Advancing the right to health in east and southern Africa

Regional workshop report

M Mulumba, J Nassimbwa, Center for health, human rights and development (CEHURD)

In the

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1. Introduction and opening

To enhance monitoring, compliance and fulfilment of economic and social rights the Centre for Economic and Social Rights, USA developed a holistic approach through a step by step framework now referred to as the OPERA framework. It applies a multi-disciplinary approach by looking at outcomes, policy efforts, resources and assessment which offer practical guidance on tool and techniques to use in seeking accountability from duty bearers.

In 2015-2018, CEHURD, under the Regional Network for Equity in Health in East and Southern Africa (EQUINET) conducted a desk review of the implementation of constitutional provisions on the right to health in east and southern Africa.

The objective of the workshop was to introduce the OPERA framework in the region, using evidence from Uganda. It aimed to

1. identify the main bottlenecks in implementing the right to health;
2. devise a common advocacy strategy that aims at removing the bottlenecks;
3. and explore opportunities for applying this within the region.

The workshop built on the previous validation of the Ugandan draft report on constitutional implementation of the right to health.

The programme is shown in *Appendix 1* and the delegate list in *Appendix 2.*

In his opening remarks, the CEHURD Programs Co-ordinator, Mr David Kabanda highlighted the timeliness of the discussion on accountability. He noted that the main conversation was to explore opportunities within the region through the OPERA framework. From the previous research, the constitution largely provides for the right to health, although not explicitly. There are challenges with implementation of this constitutional right especially by the people who own it – the Ugandans. The right to health in Uganda has several players and lawyers in particular have focused on litigation as a tool of accountability but with the Opera framework, other strategies can be explored to realise the right to health. There is need to look at policy efforts beyond the Ministry of Health, to examine the outcomes and evaluate the functionality of the health system as well as considering underling determinants of the right to health in order to appreciate how all these play out to give the required results.

A representative from the Ministry of Health, Mr James Mugisha, observed that the Opera framework is not rocket science and indicated that we need to rethink what we want to change in order to achieve the right to health. We need to evaluate and see if our targets are feasible and if we can use this framework to enhance the right to health. Accountability is important and it is a great opportunity for Uganda because civil society organisations (CSOs) influence government policies and laws.

2. Health accountability in Uganda: Experiences, challenges and opportunities

2.1 Opportunities for accountability

In this session the Executive Director of CEHURD, Mr Moses Mulumba laid a foundation for accountability by explaining how CEHURD has handled it through its structured programs. He pointed out some important elements to help identify opportunities and grounds for seeking accountability from government and other stake holders.

CEHURD as an organisation has been involved in different approaches of accountability through its three structured programs the first being advocacy where we focus on accountability in policies, laws and government programs The community empowerment program focuses on social accountability through the human rights framework while the strategic litigation program takes two approaches the first being litigation on strategically selected cases to change policies and the other offers pro-bono services to individuals. Unfortunately, litigation as a method of

accountability can be a long and costly process in the developing world. The overall approach of accountability lies in human rights and the Opera Framework will help us to unpack this.

Mr Mulumba highlighted the importance of applying transformative accountability which is not just punitive through courts of law. We need to define accountability within health systems, look at it beyond litigation and examine the legal frameworks within the health sector to see how they are leading to accountability. This will enhance the citizen's power to implement the constitutional right to health.

He raised the following opportunities for seeking accountability:

- **Human rights obligations:** This is very paramount in seeking for accountability but an aspect of responsibility on the individual should be added and extended it to other social determinants of health such as sanitation, water and housing which are equally critical.
- **Policy frameworks:** Uganda has tried to highlight accountability throughout different policies for instance the National Development Plan (NDP) has heavily emphasised accountability and it is classified as part of governance and a similar position is taken in the National Health Development Plan (NHDP). It is important to observe the national policies, health development plans which emphasise accountability, budgets and priority setting instead of only waiting for violations.
- **General Comment 14:** This provision on the right to health can be use used for accountability for several reasons:
    a) The comment points us to the core obligations and we need to ask ourselves what these would mean at national level, what the minimum essential levels that have to be reached are, an if there is access to health services without discrimination.
    b) The comment also raises an issue of comparable priorities and therefore if some areas like maternal health are not treated as a priority, can the state be compelled to provide them?
    c) In addition the comment indicates that states have a margin of discretion in assessing which measures are suitable but imposes clear duties on the state to take steps to ensure that everyone has access to health facilities.
    d) It emphasises the need to adapt a national strategy and legal framework.
- **The Social Contract: T**here are a number of arguments on social contract and how to make it realistic but this can be an entry point to hold the state accountable in provision of health.
- **The international community c**an also hold the state of Uganda accountable where it has not fulfilled its human rights obligations under social contract before releasing funds. In our opinion Uganda should not begin to ask for international help if they have not kept their own obligations.
- **The Constitution:** Although it is not fertile enough to help a launch on accountability in the health sector, we can use other provisions like Article 33 on rights of women and 8A, Article 45 to advance the right of health provided for in the national objectives.
- **National laws:** Uganda has some progressive laws but also very old laws like venereal disease, and Mental Health Act, but the state has not responded which raises questions of accountability. The 1935 Public Health Act is under review and there is hope that it will have provisions. Unfortunately, some post-colonial laws are still not explicit on accountability, and those under review may follow suit.
- **Decentralisation:** Our decentralised systems offer a big opportunity of accountability because one can be able to trace who is responsible for what right from the Village Health Teams who are at the lowest level of health service provision. But while the local government has been given powers the resources are controlled centrally and fusion of roles makes accountability difficult.
- **Budget financing:** Financing health has not really been a priority, the budget of FY 2016/17was decreased from 7% to 6.9% yet the budget for roads was increased from 18% to 23% and there is an argument that the president decides what the area of priority will be.
- **Private sector:** The private sector is a big player in provision of health care so in discussing accountability we need to move beyond the public sector. Private facilities have

been holding clients in incarceration for failure to pay hospital bills.Privatisation has also led to lack of essential amenities like power and water as health facilities are load shaded. We however have a framework that can hold private actors accountable.

- **Activism:** This is very important in bringing up issues of accountability and has resulted into CEHURD for example holding one local government accountable for a maternal death. In this case a mother died after her uterus raptured and the doctor on duty could not be found, CEHURD sued on behalf of her family and the Local Government was held liable.
- **Access to information:** There was recent ban on Comprehensive Sexuality Education and CEHURD took a case to court using access to information approach to push for accountability and for Ministry of Education to provide a policy and guidance.

Finally he observed that accountability in Uganda is important but that the state has disempowered itself leading to the private sector making the decisions on behalf of the state.

2.1 Recommendations and follow up

Delegates discussed the presentation and suggested that

- Activism can still be used as avenue of accountability.
- We need to hold the private sector accountable because it has become a big provider for healthcare.
- The regulatory function of the state has to be proactive.
- We need to confront radicalism in religion and culture.
- The Rule of law has to be in place.
- Colonial and some post-colonial laws need to be amended for clarity on accountability and other facets of human rights.

3. Health accountability in Kenya: Experiences, challenges and opportunities

The Executive Director of KELIN Mr Alan Maleche gave an overview of the legal framework in Kenya in relation to the right to health, shared experiences with accountability, the challenges faced and opportunities of engagement.

KELIN is a human rights organisation working to protect and promote health-related human rights in Kenya. The organisation works on broad issues of right to health with critical partners like lawyers, judges, the media, health service providers to help them appreciate their responsibility in delivering the right to health as well as sensitising communities to know what kind of service they should receive and how to hold the duty bearers accountable. The right to health is pursued through health policies, mobilisation of communities, facilitating access to justice and use of different forums to raise issues on right to health

3.1 The Legal framework in Kenya

The Kenyan constitution provides for health as a human right and recognises that everyone is entitled to emergency medical care. It further takes cognisance of all treaties that Kenya has ratified. The constitution provides for two levels of governance being the national government and 47 county governments forming part of the structure in the health sector. The National Government is in charge of developing national laws and policy and setting standard and guidelines, determining how many people should be in a health facility, ensuring referral hospitals are functioning, capacity building and what type of equipment should be used. On the other hand the county government primarily focuses on actual service delivery such ambulances, promotion of primary health care, licensing food outlets and they also make laws and policies as long as they are within the ambit of the constitution.

The health sector can be engaged through national government where the senate looks at the interest of any law that affect county issues, the National Assembly, the Cabinet and Ministry of Health and national referral hospitals. County government and inter-governmental structures are

all expected work inter dependently. The Constitution provides for public participation in any decision-making process that affects the community which is a progressive provision. In accordance with this provision the Government of Kenya recently sought public participation to have input into the health bill and different organisations were mobilised to have a collaborative effort in addressing issues of the health bill although a number of comments were not put into consideration.

Subsequent to government consultations the Health Act was enacted but with some provisions that are retrogressive in nature. The Act for instance requires health workers to notify government if someone undergoes a medical abortion and one must have a special license to carry out abortions which is a drawback on what the constitution has provided. Additionally the Act combines all health matters in one law which makes it confusing and CSOs are now persuading legislators to get a better law.

He indicated that the National Health Policy is fairly progressive but speaks more to service delivery than rights.

3.2 Strategies and opportunities for engagement

Mr Maleche suggested various approaches for engaging on the right to health

- **Forming Critical partnerships;** One strategy CSOs in Kenya have used is to form allies with young parliamentarians who are keen with human rights and we closely work with them in trying to get changes of the laws on the flow of parliament however there are only a few of them.
- **Strategic litigation;** The judiciary has also been useful in compelling government to formulate policies and to compensate medical bills in instances where women have been arrested for failure to pay medical bills after giving birth and where their rights have been violated in health care setting. On another case of isolation or jailing of patients court ordered ministry of health to develop an isolation policy that will be in line with World Health Organisation guidelines.
- **Human rights approach;** Subsequent to a campaign launched by UNICEF a presidential decision was made to register all children living with HIV and AIDs, to know where they lived and who their parents were in order to access them. KELIN was able to succeed using the human rights approach and the National AIDs Council issued guidelines to ensure right to privacy is observed in gathering of data.
- **Engaging the Media;** media is a critical partner and has been useful in exposing some accountability issues like the scandal on GAVI funds where the Kenyan government repaid 1.6m USD that they could not account for. This triggered the right to access of information as Civil Society sought to find out the source of the money.

3.3 Challenges

He further noted a number of challenges:

- Lack of compliance by the government.
- A shrinking space for CSOs as government locks them out of key meetings.
- Lack of respect for the constitution and court orders by both the national and county governments.
- Development partners enticing government to take loans that have no value for money and preferring to channel funds meant for county government through the national government. This takes long to disburse and sometimes it ends up returning to the funders even while the need remains.
- Low levels of participation by the affected community in the governance processes partly because they don't understand what needs to happen and how to intervene.

3.4 Recommendations and follow up

Delegates noted as opportunities for engagement that:

- The Health Act provides an opportunity to amend the unconstitutional provisions

- KELIN has developed a manual on implementing the right to health which tries to help CSOs and Community Based Organisations (CBO)
- As part of the East African Community Civil Society is considering the place of the recently enactment HIV law that is binding on all 5 member state and the only document in the East African Community that speaks to the right of health. CSOs need to assess what would be the level of keeping the member states accountable.
- Regional policies provide a space to look at how we can hold the East African states accountable.
- Kenya and Uganda have been involved in Global fund processes and there is need to assess the level of HIV community questioning and the countries' input to the concept note.
- There is potential to leverage on the Global Financing Facility which is a project largely fronted by Norway, world bank and other players whose focus is on maternal health issues.

It was noted that Kenya has a very precise constitution that provides a very good legal framework to hold the government accountable however the challenge is how to mobilise community to that level of accountability. The framework provides CSOs with the opportunity to think very broadly about ways to enforce accountability at a national, district and regional levels.

4. Panel discussion: Perspectives on health accountability

A panel discussion was moderated by Miss Juliana Nantaba, a freelance Human Rights Activist. The panel comprised Associate Professor Peter Waiswa, Makerere University School of Public Health, Mr Adrian Jjuuko, Executive Director HRAPF, and Mr Itai Rusike, Executive Director of Community Health Working Group in Zimbabwe. The panel aimed was to share perspectives on health accountability.

In their introductory remarks, the panellists defined health accountability and shared their experiences. Members of the panel agreed that accountability means striking a balance between power and politics within the health sector. Unfortunately it has been moved from power and politics to technical issues but there is need to go beyond seeking for transparency and having policies in place, to ensuring that there are consequences. Accountability is present if there are commitments, standards, obligations and consequences of not meeting them.

As emerging issues, panel members noted that:

- **Accountability must be people centred:** Health accountability should be people centred and communities must be involved because they are the ones affected and would be able to benefit but most citizens are passive. The focus should be removed from CSOs and communities be mobilised to seek accountability. Both in Zimbabwe and Uganda, CSOs are trying to lift the voices of communities but one of the challenges is that communities are not empowered enough to speak for themselves
- **The legal framework:** Law can help the health sector in developing countries with issues of accountability. Unfortunately the laws on this aspect have not been well defined. In Uganda we have not operationalised what accountability in the health sector is.
- **Performance with responsiveness to people's needs:** Focus should be placed on performance of the health sector and the guiding principle should be having health services that are responsive to the needs of people. However, there must also be responsibility of the people, the service providers, the state and CSOs instead of solely falling on service providers.
- **Paying of taxes as a basis to demand accountability:** A participant pointed out that under Article 52 of the Ugandan constitution, citizens pay taxes to the state and therefore they should demand for services as their rightfully entitlement as instead of only demanding them as human rights because government must fulfil its obligations. It was emphasised that health care services should not be a matter of privilege and government should ensure it does its role.

- **Using purchasing power to seek accountability:** Another participant countered that taxation is a poor system of accountability because citizens do not possess any power after payment of tax. It was suggested that in health systems some people have been able to use purchasing power but in the Ugandan context it is not possible because people go to the same public facilities. However, if one has insurance then they are able to select a service provider which would be practical.
- **Narrow approach by CSOs:** It was also observed that on accountability, CSOs take a narrow approach only looking at the health sector without considering other social determinants such as sanitation, housing, water and air pollution.
- **Democratisation of resources at lower levels**: As much as there is decentralisation of health services there is no trickling down of resources. The need for democratisation of resources at lower levels still exists because functionality can be compromised without budget or resources. There is therefore need for stronger institutions but they need to be empowered financially.
- **Accountability of CSOs:** There was a debate on who holds the CSOs accountable and whether government can hold the CSOs accountable. One of the participants pointed out that government should be held accountable first because CSOs only contribute to what Government should do. However in reality CSOs account to the donors financially and according to their objectives. This is true across the region.
- **No system of accountability:** By design we have systems that work without accountability. In their closing remarks, the panellists agreed that the role of the state is overstated and people are left behind and until communities are empowered to demand for their rights, accountability will not be possible.

The plenary session agreed on a simple definition of accountability as to be checking that you have done what you are supposed to do; while recognising that practice is more complex than that. The challenge is that the state does not always feel accountable to the citizens but it is important to put the pieces together and disentangle the mystery of accountability. Participants deliberated on what could be a better alternative to the CSOs seeking accountability from government and some suggested parliament. However, it is questionable if indeed parliament plays its role in holding the government accountable.

One of the members suggested that government might not be aware of its obligation which then makes the need for accountability difficult. However, another participant countered that the Constitution articulates some of these obligations and the Local Government Act clearly spells out the functions of the central government and local government although the political environment does not allow space to engage. Participants agreed that there is need for citizen mobilisation to engage their leaders because there is no capacity of citizens to engage. One of the challenges with accountability in the health sector is the tendency to think only medical doctors can talk about health issues.

Another participant suggested that we need to unpack the health budget because the biggest percentage goes to treatment instead of prevention or empowering Village Heath Teams. One participant raised an example in mental health where treatment only accounts for 40% towards recovery and the rest is perception of family. However, when the investment in mental health is assessed, it is mainly on medicines.

Delegates reflected on why government is not doing its role, what are the barriers? A representative from Ministry of Health stated that government has put in place frameworks showing that there is a will to do its role. Why are people not coming forth to access the services because there is equally responsibility on part of the citizens? One of the participants observed that people seek help from traditional healers first and only seek modern medicine when it is too late.

4.1 Recommendations and follow up

Delegates agreed in discussion that:

- There must be increased value for institutions and a state that is responsive.

- As CSOs we have a duty in terms of popularising the existing opportunities and policies.
- There is need to leverage on key partnerships with institutions like Ministry of Health and parliament. CSOs must invest in institutional relationships.
- Mobilise citizens to engage their leaders in seeking for accountability.
- Create systems that allow accountability.
- Develop mechanisms that can be used to hold the government accountable for what it is supposed to do.
- Establish the role of institutions and law because if the law is right, it makes accountability easier.

5. The OPERA framework for accountability

In a plenary session, Professor Gorik Ooms, London School of Nursing and Tropical Medicine unpacked the complex philosophy behind human rights and looked at the different components of the Opera Framework.

The utility of the OPERA framework becomes clearer when we understand the concept or philosophy of human rights and the difficulty that comes with it. It was noted that human rights that are codified in international conventions or treaties and national constitutions are easy to identify however, when the texts are not clear, then we need a tool for interpretation.

One of the difficulties in enforcing human rights is defining what a human right is and what it is not. There is no agreed definition of human rights but one of the participants defined them as those basic rights that everyone should have by virtue of being a human being. Henry Shue defined Human rights as the rational basis for justified demands, the denial of which no self-respecting person can reasonably be expected to accept.

The above definition guided participants into a discussion of what would amount to reasonable or justifiable demands which one cannot reasonably be expected to give up and participants agreed that some of these justifiable demands would include the right against torture, against slavery and the right to life. However emphasis was made that none of these rights are actually absolute because there are always limitations although lawyers usually present them as absolute.

The element of reasonableness formed a bigger part of this discussion and a participant mentioned an incident where the Ugandan Government in deciding what vaccines to procure used a ranking procedure of affordability. Other people argued that as long there is need for the vaccine then government should be able to afford it even if it means getting funds from other sources. The presenter however maintained that no government can really afford all the medicines so there element of reasonable must be used nevertheless health should be a priority.

The discussion was then redirected to the classification of human rights according to the International Covenant of Civil, Political and Cultural Rights (ICCPCR) which categorises them as negative and positive rights. Positive rights (freedoms) were classified as the essential don’ts which demand for the duty bearer not to do certain things. They include Civil and political rights like right to live, freedom of speech, freedom of religion, freedom from violence, and freedom from slavery.

Positive rights (entitlements) demand for the duty bearer to do something. They include Economic Social and Cultural rights such as the right to health. This right places a duty on office bearers to act in a certain way or offer something.

The distinction is that while positive rights are precise, cost free and subject to immediate implementation, negative rights are vague, involve costs and are hard to implement. It is more difficult to enforce the negative rights because it is difficult to identify the violator. The opera framework therefore is there to help identify where the violations are.

Article 12(1) of ICESCR provides that the state parties recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health but it has to be read together with Article 2(1) which provides that each state party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights.

The key words in the above article are that the state shall take steps toward progressive realisation of the right to the maximum of available resources. The language of the convention makes it difficult for advocacy because there is no clear commitment of the state.The commitment is to try and not to achieve the highest attainable standard. The Article therefore introduces a complexity of advocating the right to health because in seeking accountability, we need to consider the resources available and therefore the demand must be reasonable.

On the other hand having the right to health in the constitution makes some practical difference because you can use it in advocacy as well as strategic litigation. In some countries despite the lack of a clear provision on the right to health in their national constitution, court will uphold it on the basis of ratified International Treaties because they are binding in principle while other countries will be reluctant. However it is more difficult to enforce it in a country that decided not to ratify the treaty. The above background informed the development of the Opera framework realising that if we have to do successful advocacy, monitoring and holding governments accountable based on the right to health or other social rights we need a more sophisticated tool. The framework presents four levels of analysis which are outcomes, policy efforts, resources and assessment

- **Outcomes:** The analysis starts from outcomes to assess the level of realisation of the right and this must be measured over time in order to have a clear picture of what is happening and if the situation in the country improving or not. When people go to hospitals and do not receive the treatment they need, we raise violations but actually most often we are at the end of the chain of obligations that have not been met.
- **Policy efforts:** This element goes behind the outcome to assess the commitment and efforts of the state to realisation of the right to health. It allows CSOs and other stakeholders to examine the existing policies, compare with the reality on ground and evaluate if the government or the responsible institution is trying hard enough and if there is policy improvement.
- **Resources:** This step looks at whether the state is committing adequate resources to realising the right to health. If the policy says there must be a particular number of doctors in the facility and it is not happening CSOs need to ask why it is not happening. Whether it is because the salaries are too low or are there not enough doctors.
- **Assessment:** An overall assessments is important because there might be constraints that limit the government to do certain things while others things might be possible but yet government it is not doing.

After all those elements are considered, then there is need to build a strategy to determine an area of focus for a certain period of time. For instance resource allocation can be the focus looking at the Abuja target. Fifteen years on, Uganda moving away from the promise and are the available resources being used maximally. There is need to compare it with other similar countries like Kenya and Tanzania to help with our case.

One of the participants pointed out that the opera framework can be a challenge in the Ugandan situation where there is a fragmented health system and therefore there should be an advocacy strategy to consolidate the health systems The framework can be adapted according to the country's specific needs and be evaluated after every two years but the main objective is to have a broader view.

Participants had a concern on the applicability of the OPERA framework to private companies because the way human rights are formulated, they majorly point to the state's responsibility. The framework is based on the legal texts demanding for government accountability and therefore

creates a triangular relationship although government can use its power to seek accountability from individuals and private companies. The obligation of protecting human rights rests both upon government and private companies.

There was another valid concern on how the OPERA framework can take into account the unique political position of Uganda with no financial transparency and the only basis of accountability are resources that are released rather than the actually available of resources. The presenter suggested that the first step is to encourage government to declare and then investigate can be made on whether the declared what is declared is indeed true.

The question on parameters for reasonableness formed a bigger part of the discussion and the position was that there are no clear parameters. A suggestion was made that in regard to the health budget, the Abuja Declaration can be used although it is not a perfect solution because it does not consider the Gross domestic Product (GDP) of the country. If the health budget is decreasing year after year without justifiable reasons then a conclusion can be made that government could do more but it is not. It was also suggested that comparison between similarly positioned countries can be made.

No progressive state can run away from accountability and although policies and strategic plans are not legally binding they can be used to hold the state accountable on its commitments. CSOs can empower citizens to hold government accountable most especially at the time of elections and this tool is important for CSOs to be sophisticated in their advocacy strategy when engaging stake holders

6. Panel Discussion: Experiences with Accountability

This panel was moderated by Joshua Wamboga, UOPA. It included Mr Benard Mujuni, Commissioner Equity and Rights under Ministry of Gender, Labour and Social Development; Mr Derrick Kizza, Executive Director Mental Health Uganda; Mr Okwi Fredrick a Program Manager at Action Group for Health Human Rights and HIV/AIDs (AGHA); and Mr Samuel Senfuka, a freelancer with White Ribbon Alliance who shared their experiences with accountability.

One of the ways accountability has been approached by some CSOs has been through social accountability, mainly through the human rights approach. This has been done using dialogues between community and duty bearers such as local leaders. The process involves preparing duty bearers and the rights holders using an existing social accountability tool so that accountability is done in a more harmonious ways. This process makes the communities more vigilant, some demands have been put into the action plans and we have seen some positive results. And issues that are not addressed at community level are brought at the national level.

The People's parliament at health centres also tries to highlight accountability issues, although there is need to assess who attends and if the issues raised are actually representative of the whole community. There was an observation that the people who make it to people's parliament are those with some kind of status within the community and may not necessarily bring views that are representative nevertheless it creates a platform to share ideas and duty bearers have in some cases responded.

There are however a number of bottlenecks to accountability at local government level as well as national level and some of these were said to include;

6.1 Bottlenecks to accountability

Panellists and delegates identified the bottlenecks to accountability as:

- Lack of leadership and separation of roles in lower health systems Village Health Teams (VHT) and Health Management Committees (HMCs) not knowing their roles and responsibilities.
- Capacity lacking as many VHTs and HMCs are not trained and this creates a vacuum

- The quality of VHT and HMC meetings is inadequate as the minutes show discussions of administrative issues and not concrete patient's issues.
- Many lower level health facilities not making reports to the districts leading to a discrepancy in follow up.
- Lack of clarity on who is responsible for monitoring the VHTs.
- Users of services not knowing the responsibility of Health Management Committee
- Delayed disbursements and inadequate funding with conditions attached to the resources and refunds demanded if funds are not maximally used, with the need remaining.
- Parallel priorities of government for instance in infrastructure in comparison to the health sector as we have seen health financing declining against a high burden of disease
- A level of corruption and tolerance for it. Delegates noted that we should not only focus on government and forget the private health sector because there are private hospitals who have mishandled cases and people have not sought accountability from them

6.2 Recommendations and follow up

Delegates recommended various actions to address the bottlenecks:

- Mobilise citizen participation in accountability and involve them in gathering of evidence, empower them to understand why they are participating and demanding for services and they can use this information to engage with their leaders.
- Create platforms of interface with their leaders where citizens can air their issues and demand
- Extend accountability to the private sector.
- Carry out capacity building on the framework as CSOs and create a coalition of CSOs and come up with a proposal for this.
- Use the OPERA framework to understand what the problem is and to address it. The framework should integrate the community empowerment component that encourages community participation in the demand for accountability so that the advocacy is community led instead of CSO-led.
- CSOs should move beyond advocacy and the rhetoric into health development programing to see what amount is allocated where and for what.

7. Contextualising the OPERA framework in Uganda

In his remarks Prof. Ben Twinomugisha, Makerere University School of Law noted that the Opera framework is not a new thing but it builds on works of others however, the key question is how we can apply it in Uganda.

The 1995 constitution does not expressly provide for the right to health but has objectives, directives and principles of state policy which provides that the state shall ensure that all persons enjoy social services including medical care. In addition to that, the Right to life under Article 22 has been expanded through case law to include right to livelihood, education, women rights, human dignity, privacy, clean and healthy environment, disability rights and access to information which are all very critical.

Although the constitution does not have an express provision of the right to health in the bill of rights, Uganda is party to various International Instruments that recognise the right to the highest attainable standards of physical and mental health. The International Covenant of Economic Social and Cultural Rights (ICESCR) provides that state shall take steps to achieve the full realisation of the right to health however, it does not restrict the state on what steps it should take.

The framework talks about the obligation to respect, protect but majorly focuses on the obligation to fulfil which is the extent to which a state party has taken administrative, judicial, legislative and other measures towards realisation of the right to health. The framework moves beyond violations and looks at immediate and systematic causes surrounding this right. Much as

government should not act in violation of human rights, we need not to act like an ambulance that waits for the accident to happen.

The first component of the OPERA framework includes outcomes. To evaluate the level of enjoyment of the right to health in Uganda, we need to apply a multidisciplinary approach that borrows from statistics, epidemiology, public health, economics, gynaecology and obstetrics among others. We need to look at relevant indicators such as infant and maternal mortality rate, the level of air pollution, extent of access to clean water, existence of regional disparities among others.

Although the ICESCR provides for progressive realisation of the right, the state should meet the minimum core obligations and take concrete, targeted and measurable steps. In the General comment no.3 of 1990 and General comment no 4 of 2004, the Committee on Economic Social and Cultural Rights pointed out that although States can progressively realise the right to the maximum resources available, there are certain essential rights such as access to essential medicines, elimination of discrimination that the state must meet.

The question therefore is whether steps taken by the government of Uganda are reasonable in light of the maximum available resources. If there is justification of buying military jets when there is no war yet women are dying because they cannot access emergency obstetric care. If the design, monitoring and implementation of legal and policy frameworks in light to right to health conform to the human rights best approach. This raises issues of transparency, accountability, participation, right to remedy, availability and accessibility to quality goods and services.

Policy efforts can be inferred from the extent of commitments at the national, international and regional level. Budget allocation for instance is one of the indicators of commitment from government bearing in mind the promise of Abuja of 15% of national budget being allocated to health sector. The use of budget tools is important to compare the previous allocations which would show the trend whether it is progressive or unprogressive and also to make a comparison of health allocation with other sectors like education, housing and roads. These indicators reveal to what extent the state has prioritised the minimum core components of the right to health and equitable distribution of resources.

One of the fundamental elements in examining policy efforts is the existing legal and policy frameworks, strategies, interventions and programs the state has done towards fulfilling the obligation to realise the right to health. Uganda has signed a number of international instruments, covenants and treaties but have those provisions been enacted in our domestic laws. The framework guides us to interrogate the policies therefore we must go deeper and ask whose interests these policies serve. We must not look only at the face of it but at the progressive realisation which involves taking into account considerations of different levels of development.
Assessment must be subjected to the social, political, cultural, economic, structural and systemic factors that inhibit realisation of the right to health. It was noted that since the 1980s when the state adopted the Structural Adjustment Programs imposed by World Bank and IMF, power shifted to the market and therefore one of the challenges in realising the right to health is neo-liberalism. Health care is now treated as a commodity, anti-malaria drugs are now business to be determined by forces of demand and supply and capitalism is the order of the day.

The reason for human rights is to take care of poor, marginalised and disadvantaged people, who by lack of income cannot afford health care but when health care becomes a business careful consider must be made regarding the role of private persons bearing in mind their prominent part in provision of health care. Article 20 of the constitution states that every person or agent of the state shall uphold and respect human rights and therefore if a private person engages in provision of health care they have an obligation to respect human rights.

7.1 Constraints to realisation of the right to health

The framework advises that when we are assessing what steps the state can take towards the realisation of the right to health, we should look at constraints or factors that inhibit the realisation of this right. Some constraints that were identified included the following:

- Non conformity with human rights principles and standards
- Out dated laws that fail to take into account advances in science and technology in the field of health like the Penal Code Act section 240 which is the only provision that gives a lee way to a legal abortion talks of a surgical procedure when there are other means that do not require a surgical procedure like misoprostol.
- Likewise some laws operate on command theory of law with criminal sanctions yet lack genuine participation of the affected person.
- Limited domestication of the right to health, non-recognition of the right to health in the constitution, criminalisation of health rights including sexual reproductive health.
- Reluctance of court to practice judicial activism where courts are not willing to expand the right to health for purposes of promoting aspirations of people and delay in delivering judgments. Limited awareness by judges because very few judges study human rights.
- Public Order and Management Act which requires permission of police but yet police will not give the permission to demonstrate as a way to demand accountability from the state
- Lack of regulation of Private players in provision of medical services which supplement the efforts of the state but also undermine these efforts. In Tanzania there a Hospitals Act and the Minister is supposed to periodically set ceilings in terms of charges. Our Medical and Dental practitioners Act say private practitioners can levy reasonable charges but who determines what is reasonable.
- Low budget allocation, in FY 2015/2016 the health sector was allocated 7% and in FY 2016/17 the health sector budget was reduced to 6.9% which is way below the Abuja promise of 15%
- Non prioritisation of health care services for marginalised and vulnerable groups. An example was given by one of the participants of a pregnant woman with disability being pushed on a wheel barrow because health facilities and equipment are not conditioned to cater for her.
- Corruption and nepotism is also a big constraint. Uganda has high levels of corruption when you look at the data of transparency index. An example of this was the Global fund scandal that was meant for TB and HIV drugs.
- Negative cultural norms, values and practice although our constitution settled the cultural relativism debate in Article 137 which provides that every person has a right to belong or practice his or her culture as long as it does not undermine provisions of the constitution including human rights.
- Poverty and discrimination as seen with disparities in terms of services and other resources in different regions of the country
- Budget policies are not made in the interest of the people but rather in the interest of the business and elite class to the detriment of the poor, marginalised and the vulnerable.
- International trade policies that provide for monopoly of patents also are a direct hindrance to access to medicine which is likely to affect the state's capacity to realise the right to health.

7.2 Recommendations and follow up

Delegates proposed in the discussion that

- Civil society go beyond the policies and use a multifaceted approach to examine these factors; and to unpack the percentage of budget allocation because an increment in the block figure does not necessary mean better health care services because it might be towards buying vehicles for the staff.
- Explore whether the level of debt repayment is sustainable because such money could go to provision of social services. In the event that it is not sustainable, CSOs can advocate for debt relief or cancellation and should lobby for explicit constitution recognition of the right to health in the constitution.
- There is need to advocate for the repealing and amendment of laws that criminalise health rights; ensure that the private sector is regulated; prioritise the health rights of the poor and

marginalised and ensure availability and quality in health care goods and services such as emergency obstetrics care, essential medicines.

- This calls for increasing remuneration for health workers and increased numbers of health workers.
- Include gender perspective in all programs and policy making, with participation that is active and genuine not mere consultation
- Enforce the rights through court- strategic litigation

8. Panel discussion: Opportunities FOR CSO engagement with the OPERA framework

The panel was moderated by Mr James Nkuubi a program manager at HURINET. It was constituted by Dr Peter Waiswa, Associate Professor, Makerere University School of Public Health, Mr James Mugisha, Ministry of Health and Mr Okwi Fredrick, Program Officer Action Group for Health Human Rights and HIV/AIDs (AGHA).

The panel addressed the questions of when we can use the framework, with whom to use it, for what and why we should use it. One of the discussants pointed out that the framework is good and applicable but it can be improved on if civil society and other stakeholders come out of their confines and take a multidisciplinary approach.

The panel noted as opportunities:

a. **Systems Performance**: Understanding system performance and its bottlenecks is important in carrying out strategic litigation. There is need to look at the outcomes of the entire health system and its consequences. A participant suggested that Civil Society can develop an index to use for assessing system performance.
b. **Policy implementation,** government makes several consultations with organisations that promote human rights when formulating policy framework and therefore the policies are well seasoned but the implementation is lacking. The framework should therefore look at aspects of implementation irrespective of resources.
c. **Remuneration of public servant:** The level of welfare of public servants reflects on the quality of their performance. Therefore, when doctors earn $200 and yet controls Global fund of $500,000 it causes the public servants to become creative in pursuit for survival.
d. **The Social and Environmental Impact Assessment legislation** has been proposed to ensure all huge investments comply with a delicate level of assessment. The road infrastructure is currently the most thriving activity and with the inflation of workers in those communities where road construction is ongoing there has been an impact on health issues such as teenage pregnancy and high rates of HIV/AIDS infections.
e. **Equal opportunities commission Act**: is a great opportunity to litigate because Tribunal take a shorter period of time to determine a matter while courts take so many years to do so.
f. **International standards and guidelines:** The health sector reports on a large number of International standards however most CSOs have not interested themselves in these conventions. Interest should be taken especially on the Convention of Rights of Immigrants because migration is a big issue yet politics takes over issues of refugees for purposes of international branding and mobilisation of resources. The question however remains whether these resources trickle down to the refugees
g. **Ministerial policy statements;** they now must have consideration of gender rights and equity issues but this is a new concept of people setting priorities for government and therefore the CSOs have a task to pass on this knowledge and should seek opportunity to engage.
h. **Benchmarking;** the framework helps us to benchmark on equity indicators, to see whether they are up to international standards and it can also be a model for other sectors. There is gender and equity budgeting sector assessment and when a score of at least 50% is not reached, the expenditure cannot be approved.
i. **International reporting** is very useful but the research should have depth and contribute to government especially when civil society teams up with academia. The civil societies

need to be more transparent on shadow reporting and shouldn't only be reminded to report when it is due but it should be a continuous process.

Various bottlenecks were also noted:

- One of the biggest problem in the health sector lack of specialist in health systems
- National leadership; the greatest bottleneck in accountability is not necessarily the money but where the money is going and these are issues of national leadership because other countries like Rwanda and Ethiopia have made progress largely because of good leadership and governance.

8.1 Recommendation and follow up

Delegates made proposals to

- Incorporate ICT into the delivery of services especially in the health sector because it solves a lot of bureaucracy and limits on opportunities of corruption.
- Carry out capacity building on the OPERA framework to accountability centres like the Human Rights Commission, Equal Opportunities Commission and other semi-autonomous accountability centres to enable them dissect cases brought before them using the OPERA framework.
- Use the OPERA framework to enhance the reporting capacities of civil society organisations and be clear on the intention of using the OPERA framework to help find its application and value, including to find out how the health system is working.
- Use evidence based advocacy into the Ministerial budget framework to inform budget priorities and involve health system experts to enhance performance of health systems.
- Civil society collaborate with the academia for research to inform strategic litigation; explore and develop indicators for health system performance to see where it is going wrong.

9. Engaging on the framework in the region

Delegates aimed to concretise the discussion by looking at the benefits, bottlenecks and opportunities of the Opera framework as well as the next steps to take.

Various **benefits** were raised in using the framework., viz: in that it pushes people out of their comfort zone and is an opportunity to undertake deeper research to enable breaking through technical barriers in terms of engagement. It helps to build capacity for CSOs and will force CSOs to be more organic in collecting data from primary sources backed by sufficient evidence. The OPERA points CSOs to deep analysis research instead of going with what is trending and will help in gathering credible evidence to use in advocacy. The framework allows flexibility and can be adapted to unique situations of different states and supports CSOs to move from generic issues and focus through processes of the framework.

Delegates noted that it is not confrontational and therefore takes CSOs away from the approach of activism but is a tool that will help CSOs to work together and become sophisticated in their engagement and to easily articulate when engaging with technocrats. The framework helps to identify where the problem is which makes it easier to convince the judge of the violations made, to determine liability, make accountability work measurable, give clarity on roles and responsibilities and on the role of resource allocations. It helps to go beyond violations to factors leading to violations.

Various **challenges** were noted in the lack of engagement of private sector and the community in supporting a citizen manifesto. It makes an assumption that duty bearers will only be accountable upon engagement of rights holders and there are capacity demands and costs to implement it. It may also meet excuses of reasonableness from duty bearers.

The panel then suggested the following partners and stakeholders that we need to bring on board, noting a need for mapping of all stake holders for this to function:

Nationally

- Trade unions and CSOs to access to research and influence policies, such as in labour health human rights, medical and dental practitioners and allied medical workers.
- Religious and cultural leaders. most of our health facilities are in the hand of religious institutions; traditional healers and birth attendants.
- Local government; judiciary, parliamentary committees- clerks.
- Health economists; environmental researchers (for preventive).
- Private sector-industrial partners (involved in innovations); medical insurers and external funders

Regionally

- East African Legislative Assembly (EALA)
- East, Central and South African Health community (ECSA)
- European Network of Equity

Globally

- Developers of the Framework (this might be very expensive)
- World Health Organisation (WHO)
- Human rights-Global fund
- Global Health Systems Research
- COPASAH

It was also noted that collaborations would be important with fiscal experts; intra civil society collaboration between health and other areas of civil society, those working on and in accountability structures and the media.

9.1 Resources and opportunities

Delegates identified a number of potential resources for this work, ie:

- Human resources starting with Team OPERA composed of all participants at the workshop
- Government and local government collaborations
- Ongoing processes, social media, collaborations with academia and CSO's already involved in budget accountability
- The 'Supporting Policy Engagements for Evidence Based decisions' (SPEED) project team

They proposed leadership and coordination from CEHURD.

At the same time it was noted that lack of technical expertise in tax analysis; lack of exposure to the framework and inadequate financial resources would be a constraint.

9.2 An action plan for engaging regionally

Delegates proposed an action plan for engaging on the work in the region, shown in the table below:

SHORT TERM 4 months	MID TERM 2 years	LONG TERM >2 years
a. Mapping of stakeholders b. Identification of ongoing government processes to use as entry points c. Group mailing lists and WhatsApp group d. Conversations by possible collaborators and funders e. Boardroom convening f. Mapping of capacities of partners and interests g. Develop a work plan to	a. Passing of the National Health Insurance legislation b. Framework proposal c. Institutionalising the framework in our organisations d. Another meeting e. Capacity building and coordination f. Use the opportunity of the mid-term review of	▪ Laws informed by OPERA analysis ▪ Strong advocates with the government and community ▪ Documentation and storytelling externally and internally on what has worked and what hasn't ▪ Using the OPERA framework to monitor state obligations. ▪ Updating the existing report tools in light of the Opera

guide the long term h. Develop generic slides of the framework i. Presentation to senior management of Ministry of Health	recommendations of the International Convention on Economic, Social and Cultural Rights (ICSER) g. Meeting with relevant ministries, departments and agencies.	framework ▪ Adopt guidelines for monitoring (gender and equity) ▪ Setting a monitoring and evaluation framework on progress

10. Concluding remarks

In his closing remarks, Mr Mulumba, CEHURD emphasized that the opera framework does not introduce new concepts, but is a critical tool in monitoring state compliance on the right to health. He mentioned however that it should be revised to also assess the role of business and other private actors in the promotion or negation of the right to health, taking into account the special needs of third world countries.

The framework can be applied in combination with other frameworks in a multidisciplinary approach but should also build on common law approaches especially on the doctor-patient's right issue. The interests of public law and health sector meet but CSOs must find a way to interface and collaborate on common issues. There is an uphill task to get the framework known to the stakeholders and we therefore need to carry out sensitisation so that it can be used as a tool in government planning. Overall, he stressed that the framework has value. There is an opportunity to engage with the framework, and citizens should be mobilised to participate in accountability of duty bearers.

He thanked participants for honouring the meeting and staying active. He expressed gratitude partners from Kenya, Zimbabwe and the UK, for making the trip and for their participat6ion in the meeting and closed the meeting.

Appendix 1: Programme

Session Moderator – Ms. Nassimbwa Jacqueline		
DAY ONE: 29/8/2017 Arrival of Participants/Check in, into Hotel		
Time	**Topic**	**Responsible Person**
7.00 – 8.30am	Arrival and Registration	CEHURD Secretariat
8.30am – 8.35am	Opening Remarks	Mr Kabanda David (CEHURD)
8.35am – 8.40am	Participants Introduction: Name, Country, Organisation, Field of Work	Session Moderator
8.45am – 8.50am	Opening Remarks	Mr Mugisha James (MOH)
8.55am – 9.10am	**Presentation:** The state of Health Accountability in Kenya: Experiences, Challenges and Opportunities	Mr Alan Maleche (CEHURD)
9.15am – 9.30am	**Presentation:** The state of Health Accountability in Uganda: Experiences, Challenges and Opportunities	Mr Mulumba Moses (CEHURD)
TEA BREAK		
10.00am – 10.30am	**Panel Discussion:** Perspectives on health accountability Dr Waiswa Peter – (MUK-SPH) Mr Itai Rusike – (CHWG - Zimbabwe) Mr Adrian Jjuuko – (HRAPF)	Ms Juliana Nantaba
10.30pm – 11.00am	Plenary Discussion of Panel Discussion	Session Moderator
11.05pm – 11.40am	**Presentation:** The Opera Framework for Accountability	Prof Gorik Ooms (LSHTM))
11.45am – 12.30pm	Plenary Discussion of Presentation: Questions and Answers	Session Moderator
12.35pm – 1.00pm	**Panel Discussion:** Experiences with Accountability Mr Bernard Mujuni – MGLSD Mr Senfuka Samuel – WRA Mr Fredrik Okwi – AGHA Mr Derrick Kizza - MHU	Mr Joshua Wamboga
1.05pm – 1.30pm	Plenary Discussions: Questions and Answers	Session Moderator
LUNCH BREAK		
2.30pm – 3.00pm	**Presentation:** Contextualising the Opera Framework in Uganda	Prof Ben K Twinomugisha (MUK-SOL)
3.05pm – 3.30pm	**Panel Discussion:** Opportunities for CSO engagements with the Opera Framework Dr Peter Waiswa (MUK-SOL) Mr Mugisha James (MOH) Mr Fredrick Okwi (AGHA)	Mr James Nkuubi (HURINET)
3.35pm – 4.00pm	Plenary of Panel Discussions	Session Moderator
4.05am – 4.25am	Plenary Discussion of Issues arising and Opportunities for Further Engagement on the Framework in the region	Mr Mulumba Moses and Prof Gorik Ooms
4:30pm – 4:40pm	Closing Remarks	Mr Bernard Mujuni (MGLSD)
DEPARTURE		

Appendix 2: Delegate list

	Name	Organisation
1.	Mr Derrick Mbuga Kizza	Mental Health Uganda
2.	Mr Allan Maleche	KELIN
3.	Mr Opio Geofrey Atim	COPASH
4.	Mr Bimanywa Charles Matovu	Coalition for Health Promotion and Social Development (HEPs Uganda)
5.	Mr Okwi Fredrick	Action Group for Health Human Rights & HIV/AIDS (AGHA Uganda)
6.	Mr James Mugisha	Ministry of Health
7.	Mr Kabanda David	Center for Health, Human Rights & Development (CEHURD)
8.	Mr Itai Rusike	Community Working Group on Health (CWGH Zimbabwe)
9.	Mr Francis De Beir	Helene De Beir Foundation, Belgium
10.	Ms Juliana Nantaba	Uganda Christian University
11.	Ms Nabatte Susan	Center for Health, Human Rights & Development (CEHURD)
12.	Mr Muhumuza Adulkharim	Center for Health, Human Rights & Development (CEHURD)
13.	Ms Anne Lumbasi	Center for Health, Human Rights & Development (CEHURD)
14.	Ms Jacqueline Nassimbwa	Center for Health, Human Rights & Development (CEHURD)
15.	Dr. Peter Waiswa	Makerere University, School of Public Health
16.	Professor. Goric Ooms	London school of Hygiene and Tropical medicine
17.	Mr Mulumba Moses	Center for Health, Human Rights & Development (CEHURD)
18.	Mr Senfuka Samuel	White Ribbon Alliance
19.	Ms Tamale Cynthia Nona	Institute for Social and Economic Rights (ISER)
20.	Mr Joshua Wamboga	Uganda Alliance of Patients Organizations (UAPO)
21.	Mr James Nkuubi	Human Rights Network (HURINET)
22.	Mr Adrian Jjuuko	Human Rights Awareness and Promotion Forum (HRAPF)
23.	Mr Mujuni Benard	Ministry of Gender, Labour and Social Development
24.	Professor Ben Twinomugisha	Makerere University, School of Law