special center we refer them as well. I have been trained in handling people with special needs and I have disseminated this knowledge to all the staff at the clinic"* **(KII. PFP. Lira)**

4.2.5 The 'AAAQ' Framework and Indivisibility

4.2.5.1 Availability

Figure 5.6 shows that 82.5% have essential medicines but regular stock-outs are reported especially in HCIIIs, but also in higher levels of care.

75% of the health facilities have not stocked the hepatitis B vaccine. Hepatitis B is endemic in Uganda and it kills faster then HIV. The country is also reported to have one of the highest prevalences in the world and northern Uganda particularly has an even higher prevalence between17-22%.This lack of availability of the essential vaccine is a risk to health and life and requires urgent attention. In 25% of the facilities that have the vaccine, it is sold to the patients. This cost may deter clients from demanding for it and it is probably a reason why facilities may not be stocking it. Stocks outs of medicines and supplies in the facilities is mainly because they do not order for what they need. Instead a specific consignment is sent to them by the National Medical Store through a Push system.

1. *"You can't imagine that a General Hospital has had stock outs of gloves for the last three months, we have written reminders and petitioned the RDC and National Medical Stores but no action has been taken", (Assistant DHO)*
2. *"We receive many packets of condoms compared to coartem yet we are having a malaria epidemic in the district"(CSO leader).*
3. *"if sometimes supplies are out of stock clients are told to contribute although it is not often, some unscrupulous health workers solicit money from clients" (DHO)*
4. *"Services offered in health facilities are inadequate and most inadequacies are superficial for example national medical stores (NMS) packs and delivers things which are not necessary for instance they deliver drugs which are about to expire, supply non-essential things in big quantities like condoms at the expense of essential drugs like anti malarials"(CSO leader).*
5. *"Our theatre is not functional, the floor has a problem. Sometimes we get medicine stock outs, deliveries are made every two months, at times medicines get finished and this depends on the season like for malaria cases; sometimes we go and borrow medicines at nearby facilities and these include lower health facilities as long as they have excess"(KII, HCIV)*
6. *"Health facilities lack basic necessities including gloves and that they ask for mama kits from*

Figure 5.4: Availability of medicines

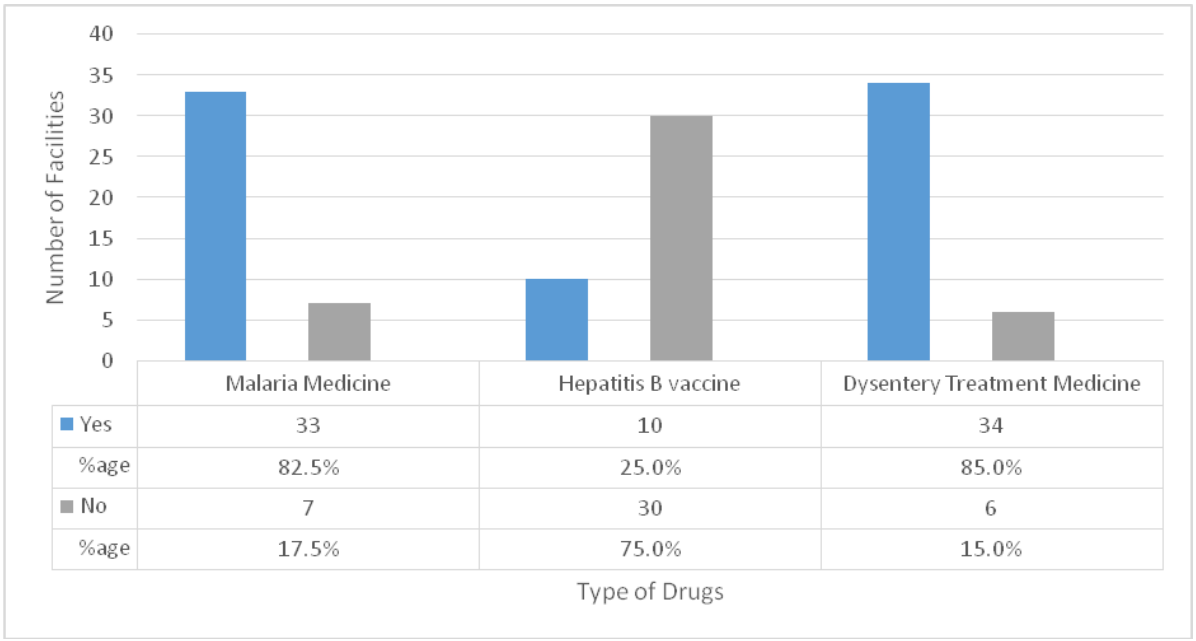
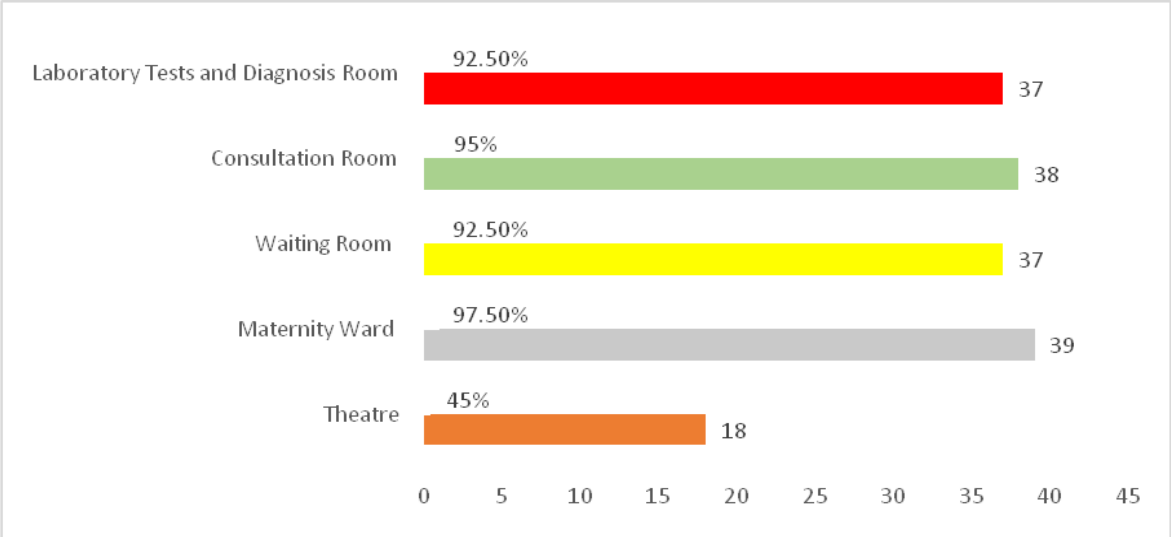


Figure 5.5: Nature and availability of treatment/waiting rooms



Almost all Health facilities have treatment and waiting rooms (Figure 5.7). Theatres are not in HCIIIs as expected. In one HCIV, the Doctor refused to perform any surgeries in the theatre because the floor is extensively cracked and a risk for infection. It is currently under repair.

The CSO leaders whose work includes health governance in Lira and Apac generally acknowledged that health services in public health facilities are inadequate. Clients have to purchase basic medicines from pharmacies and mothers have to carry some items for delivery.

In some facilities, equipment have been installed but are not operational for example XRAY machines, dental chair with accessories and some laboratory machinery. Some also have defects. This was mainly because they lack trained personnel to operate such equipment.

4.2.5.2 Access Parameters

4.2.5.2.1 Economic Access

Of the 40 health facilities studied 47.5% charged user fees for health services. This would be expected in the PFPs and PNFPs which constitute 42.5% of the study sample. Public health facilities should not be charging for user fees at the facility but of the 23 public health facilities, only 21 do not charge user fees. Government abolished user fees in public health facilities in 2001 in attempt to increase access to care. However, this study found that some public health facilities still charge people for care. In one such facility, we learnt that these fees are charged to improve the general maintenance of health facilities. A peculiar example is a charge of 200UGX to access toilet facilities at one regional referral hospital.

Table 5.3: Parameters of economic access

	Parameter of access	Number and Percentage
A	Public health facilities	23 (57.5%)
B	PNFPs + PFPs	17 (42.5%)
C	Facilities that charge user fees	19 (47.5%)
D	Facilities that do not charge user fees	21 (52.5%)
E	Clients who failed to pay user fees (% of C)	10 (52.6%)
F	Clients who paid user fees (% of C)	9 (47.3%)
G	Exit clients that paid for medicines	89 (38.9%)
H	Exit clients that did not pay for medicine	140 (61.1%)
I	Exit clients that could afford the medicine (%age of G)	57 (64.04%)
J	Exit clients that could not afford the medicine (%age of G)	32 (35.95%)

Of the 19 health facilities that charged user fees, 52.6% had cases of clients who failed to pay for health services. This may mean that clients prefer PNFPs or PFPs as first points of care and only resort to the Public health facilities because they cannot afford the fees. This can be further assumed from the client exit interviews where only 38.9% admitted to buying medicine from the facility. The other 61% did not pay for the medicine. Of those that bought medicines, 64% found the cost of medicines affordable and the other 35.9% struggled to pay. A number of scholars have already emphasized how user fees undermine access to care among the poor quintile.[56]

4.2.5.2.2 Information Access

The right to information access includes the right to seek, receive and impart information and ideas concerning health issues.

Platforms for information exchange: As already observed, there are a few spaces for information exchange to support community participation and mutual accountability. They include health unit management structures, suggestions boxes, and barazas or community dialogues. HUMCs and suggestion boxes were present but not utilized or weak in most facilities. The management board in Lacor hospital was found to apply the human rights based approach more widely. Barazas too, are commendable approaches for information exchange.

Access to medical information: Table 5.4 below indicates that 33 (82.5%)of the facilities visited were providing medical records and even more 37 (92.5%) of the facilities explained medical records to Clients. This was confirmed by results in table 5.5 below that shows that188 (80.3%) of the 234 clients, indicated that they had been informed of their medical condition following diagnosis and the medicine was explained.

[56] Juliet N et al. 2011. Abolition of user fees: The Uganda paradox

Table 5.4: Access to Medical Information – Provider Perspective(N=40)		
	Parameter on information access	No (%)
	Facilities that provide medical records	33 (82.5%)
	Facilities that do not provide medical records	7 (17.5%)
	Facilities where medical records are explained to clients	37 (92.5%)
	Facilities where medical records are not explained to clients	3 (7.5%)

Table 5.5: Access to Medical Information – Client Perspective(N=234)		
	Parameter on information access	No (%)
	Clients that were informed of their health condition after diagnosis	188 (80.34%)
	Clients that were not informed of their health condition after diagnosis	46 (19.66%)
	Clients that received a description of the medicines they received	188 (80.34%)
	Facilities where medical records are not explained to clients	46 (19.66%)

Despite the high access, vulnerable groups remain marginalized. The lack of sign language services or services for the visually impaired is a deprivation of access to information for concerned clients and it impairs the right to have personal health data treated with confidentiality because a second party will have to interpret for them. This right is further provided for under *Article 2, Article 9, Article 21, Article 24 and Article 30 of the Convention on the Rights of Persons with Disabilities*[57].

Medical records were most common at regional referral hospitals and least found at HCIIIs. However, it is also more common to find Ministry of Health client record tools at regional referral hospitals than at health centers. Actually we found that at most HCIIIs, the health workers demanded that the clients bring books and stationery where their records will be written. In the event that the client cannot afford these items, they will not have a record to take home. This contravenes the African Charter on Human and Peoples' Rights that provides for freedom of expression Article 9[58] and the International Covenant on Civil and Political Rights which specifically provide for the right to receive information either orally , in writing or in print" .

"I can't understand the medical information as the facility lacks a sign language interpreter and has no braille facilities, how can I adhere to treatment?" (Client with hearing impairment)

4.2.5.2.3 Physical Access to Health Facilities

Table 5.6 below shows the time it takes for the clients that participated in the study to reach the health facilities. It takes over an hour for most of them to physically reach the health center. 60.3% of the exit clients actually used the nearest health facility. Many scholars have highlighted distance as a factor that deters access to care. This distance may be further multiplied especially

[57] Convention of the Rights of Persons with Disabilities
[58] African Charter on Human and Peoples' Rights, Article 9

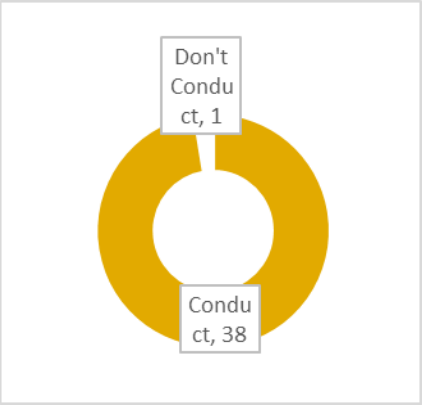
if there is a shortage of drugs and clients have to return on a day the facility re-stocks. This puts lives at risk. Non functionality and absence of ambulances in most facilities further compounds the risk on life during times of emergency.

Table 5.6: Time Taken by Clients to Reach the Health Facility

Sn	Time Range	No (%)
1	Used less than 15 mins	34 (14.53%)
2	Used 15 - 30 mins	52 (22.22%)
3	Used 30 – 45 mins	4 (1.71%)
4	Used 46 – 60 mins	65 (27.78%)
5	Used over 1 hour	79 (33.76%)

Accessibility further means that health services and causal determinants of health, such as safe water and adequate sanitation facilities, are within safe physical reach, including services for persons with physical impairment. Facilities are also mandated to carryout community outreach programs to increase physical access to services. In the survey, 38(97.44%) conducted outreach programs but health facility leaders reported lack of funds to regularly hold outreach programs as presented by figure 5.4. Outreaches offer mainly HCT, immunization and health informative. This implies that most of the services are static and mainly accessible at health facilities.

Fig 5.5. Conducting outreach programs



"Health facilities are understaffed and health workers lack accommodation facilities and hence commute long distances to health centres" (CSO leader, Apac)

4.2.5.3 Acceptability

In this study we found that all HCIIIs are not open at the weekends and during the week, some open up to 1:00pm. Further, patients complained about abusive health workers and having to wait long hours to receive care. Some actually end up going back without receiving care. Those that receive care may end up not getting medicine due to drug stock-outs, including essential medicines.

4.2.5.4 Quality

Quality is observed when Health facilities, goods and services are culturally acceptable, medically and scientifically appropriate. It includes, among others, skilled personnel scientifically approved and unexpired drugs, hospital equipment, portable water of drinking quality and adequate sanitation.

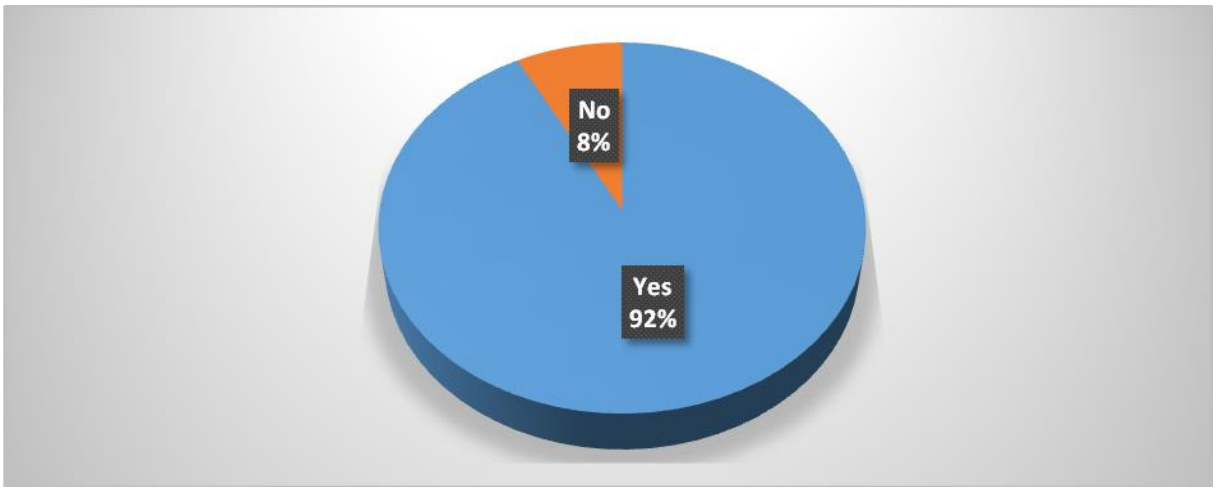
4.2.5.4.1 Staffing levels and staff development

Some facilities ensured that health workers had the required academic qualifications and competencies to offer specific services. However staffing levels are reported as low in public health facilities as compared to the required staffing standards.For instance some HCIIIs lacked the three required midwives and only operated with two and at times one. Therefore the workload was relatively heavy on the serving midwives. This increased clients' waiting time for care at times to four hours.

> *"I brought here my daughter to be delivered but we found only one midwife who was very busy to attending to many other mothers. My daughter required urgent attention as she was having contractions and was suffered labour pains. However the health worker delayed and she lost her baby. I was asked for money to buy a mama kit which I didn't have and her husband went to look for the money as we waited for him in the facility. He delayed and by the time he returned we had lost the baby. Health workers are absent on weekends and its very challenging to seek medical treatment on weekends in public health facilities. (Client at a facility)*

When staff development/ improvement efforts were explored, it was established that of all 40 health facilities sampled, 38 (95%) had staff that had received continuing medical training in the last 06 months before the survey as shown in Figure 5.5 below.

Figure 5.6: Health Facilities whose workers had attended Continuous Medical Education



St Mary's Lacor hospital in Gulu has a particular program to sponsor health workers in specific disciplines to upgrade their skills every year. The facility also undertakes periodic client satisfaction surveys to determine clients perceptions on the quality of services provided.

A study from 2014 reported that 27% (18-30.4%) intravenous infections in Lacor hospital Gulu district were hospital acquired Infections (HAI) that patients did not have at admission. It is not clear if this sparked a change in practice or what the current indicator is.59

4.2.5.4.2 Sanitary facilities

Table 5.7 shows the sanitary facilities available in the facilities. Incinerators were the most common sanitary facilities found in the districts with 97.5% coverage. The pits are constructed with chimneys to control emissions. These facilities were also found to have placenta pits and 77.5% use safety boxes to dispose of sharps and solid medical waste. Therefore in 22.5% of the facilities, clients are exposed to hospital acquired infections. Furthermore, Fumigation is only done in 36.8% of the facilities.

1. *"Mothers bathe under mango trees, we have engaged the district but no action has been taken to address the problem" (CSO leader, Apac)*
2. *"I have to send a care taker to the swamp to collect me water as the facility has no piped water and lacks a water tank. If you don't have a care taker you find it hard to fetch water from the swamp which is also far from the facility"(Client at HCIII in Apac district)*
3. *"Patients have to send care takers to the swamp to collect them water and if she comes without a care taker she finds it hard to access water" (HUMC HCIII)*

65% of the facilities had bathrooms for patients. Of these however, 35% do not have separate bathrooms. Bathroom are shared by clients and health workers, regardless of gender. This compromises privacy and access. Mothers have to bathe under trees and those who are shy will forfeit bathing.

Access to safe portable water is a challenge in many facilities. Of the 40 health facilities studied 60% had a source of clean water. Some facilities rely on rain and clients harvest the rain water. Some clients have to collect water from wells and swamps especially during the dry spell.

Table 5.7: Availability of Sanitary Facilities/Services(N=40)

Sanitary Facility/Service	Number	Percentage
Incinerator	39	97.5%
Bathroom	26	65%
Safety Boxes	31	77.5%
Fumigation	14	36.8%
Clean source of water	24	60%

4.2.5.4.3 Support services

Most of the facilities that were surveyed have support services although challenges are cited (Table 5.8).

[59] Emmanuel O et al. 2014. Routine Hospital Acquired Infections survey are feasible in low income health care settings and can inform quality improvement interventions

The biggest challenge was referral of clients using the ambulance. Only 55% reported having an ambulance. Some however, are non- functional due to mechanical break downs or absence of fuel or a driver to operate them. Clients in one HCIV mentioned that they have to buy fuel or pay drivers if they have to use the ambulance. Clients in this facility further shared that nurses avoid working in the ambulance because no allowances are given for this service. In one hospital, the ambulance is not hygienic so the health workers shun any related work because it may risk their health.

1. *"We have an ambulance however it is not functional as we don't have a driver" (facility in charge HCIV)*
2. *"It is very easy to contract respiratory tract infections in such ambulance systems as they are not well treated and you sit close to the patient" (facility in charge , district hospital*)

Table 5.8: Availability of Support Services(N=40)

Support Service	Response			
	Yes		No	
	Number of Facilities	Percentage	Number of Facilities	Percentage
Stable Power Source	30	75.0%	10	25.0%
Alternative Power Source	31	77.5%	09	22.5%
Drinking Water for Patients	29	72.5%	11	27.5%
Ambulance System	22	55.0%	18	45.0%

A stable source of power is a challenge for 25% of the facilities. Most of these also do not have an alternative power source either. Health workers use lanterns and candles to attend to clients and pregnant women are requested to bring a lantern when they come to deliver.

"I had to carry a lantern to be delivered as the hospital lacks electricity and has no generator to provide light energy", (mother at HCIII)

4.2.5.4.4 Mechanisms for quality service provision

Quality improvement committees: These were mainly found in public health facilities as mandated by the Ministry of Health. The committees monitor quality through maternal death audits and patient registration forms. We also found that some public health facilities adhere to national quality standards including clinical guidelines and laboratory operation standard guidelines.

1. *"We carryout support supervision on a quarterly basis at health sub district level, mentorship also happens regularly to orient health workers on new data in their field (Assistant In charge, HCIV)*
2. *"We have a quality improvement committee, this committee targets every department. We also have monitoring and evaluation teams from headquarters and NGOs like ASSIST under USAID".*

Supportive Supervision

Quality improvement at public health facilities is often monitored by district health managers through quarterly supportive supervision. District health team members visit health facilities quarterly to assess the performance of the different departments. During this time, they utilize the opportunity to mentor health workers on different service indicators and carry out continuing medical education (CMEs) where necessary

4.2.6 Rule of law provisions in health care delivery

This requires that the approaches and measures utilized in health service delivery are no contrary to the legal framework and are grounded as legal rights set out in either domestic or international law. The principle also recognizes the Common Law and ethical principles which have shaped the practice of medicine for a long time. As already discussed in the normative framework, the international and regional instruments provide us with the standard to follow. This needs to be read together with common law principle and the ethical codes for health professionals. These should be the guidance tool for delivery of health care under the HRBA.

Patients' Charter: Through this charter, government demonstrates its commitment to realizing the right to Health for every Ugandan. The charter aims at ensuring that the Rights of Patients are protected in the course of seeking health services. It provides a basis for a legal and regulatory framework in health that contributes to improved quality of health care. The charter also spells out the patient responsibilities which are pertinent to observe for the realization of their rights.

1. *"We have displayed the patient charter on the wall in OPD (Outpatient department)" KII at HCIII*

2. *"I can't ask the health worker about the treatment procedure and approach, he is trained and an expert in that field unlike me, so I trust whatever he does" (client at general hospital)*

Health service providers were asked whether they had patient charters displayed in their health facilities where patients could obtain information about their rights and responsibilities. Our study found that 55% of the facility based respondents have heard about the charter and 54% of these can access it. Surprisingly, only two health facilities in Gulu and Apac had patient charters, and only one of them (Laroo HCIII) in Gulu displayed it in the facility for the patients to see. Unfortunately, the clients are not trained or sensitized about the patients' charter even where it is displayed. Those clients that do not read English are discriminated on a language front because the document is in English. Patients therefore do not know their rights, more so in communities where there are no avenues for participation or redress.

Table 5.9: Use of the legal framework documents in health facilities		
	Parameter	No (%)
Patients charter		
A	Facility leaders that heard about the patients charter	22 (55%)
B	Facility leaders that never heard about the patients charter	18 (45%)
C	Facility leaders that had a copy or can access the patients charter (%of A)	12 (54.5%)
D	Facility leaders that have only heard and never accessed the patients charter	10 (45.45%)
e		
Professional code of conduct& ethics for Nurses & midwives		
	Facility leaders that had a copy of the professional code of conduct	34 (85%)
	Facility leaders that did not have the professional code of conduct	6 (15%)

Ethical code of conduct: The Code of Conduct and Ethics for public officers is a government initiative that aims to model public servants who are loyal, committed, results-oriented, customer-centered and observe a high standard of conduct in both official and private life. This document should enhance performance and reflect a good image of the Public Service and promote good governance. It is expected to be reinforced by professional codes of conduct.

While the code for public officers was not found in the Public health facilities, 85% of the health facility leaders in the 40 health facilities acknowledged having a copy of the Professional Code of Conduct and Ethics for Nurses and midwives but 75% were aware that they were mandated to observe human rights. The code guides nurses and midwives to respect human rights to life, dignity and respect, there is a gap in training and practice if 25% of the health care workers, are not aware of their role as rights bearers. A disconnect was observed between having the copy and adhering to the guidelines therein. For example, many HCIIIs close at 1:00PM and clients who come after that time cannot access health care services. Considering that the Country is generally short of human resources for health, including out cries of workloads as seen above, it is also true that some health workers may be under-employed or just unsupervised. In an interview with one of such health workers in the North, we learnt that they lack accommodation at the health facility and some have to walk over 6 kilometers to the facility. They therefore arrived late and left quite early to reach home early.

Never the less, health workers do adhere to the code in some ways. For example of the 234 exit patients that were studied 190 (81.2%) reported to have been worked on by health workers who had put on uniforms, some of whom even had name tags.

4.3 Case Studies on application of the HRBA

4.3.1 Attempt at St Mary's Hospital Lacor

St Marys Lacor Hospital is a Faith based PNFP facility. As illustrated in findings from the cross-sectional study, Lacor clearly presented a functional Health Unit management structure which could probably explain why elements of the HRBA are important in their operations. Lacor has six suggestion boxes which are opened every two days and arising issues addressed accordingly. The board further ensures engagement of the community through radio talk shows, client satisfaction surveys and bi-annual stakeholders meetings. The hospital further ensures quality of their staff through annual staff training programs.

The reasons for exemplary practice in Lacor are unclear. Lacor is a Faith based PNFP hospital, managed by the Roman Catholic Archdiocese of Gulu. It is also a teaching hospital and was a refuge for people during the rebel insurgence in the North. Through these mechanisms, the hospital may be driven to serve. Furthermore, having built rapport with the community especially during difficult times, management may feel obligated to engage them so as to fully restore peace and healing. Further research would need to be done in similar health facilities. Important to note though, a study from 2014 reported that 27% (18-30.4%) intravenous infections in Lacor hospital Gulu district were hospital acquired Infections (HAI) that patients did not have at admission. This could also have triggered changes in management and practice and should be further explored.

The hospital is mainly funded by CORTI foundation in Italy and local contributions make less than 25% of the hospital budget thus the facility has the funds and capacity to offer health services at relatively low cost to the poor.

4.3.2 Summary of Good and Bad Practices

Participation

1. In Lira, budget conferences are held with communities as an initial stage of the budget process. This happens at barazas described under accountability above. Some planning is also done at the parish level by the Parish Development Committee. District authorities further utilize data from different surveys conducted in the communities. While barazas are

good platforms for accountability and participation, they have to be supported by Civil Society Organizations so as to cause positive change

Non discrimination

Good practices

1. Services for people with physical and mental impairment:
    a. Only three facilities had ramps – Laroo HCIII, Mubende hospital and Lacor hospital. Apac hospital included ramps on their most previous budget and they will be constructed with their new structures
    b. Special toilets for people with physical impairments were found in Ogur, Apac Hospital
    c. Lira regional referral hospital and Apac hospital were the only two facilities found to have specialized personnel to cater for people who are mentally impaired.
    d. The only health center that provided care for albinism was
2. Services for vulnerable groups
    a. Laroo Health Centre III and Gulu Regional Referral Hospital provide outreach services for sex workers, once a month. The health workers do moonlighting at the hot spots where they provide condoms, HIV testing, and counselling. These services should be strengthened to offer a wider range of sexual and reproductive health services including regular supply of condoms, HIV care, abortion care and others

Bad practices

1. Health centres like Gulu HCIII and Nakaseke hospital reported cases of gender based violence especially rape but they do not have records for such cases. They also reported the matter to the police but could not articulate the secondary prevention services they provided to the victim (s).

Indivisibility and the AAAQ framework

Good Practices

1. Mild may has improved access to clean water in some facilities in Nakaseke. These facilities further treat water and avail it for drinking.
2. Lacor Hospital sponsors health workers every year for training camps/ opportunities in many disciplines. The facility also carries out client satisfaction surveys so as to keep improving
3. In almost all facilities, there were consultation rooms to enhance privacy and promote patient – provider communication

Bad practices

1. Stockout of medicines was reported in many facilities especially HCIII. This is because they are part of the push system of the National Medical Store. If the NMS sends an emergency stock, they don't send on the next round. Stockouts were also reported in hospitals and therefore logistics

management needs review. The push system also sends excess of some supplies considered unimportant and limits supplies such as anti-malarials
2. Poor access to water is reported in many facilities and patients have to travel to swamps and wells to collect the water. In Nakaseke, boreholes were drilled but some are non-functional and others provide dirty water, probably due to rust.
3. Outreaches are not consistent in most facilities and this is due to irregularity in funding.
4. Failure to provide abortion care. Facilities like Awachi HCIV do not provide abortion services because they consider that illegal. They instead refer to Gulu regional referral hospital. Nakaseke Hospital specifically reported on providing post abortion care to 65 victims of GBV in 2015, but there are no records because abortion is illegal
5. In many facilities, patients have to pay user fees especially for medical care. There is one peculiar case in Gulu regional referral hospital where patients even pay 200 Ugx to use the toilet
6. Poor access to privacy: 35% of the facilities lack bathrooms and patients have to share with health workers. Some mothers opted to bathe under trees, and others not at all.
7. Public health facilities are closed at weekends, and many HCIII close at 1:00pm during weekdays thus limiting access to care for the most vulnerable
8. Many facilities lack hydropower electricity and some use solar power. There was one particular case in Apac where a mother had to carry a lantern to the health center for her delivery

Rule of law

Good practices

1. The patients' charter was found at the DHOs office in Apac, and Laroo HCIII in Gulu. The DHO in Apac volunteered extensive information about the contents of the charter and has communicated these to the health workers and to the community via radio talk shows
2. Only the DHO in Apac mentioned the hypocratic oath and how he encourages the staff to live by it. Unfortunately, it was an oversight of the study not to assess the extent to which health workers live by the oath.

Bad practices

1. The patients' charter was only available with administrative structures and it was not displayed in the facilities for open access.

CHAPTER FIVE:

CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

The Human Rights Based Approach (HRBA) requires making health care services and systems functional using human rights lenses. This approach calls for participation of those served, existence of accountability systems, recognition of the rule of law and ensuring that Health services are available, acceptable, accessible and of quality. From this assessment, there is evidence of existing legal frameworks to guide the implementation of this approach in health service delivery. Indeed the assessment also presented cases of litigations that demonstrate some effort to ensure that the HRBA is entrenched in the provision of health care in Uganda. These principles are applied with varying degrees in both the public and private facilities, with the private facilities indicating more compliance at least from the sample of the 40 facilities assessed.

It can also be concluded that some commendable practices exist for the application of the HRBA including the use of the uninvited spaces of participation like the community barazas and budget conferences in Lira and Apac. Some facilities also had accessibility options like ramps and others had special clinics for groups like the albino and prostitutes. From the assessment, partnerships provided opportunity to improve health care delivery like the case of Mildmay which has improved access to clean water in some facilities in Nakaseke. On the other hand Lacor Hospital indicated evidence of sponsoring health workers every year for training camps/ opportunities in many disciplines and indeed undertakes client satisfaction surveys so as to keep improving. In a number of facilities there were consultation rooms to enhance privacy and promote patient – provider communication.

However, critical gaps in the integration of (HRBA) in health facilities were also found. These include inaccessible structures for persons with physical impairments, poor application of key guiding documents such as the patients' charter, stock outs of medicines and other essential supplies for the provision of health care. Other factors affecting the application of the HRBA in health care provision include the semi and/or nonfunctional participation structures like the HUMCs and the absence limited empowerment of both the providers and the patients in HRBA to health care provision. Costs of health care continue to impede access to health care and a threat to the application of the HRBA to health care provision especially to the poorest communities. In facilities where even access to toilets attracts a cost there were major dissatisfaction to those accessing care.

Finally, the general observation was that the PNFPs made an effort to integrate the HRBA, however, those health facilities supported by CSOs also show some efforts to embrace the HRBA. The public health facilities may be slower but seem more flexible to provide services for the vulnerable and marginalized groups.

5.2 Recommendations

In light of the conclusions above, it is clear that steps need to be taken to ensure the achievement of the goal of HRBA in the provision of health care services at various levels including: at the national level, district/local government level, facility level and at the level of the individual health care providers.

a. National Level

This assessment was only carried out as pilot study in selected facilities. The sample is not representative enough to generalize findings for the whole country. As such it is recommended that a national level assessment of application of HRBA principles in delivery of health care be carried out. The assessment could be done in both the public and private facilities using the parameters tested in this assessment. Such a comprehensive assessment will provide an impetus for interventions that could improve the application of HRBA principles in health care delivery.

This assessment also points to an important need to reviewing and strengthening the current legal and policy frameworks affecting the provision of health care. Despite the General Comment 14's recommendation of a framework legislation on health, the assessment indicated that Uganda's legal framework affecting health care provision is highly fragmented with a number of old colonial legislation and in other aspects relatively recent legislation with problematic provisions as indicated in the study. This could begin with a formal recognition of the right to health under Uganda's substantive Constitutional provisions. Such a legal framework will be a central role in giving a place to the right to health in Uganda's Constitutional and legal framework. This will then guide the application of the HRBA principles in health care provision.

The results of the assessment also point to an important need of developing and implementing a national action plan on rolling out the implementation of the HRBA principles in health care delivery in both the public and private facilities. This plan could be co-implemented between the Ministry of Health and the Uganda Human Rights Commission through their designated focal points on health. Through these, the other stakeholders could be brought on board to help and support the rolling out of such a program.

The training programs of health care providers need to be revisited to integrate that HRBA principles in both the academic institutions and also as part of the continuing medical education which is managed by the various

professional bodies of health care providers. The health service commission could play a vital roles in overseeing the implementation of this recommendation.

The Ministry of Health in collaboration with the other partners needs to identify the access to health care special needs of the various vulnerable groups at health facilities. Based on these needs, the Ministry can then develop a guiding policy document for adaptation and implementation by the health facilities.

From the findings, health units have equipment that are new but un-used because there are no trained personnel to operate them. Participants at the validation recommended that government should institute a policy which ensures that providers of machinery, whether as donations or purchased goods, ensure that the equipment are properly installed, tested, piloted and that people are well trained to use and maintain them.

In relation to the point above on equipment, resident medical schools do not have modern equipment on which students can train. The latter have to learn theory and are left with capacity gaps. The recommendation is for government to set up medical technology institutions.

The Ministry of Health needs to review the current mechanisms of community participation in the health system. The current HUMCs system needs to be reviewed to ensure that representation on the HUMCs is as result of a popular vote by the community members. At the validation meeting, participants observed that many HUMCs positions are political appointees and some get positions as rewards for say, previously campaigning for the appointing officer. Such persons are more interested in the title as HUMCs that the actual role of the position. Some HUMCs members never say one word throughout the year and others are just not interested. The recommendation is emphasis on popular vote.

Given the importance of accountability mechanisms in applying the HRBA principles. The Human Rights Commission, the Equal Opportunities Commission and the Courts of law roles have to be engaged more on the issues involving the delivery of health care. The officials working in these agencies should be exposed more to the health care delivery issues to ensure that they face these issues with knowledge of the context. Conversely, health workers need to be equipped with legal knowledge so that they understand the scope within which they are legally accountable.

b. District Level:

The local governments should introduce more district based mechanisms for the implementation of the HRBA to the delivery of health care. The various districts could for instance adapt measures for monitoring the functionality and health facilities in their jurisdiction and how these apply the HRBA principles. The District Health officer could work with the district systems to ensure compliance of facilities.

The local governments are placed in a strategic position to ensure that their mechanisms and procedures for ensuring adequate supply of goods and services for health facilities. This starts from the planning, budgeting through to implementation of district priorities. It is through this process that the essential commodities at the health facilities could be provided in a manner that fulfills the 'AAAQ" framework.

The local governments also have a big opportunity in forging partnerships with stakeholders that can support health facilities in delivering health care. It was evident in the assessment that districts with partnerships stood better opportunities of resourcing health facilities and supporting structures central in delivery of health care. The local government ought to negotiate for partnerships that advance the implementation of HRBA principles.

The local governments have a critical role to play in advancing community participation in decisions affecting their health. As such, they have to deepen the spaces of community participation in processes such as priority setting, budgeting, implementation and monitoring.

c. Facility Level:
The facilities have to implement key government programs that advance the HRBA principles in their health care delivery. Some of the health policies already address the HRBA in provision of health care and key documents such as the Patient Charter are customized to see this happen at the facilities. As such, facilities should popularize the patient charter as part of implementing the policy on advancing HRBA principles;

The facility also plays a central role in ensuring that the HUMCs operate and that their meetings take place, It is therefore important that the in charge of the facility embraces the HUMCs structure as a participation structure for the community and this should be provided with space and opportunity to input into the decisions including the implementation of such decision affecting health care provision;

The facility should also ensure that functionality of the basic feedback mechanism such as the suggestion boxes which are installed at the facilities. These should be often referred to and appropriate action take from the suggestions provided by the community members.

The facilities should also organize in-house training for health professionals to ensure that principles from the HRBA are always prioritized in the delivery of health care. Such trainings could be requested for from the Ministry of health or undertaken through partnerships with other non-state actors that are specialized or even through the Uganda Human Rights Commission.

As part of addressing the access gaps identified in some of the facilities, their facilities should strengthen the outreach program to ensure that those incapable of receiving or following up of treatment courses are reached

through this kind of program. This could also be done in partnership with other actors that could have been sources by the facilities.

Facilities have the opportunity to establish special initiatives at the facility to ensure that even the vulnerable are served. This could include running special clinics in an integrated manner to reach to those usually unreached.

d. **Provider Level:**
The providers need to take personal initiatives to refresh themselves on a number of ethical and human rights aspects that crosscut their provision of services at the facilities. This is critical in observing the key tenets of a providers/patient relationship;

The providers also have to take the key steps of requesting for the commodities that are necessary for the treatment of the patients. In many cases, such requests are not done consistently which cuts the communication chain between the patient needs and what is delivered at the facilities;

During a validation meeting, some of the cases which CEHURD has litigated were discussed and health workers were advised to document detailed processes during care provision. In an event that a patient suffers any adversity under responsibility of the health worker, the documentation serves as evidence to rule out negligenceor any failure on the part of the provider.

The providers also have to always make reference to the clinical guidelines issued by the ministry of health for the provision of care. This guidelines ensure that the patient receive accurate and acceptable care.

CHAPTER SIX:

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ANNEXES

Annex 1: Health Center Profiles

District	Health facility	Health facility level	Catchment population	Catchment area	No of patients seen	No of beds
Amuru	Atiak HCIV	HCIV	37300	Atiak subcounty, Pabbo, Bibia, Elegu, Amuru, Otwe and Amuge		250
	Pabbo HCIII	HCIII	27,000	Kal, Parudanga parish, Palwond parish, Labala and Apaa	90	20
	PabboLacor HC III					
	Pawell HC III	HCIII	8998	Kal, Pamission, Pe- mission and Pujinya	108	0
	OT YAT Medical Centre					
Gulu	Gulu RRH	RRH	436,345	Amuru, Gulu, Kitgum, Lamwo and Pader		397
	St Mary's Hospital Lacor	PNFP hospital		Gulu Municipality, Gulu District, Acholi sub-region, Northern Uganda.	600 in patients and 500 outpatients per day	482
	Awachi HCIV					
	Laroo HC III					
	Mola Clinic Gulu					
Apac	Apac Hospital	General hospital	65,000	Apac sub county and Apac	300	100

District	Health facility	Health facility level	Catchment population	Catchment area	No of patients seen	No of beds
				Municipality		
	Aduku HC IV	HCIV	150,000	Aduku, Apac district	150-200 patients per day	30
	Abongo mola HC III					
	Abedober HC III					
	Apac Medical Centre	PFP	20,000	Apac Municipality	10	10
Mubende	Kasanda HCIV		198000			
Mityana	Mityana hospital	General hospital	600,000	Mityana municipality, Banda sub county, Manyi sub county, Butayunja sub county, Kakindu sub county, Malangala sub county, Namungo sub county, Sekanyonyi sub county, Kikandwa sub county, Kalangalo sub county, Bulela sub county, Busunju trading centre, Myanzi, Kasanda, Bukuya, Butambala and Gomba district.	350	
	Magala HCIII	HCIII	789	Wabigalo, Samu, Kikumambogo, Kiganwa, Ndibulungi,	30-40	0

District	Health facility	Health facility level	Catchment population	Catchment area	No of patients seen	No of beds
				Mitimbojje and Kitinkokola		
	Mityana HCIII	HCIII	817	Busimbe, Buswabulungo, Nakaziba, Zigoti, Jungwe and Bamunanika	6-10	13
Nakasek e	Nakaseke hospital	General hospital	120,000	Kasangombe, Nakaseke Town Council, Kito, Semuto and Kikamulo	200	100
	Kiwoko hospital	General hospital	820	Nakasongola and Luwelo	225	167
	Kapeka HCIII	HCIII	19,500	Kapeka TC, Kisimula, Kyelelezi, Lwentunga, Kifamba, Butakuli, Kabugwe, Mpozi, Mbalatila, Naluvule, Namusale, Kabele and Corner Clerk	40	7

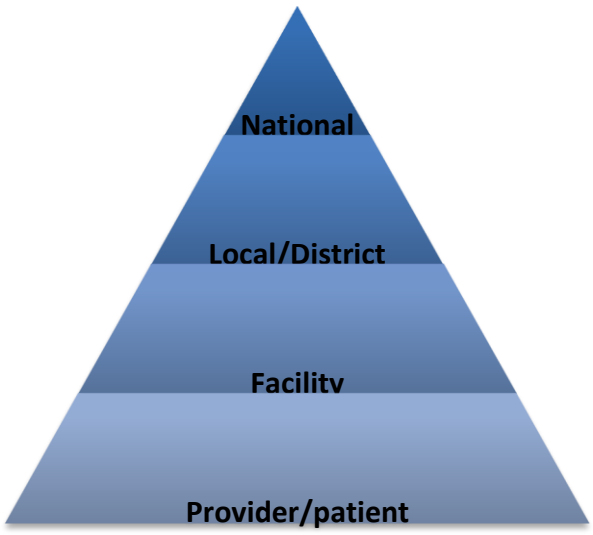
Annex 2: Applying a HRBA to Health

(Adopted from A Yamin (2014) Health Service Providers Guide for Providers on Applying a Human Rights-Based Approach to Health In the Context of Maternal, Sexual and Reproductive Health in East Africa; FXB Center for Health and Human Rights, Harvard School of Public Health)

APPLYING AN HRBA TO HEALTH

You can think of application of an HRBA to health as occurring at four levels:

1. *Provider/patient level* – your direct interactions with patients and their families
2. *Facility level* – how your facility applies and respects human rights
3. *Local/District level* – implementation of national policies, and budgeting for health service delivery
4. *National level* – laws, policies and guidelines, and plans of action, that support or impede human rights



Provider/patient level

Identifying problems, and the responsible duty-bearer, is necessary for accountability. It is very important that health service providers are not punished or treated as scapegoats for "institutional" failures in the health system. However, practitioners still need to be accountable to their patients. Establishing professional accountability ensures quality of care and prevents negligence, abuse and malpractice.

How do you communicate with your patients?

Healthcare practitioners, as duty-bearers, should treat their patients with dignity. This means that patients should be treated as they are full human beings.

Example:

- Do you wear a name tag that clearly displays your name and title?
- How do you greet your patients when you first meet them, and when you see them afterwards?
- How do you communicate sensitive or complex information with patients? For instance, about diagnoses, or procedures?

Think about the way you would want to be treated, or your wife or daughter. You would want to be treated courteously, in a way that respects your rights and autonomy, and this is how you should treat patients.

How do you approach patients before examining or performing procedures on them?Patients, as rights-holders, are *entitled* to refuse treatment, and have *freedom* from any interference with their body that they do not want. For this reason, healthcare practitioners, as duty-bearers, should not touch or perform procedures on patients without their consent (except in very limited circumstances). Male health providers who touch women patients should be especially conscious of cultural norms around private parts of the body and respectful touch.

Example:

- How do you approach a situation where a pregnant woman would like to have a vaginal delivery after having a previous caesarean, or a fistula? Do you ask them what their preference is? If not, why not? How do you explain their options to them and the relative risks?
- Taking the example of a woman who is HIV positive, how do you approach a discussion about contraception with her?

It can be difficult when you feel that you know what is best for a patient, but they disagree. Applying an HRBA means that a patient's views must be taken into account. An HRBA also requires that patients are not touched, or operated on, without their consent. There are only a few emergency circumstances where a practitioner can override a patient's refusal of treatment.

How do you manage interactions with family members and friends?
As part of the healthcare service provider's obligation to respect the rights of their patients, it is important that family members are involved in their care, when the patient desires.

Example:

- Are families or close friends allowed in patients' rooms? If not, why not? If families are not allowed in because of overcrowding, do you think this is justified? What other solutions might be provided?
- How do you manage delicate situations, such as breaking bad news? Do you include or exclude family members from these conversations?
- Do you actively involve family members in patients' treatment and discharge planning, including financial needs for medication, care, infant feeding?
- What if a woman is (or a deceased woman was) HIV positive and her family is not aware of this situation? How do you manage this situation, and how do you communicate with their partner, who may or may not have infected her?

Family members should not unreasonably be denied access to patients. There are always exceptions – for example, in the case of certain infectious conditions– but as a general rule, families should be encouraged to be involved in patient care, and healthcare practitioners should be supportive of this.

How do you treat patients with special needs?
As part of the right to health, individuals enjoy the right of non-discrimination, on the basis of race, gender, language, physical or mental disability, and so on. For this reason, patients should not receive a lower level of care because of one of these factors. This may require a duty-bearer to take additional steps to ensure that the care a patient receives is both acceptable and of adequate quality, under the AAAQ framework that is a part of the right to health.

Example:

- When a patient does not speak your language, how do you talk to them about their diagnosis and treatment? Do you arrange for an interpreter to be present when you speak to them, or does a member of the patient's family translate for you? Having a family member translate is much better than not being able to communicate with a patient at all, but this can create some problems between the practitioner and their patient.
- When a patient has an intellectual or physical disability, how do you manage that situation? Do you take extra steps to ensure they get the treatment or aids that they need? If not, why not? What would enable you to ensure that, for example, disabled women are helped to ambulate to avoid blood clots? Or, what would enable you to ensure that intellectually disabled women are helped to communicate?

Applying an HRBA means that patients cannot be discriminated against for arbitrary differences they may have. Tribal membership, religion, political belief, skin color, HIV status, gender, and disability are all considered **arbitrary** differences. For this reason, it is very important to meet the individual needs of patients, so they can substantively enjoy their rights to health equally, even if this requires changes at the facility level.

How do you manage patient confidentiality?
Patients have a right to have their own health data treated with confidentiality. As duty-bearers, healthcare providers must keep this information confidential, and not reveal it to other people without good reason, or without permission.

Example:

- How do you make sure that written patient notes are not easy to access by non-healthcare professionals? Are patient notes kept in a safe place in your facility, or are they kept where anyone can read them?
- When you are examining a patient, and there are other patients present in the room, what do you do to improve privacy? Can you use things like screens to shield patients when you are examining them? If not, why not? Are these not available in your facility? Could they be made available?

- If you have to tell a patient that they have a certain illness, and it might be sensitive for others people in the room to overhear, can you take them to a different room? Do you know of any other ways that health practitioners try to keep information private?
- When a family of a woman who has died a maternal death requests her medical records, are they immediately provided with them as they should be? If not, why not?

It is easy to disclose confidential information to other people without meaning to, especially when there are many people around. Health practitioners should minimize the chance of revealing private information, wherever possible. It is also important to improve confidentiality at the facility level – for example, by reducing overcrowding to make it easier for staff to have confidential discussions with patients, or through keeping written patient files out of sight of visitors.

At the same time, keeping personal health information confidential is the right of the patient, not the practitioner. Therefore, the patient has a right to his or her records whenever s/he wants, as does the estate of a deceased woman.

Facility level

Healthcare practitioners have an important role to play in holding facilities to account in terms of the care they provide to patients, and also in terms of the responsibilities that facilities owe to the workers themselves, to provide an environment in which they can safely perform their work without interfering with patient's rights. Monitoring and evaluation of what is actually going on in a health facility is essential to a circle of accountability, and to creating a responsive health system that is part of a democratic society.

Does your facility have a patients' rights charter? Are all patients made aware of their rights? Each institution should publish a charter of patient rights, which explains patients' rights when they come to a facility. These charters are usually produced at national level. This charter needs to be given to patients, and explained adequately, so that they know what their rights are.

Example:

- Have you ever seen a charter in your facility? Do you know who is responsible for giving it to patients and explaining the content?
- A patients' rights charter should clearly tell patients that they have a right to pain relief when they need it – do patients in your facility know this?
- Have you taken steps to inform patients about their rights in simple accessible language? If you haven't, why not? How might you do so?

If patients are not aware of their rights, they will not be able to claim them and hold the facility to account. It is important that they are told what their rights are and that changes are made in the facility to ensure the conditions necessary for them to be realized.

Is your facility implementing national policies?
Facilities must be in a condition to implement evidence-based national public health policies. Some of these relate to treatment protocols; others relate to financing. For example, under the right to health, financial accessibility (from the AAAQ framework) is very important. The right to health says that the poor must not be forced to bear disproportionate healthcare costs, and States must remove barriers that make it difficult for women to access healthcare services: for example, through fees-for-service. For this reason, many States have made maternal health care free, or have introduced laws banning out-of-pocket payments, to improve access to services.

Example:

- Are there policies in your country calling for free maternal health care? Can patients really access maternal health care for free in your facility, or do they still have to pay some money? If so, why? How might this be changed?
- Do you ever have to pay out of pocket to buy supplies for your patients?
- Is the full range of contraceptive methods recommended in government policies provided to patients? If not, why not? Is this a facility problem, or a problem with supply from the local or district level? (See *Local/District level*, below)
- Are condoms readily available, and is education about condom use provided to patients? What barriers exist to providing this service to patients?
- Are the birth or mama kits actually available free of charge? If not, why not?

Think about whether the "official" government policy concerning free maternal and child healthcare is implemented in your facility. If not, why is this? Is there a funding gap at your facility that is met by patients paying out-of-pocket? Or, do some healthcare providers charge patients fees so that they can make more money? Is this because they are not paid adequate salaries?

Also, are there any gaps where policies and laws are not being implemented in your facility? Are treatment protocols and guidelines readily available and understood? Healthcare practitioners have the *right* to work in conditions where evidence-based management is used, but also have a *responsibility* to ensure that their management of patients is evidence-based. If you are having problems delivering a good service, think about whether this is because of your facility's own management problems, or whether it is due to bigger problems in the district.

Does your facility provide services to the most vulnerable and marginalized members of society?

An HRBA is concerned with providing care for all. In relation to sexual and reproductive health, minority groups should not experience more maternal morbidity and mortality than other people, and those that have historically been excluded must be able to access health services.
Accessibility is an important part of the AAAQ framework. Because of this, a facility:

(i) must not deny care to vulnerable members of a society, and
(ii) should also actively take steps to provide services to people who are marginalized or disadvantaged.

The kinds of people that might be vulnerable include poor people; people from a racial minority or tribal group; sex workers; adolescent girls; or, women who do not identify as heterosexual.

Example:

- Does your facility refuse to provide a service to people who cannot pay, because they are poor?
- Is it hard for people in rural communities to access your facility? Is anything done to help them with physical access? (note that sometimes this will not be relevant depending on where your facility is, but some facilities must be accessible for rural and remote populations)
- Does your facility discriminate against people who use IV drugs, who perform sex work, or who are living with HIV? This discrimination can take many forms – for example, physical abuse, or a total refusal to treat the patient at all.

What can you do as a health provider to help ensure that vulnerable people are able to access care at your facility? If there are problems with certain people accessing your facility, check whether this is due to a policy of your facility, or due to a district policy, or a national law that stops people from getting equal access to services (see *Local/District Level* and *National level*, below). Can you take steps to change this situation in your facility?

Does your facility have complaint mechanisms that can be used by staff and patients, and other monitoring mechanisms?

Accountability is a vital part of the right to health. The way that people are held accountable is through *monitoring mechanisms*. These mechanisms are not about blaming practitioners for mistakes – because everyone makes mistakes.

Instead, monitoring mechanisms should be available for staff and patients to provide feedback to managers of a facility, who can use this information to improve patient care, and provide compensation if harm occurs. There should also be mechanisms in place to record maternal deaths, and identify "structural" factors that lead to these deaths.

Example:

- Is there a complaint mechanism that staff can use to report incidents where patients were harmed or nearly harmed, or to report things like drug stock outs?

- Can patients safely and confidentially complain about physical or verbal abuse by a staff member, without fear of attacks or reprisals?
- What mechanisms are available to you to complain about violations of your human rights as a practitioner? These include both labor rights, and other rights. Can you complain if a patient or other staff member abuses you, or if you are not paid properly? What about if you are not provided with gloves to protect yourself while you are working?
- Is there a policy in place at the health facility requiring reviews of each maternal death? Who monitors these maternal death reviews? Does the health facility institute policy and programming changes based on the findings? Or are they used to scapegoat providers?

If there is a complaint system at your facility, check how complaints are kept confidential, and what the process is for following up complaints is. Is there a lack of confidentiality in the reporting process? Are complaints ever acted upon? If complaints are not acted upon, there is not meaningful accountability.

It is equally important for healthcare providers to be able to complain about violations of *their* rights – for instance, being physically or verbally abused by a patient or colleague.

If there is a monitoring system for deaths, check whether it is working effectively. Do health workers in your facility report deaths, or are they afraid to? What would it take for maternal death reporting to be used in a way that created institutional changes? This is what an HRBA seeks. A facility must ensure that healthcare professionals are not punished for reporting deaths.

What training and evaluation programs does your facility have for health providers? Under the right to health States and facilities are obliged to provide adequate training and support for doctors and other medical personnel. There should also be opportunities for performance evaluation in your facility, so that practitioners can constantly improve their standards of care.

Example:

- Does your facility have training programs about protecting the patient's privilege with respect to confidentiality?
- Does your facility have training programs about appropriate and respectful treatment of patients: e.g. not hitting or slapping patients, or touching them without consent or touching women in a disrespectful manner?
- Does your health facility conduct annual reviews of your performance, including how you respectfully you interact with patients?

Both training programs and evaluations are necessary to ensure that enough providers are recruited and trained to meet the needs of the patient population, and that patients are not treated with disrespect and abuse.

Local/District level
Practitioners have an important role to play in influencing policy-makers at district levels to improve healthcare delivery, and help citizens to realize their right to health. Practitioners can do this on their own, and through their collective associations.

What are the mechanisms and procedures in place at the local or district level for ensuring adequate goods and services?
Even where there are severe resource constraints, some services are considered "essential" and a State will be in breach of international law if it fails to provide these. This is an example of availability under the AAAQ framework. Certain maternal health goods and services fall into this category, and facilities must provide these even when budgets are stretched. Under an HRBA, no budgetary decision should result in vulnerable people's rights being denied.

Example:

- Essential maternal health goods and services include: a range of contraceptive methods; oxytocics, anti-convulsants, including magnesium sulphate, and all appropriate antibiotics. Are "essential" goods and services consistently budgeted for in your district, and in particular, your facility? If not, why? Is it a problem in your facility alone, or a district-wide problem? Has you asked someone at your facility why these are not being provided to patients?
- Have you noticed that other districts seem to provide better services to patients? For example, are services better in Nairobi than in your district? Why is this?

Healthcare providers are vital in reporting failures to provide essential services, and determining whether it is only an issue in their own facility, or a district or nationwide problem. It is essential to work out ***who***in the circle of accountability is responsible, so that **when failures are identified**, **there is some feedback mechanism through which problems can be fixed**.

Think about what can you do individually or collectively to put increasing pressure on your district or local government to provide essential services. If you made their failures public, would there be any negative consequence for you? Is there any way that you and your colleagues can collectively change the situation? What kinds of risks exist to doing this?

Does the district budgeting process take into account the views of health professionals? Budgeting under an HRBA should be transparent and open to scrutiny from civil society, as well as health service providers. Health service providers should be involved in making budgetary decisions, to help, for instance, in identifying needs of patients, providers, and facilities – even in settings where resources are scarce. At the same time, the salaries allocated

for given facilities within a district should also be made available to the public.

Example:

- Were healthcare providers permitted to participate in the formulation of the district health budget? If so, at what point? How were their views as to different needs taken into consideration?
- Do healthcare providers participate in monitoring the execution of the budget? (for example, how the budget money is actually spent at facility level, by health area, where leakage is identified?

If health service providers are not involved, are their concerns reflected in the budget for health at all, or in the monitoring of the budget? In an HRBA, those who will be affected by budgetary allocations should be able to express their views when priorities are set, as well as when monies are spent. If this is currently not the case, how might you work with other actors to change the situation?

National level

National governments have certain obligations under international law – for example, they must create healthcare plans that include sexual and reproductive health. Healthcare practitioners are important in monitoring implementation at the facility level, and ensuring that governments are held accountable for any failure to fully consider sexual and reproductive health.

Is there a national plan for health?

Under international law, States must develop national public health strategies and plans of action ("national plans") to guarantee the right to health. These plans must be evidence-based, comprehensive, and include an analysis of sexual and reproductive health needs and capacities in the country.

Example:

- A country may have a national plan for health that addresses safe birthing facilities, access to skilled birth attendants, and antenatal care, but does not address prevention of mother-to-child transmission of HIV ("PMTCT"), or link to the national HIV policy, and does not state who is responsible for PMTCT or follow up HIV care for HIV + infants.
- Does your country's sexual and reproductive health plan include the issue of domestic violence? Does it include the issue of reducing maternal deaths from the complications of unsafe abortions? Women's sexual and reproductive health is also dependent on power relationships within homes and communities, as well as the effects of law as a social determinant, not just biological mechanisms.

Practitioners can use national plans to identify whether there are gaps in accountability. In particular, a national plan should reveal whether there is enough funding for operating and staffing facilities; for training (including human rights training); and, whether better accountability mechanisms are needed, to ensure citizens can realize their right to health. If there is

nonational plan, or if the plan does not include a comprehensive approach to sexual and reproductive health, the government cannot plan out what steps to take to move toward guaranteeing everyone the right to health, including women.

What laws and policies have been enacted in your country to protect and advance sexual and reproductive health (including maternal health), and are there legal remedies that can hold the health system more accountable?
States must introduce and implement laws that promote and protect the health rights of women. Laws and policies are not alone sufficient to guarantee sexual and reproductive health, but they are ***necessary***, because otherwise there are no standards or institutional mechanisms that women can use to claim their rights.

Example:

- Has your country decriminalized therapeutic abortion, or abortion in cases of sexual assault? Would you be able to provide a woman in your facility with a serious or life-threatening illness with an abortion?
- Is child marriage prohibited?
- Are there laws supporting female education, even where girls become pregnant?
- Are there laws prohibiting harmful traditional practices, such as female genital mutilation (FGM)?

If there are such laws, are they enforced? Are harmful practices seen, or even practiced, in your facility? Have they impacted upon your practice at all? Health practitioners can individually or collectively lobby governments to introduce laws supporting sexual and reproductive rights, or hold governments to account where laws are not properly implemented or enforced.

Are the public health measures adopted by your State evidence-based?
Under international human rights law, States must adopt evidence-based public health measures, including essential interventions, services and medicines.

Example:

- What specific policies have been adopted by your State concerning sexual and reproductive health? For example, are their policies concerning appropriate drugs used in managing pregnancy and childbirth?
- Are there inappropriate policies? For example, are women coerced into delivering at facilities even when such facilities cannot deal with obstetric emergencies?
- How do you, as a practitioner, find out what the "official" national policy is on maternal health, and check whether your practice is based on this policy?

Health practitioners are directly involved in enforcing State public health measures, and are often best informed about the latest developments in public health interventions. For both of these reasons, as part of the circle of accountability it is important for them to individually or collectively call attention to practices that are not evidence-based, and that should be changed.

Telephone: General Lines: 340874 / 231563 / 9
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IN ANY CORRESPONDENCE ON
THIS SUBJECT PLEASE QUOTE NO. ADM 515/01

THE REPUBLIC OF UGANDA

Ministry of Health
P. O. Box 7272
Kampala
Uganda

July 8th, 2016

The Chief Administrative Officer
.....
.....

Dear Sir/ Madam.

RE: **HUMAN RIGHTS BASED APPROACH (HRBA) ASSESSMENTS IN HEALTH FACILITIES**

The Ministry of Health in collaboration with the Center for Health, Human Rights and Development (CEHURD) and the Uganda National Commission for UNESCO will conduct assessments in your health facilities to assess various aspects of the Human Rights Based Approach (HRBA) to health service delivery in the months of July and August, 2016.

These assessments will contribute to the building of evidence -based best practices for rights based approaches to health service delivery which have not been previously sufficiently documented in Ugandan health system. The findings from this assessment will be used to develop a Human Rights Based Approaches (HRBA) model for medical professionals for online use. The findings will also contribute to the overall Ministry of Health approach of integrating gender and human rights to health service delivery in Uganda.

This is therefore to inform you that an assigned team will be coming to your district and will need to visit selected health facilities in the aforesaid months. They may require field guides to locate the selected health facilities.

Please accord them the necessary support and assistance.

Thank you.

Tom Candia Aliti.
For: PERMANENT SECRETARY

Copy to: District Health Officer

LIST OF PARTICIPANTS AT THE VALIDATION WORKSHOP ON THE REPORT OF THE ASSESSMENT OF APPLICATION OF HRBA IN HEALTH CARE DELIVERY

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