



Mainstreaming Human Rights and Gender in the Health Sector

Trainee Manual

August 2018



MINISTRY OF HEALTH

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LIST OF ACRONYMS

AAAQ	Availability, Accessibility, Acceptability and Quality
ACODEV	Action for Community Development
AHPC	Allied Health Professionals Council
AU	African Union
BFP	Budget Framework Paper
CAO	Chief Administrative Officer
CEDAW	Committee on Elimination of all forms of discrimination against women
CEHURD	Centre for Health, Human Rights and Development
COMESA	Common Market for Eastern and Southern Africa
CSOs	Civil Society Organizations
DAC	District Accounts Committee
DDHS	District Director of Health Services
DEVAW	Declaration on the Elimination of Violence Against Women
DPP	Director of Public Prosecution
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
DWD	Directorate of Water Development
EAC	East African Community
ECP	Emergency Contraceptive Pill
EOC	Equal Opportunities Commission
FPP	Focal Point Person
FY	Financial Year
GAM	Gender Analysis Matrix
GAQ	Gender Analysis Questions
GEB	Gender and Equity Budgeting
GDP	Gross Domestic Product
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HRBA	Human Rights Based Approach
HSSIP	Health Sector Strategic and Investment Plan
HSSP	Health Sector Strategic Plan
ICESCR	The International Covenant on Economic, Social and Cultural Rights
ICCPR	International Covenant on Civil and Political Rights
IEC	Information, Education and Communication
IGAD	Inter Government Authority on Development
IPV	Intimate Partner Violence
LGs	Local Governments
MDAs	Ministries, Departments and Agencies
MGLSD	Ministry of Gender, Labour, and Social Development
MoFPED	Ministry of Finance, Planning and Economic Development
MOH	Ministry of Health
MPs	Members of Parliament
MUK	Makerere University
MWLE	Ministry of Water, Lands and Environment
NDP	National Development Plan
NEPAD	New Partnerships for African Development
NGO	Non-Governmental Organization

NHP	National Health Policy
NPGEIs	National Priority Gender Equality Indicators
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Care
PS	Permanent Secretary
PwDs	Persons with Disabilities
R&S	Rewards and Sanctions
SEGA	Social Economic of Gender Analysis
SERAC	Social and Economic Rights Action Centre
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender-Based Violence
SH	Sexual Harassment
SPDC	Shell Petroleum Development Corporation
STD	Sexually Transmitted Infection
STI	Sexually Transmitted Infection
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UDHR	Universal Declaration of Human Rights
UDHS	Uganda Demographic and Health Survey
UHRC	Uganda Ugandan Human Rights Commission
UMDPC	Uganda Medical and Dental Practitioners Council
UNHCR	United Nations High Commissioner for Refugees
UNMC	Uganda Nurses and Midwives Council
UNMHCP	Uganda National Minimum Health Care Package
VAC	Violence Against Children
WHO	World Health Organization

FOREWORD

The Government of Uganda has at the local level passed a host of laws and policies, and at international level, ratified several others that promote gender equality and uphold human rights. Particularly to health, the Government of Uganda is committed to facilitate the attainment of a good standard of health for all the people in Uganda. To this effect, Uganda is a Party State to the International Covenant of Economic Social and Cultural Rights (ICESCR) and other international human rights instruments whose provisions have been domesticated in our national laws and policies. Thus, Ministry of Health is enjoined to provide the highest possible level of health services to all people in Uganda through effective delivery of health services at all levels. While implementing its mandate, the Ministry makes the right to the highest attainable standard of physical and mental health one of its core values and gives it a central focus.

The right to health envisages participation of the population in all health-related decision-making at all levels. It is also linked with principles of equality, equity and non-discrimination and prioritizes the needs of the poor and vulnerable groups such as children, women, refugees, and the elderly among others.

It is important to note that the right to health is linked with the realization of all other rights and is a bedrock for enjoyment of other rights. Human rights are universal and inalienable; indivisible; interdependent and interrelated. Thus, there is no single right that can be enjoyed in exclusion of all others but rather as a whole.

The right to health, like all human rights, imposes on States Parties the following obligations: to respect, protect and fulfil. To this end, Ministry of Health as a chief custodian of this essential right and in partnership with IntraHealth Uganda, WHO, CEHURD and ACODEV developed a manual for mainstreaming human rights and gender for the health sector.

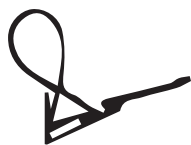
The main purpose of this manual is to bridge the knowledge and practice gap between duty bearers and rights-holders in health service delivery which impedes effective service delivery leads to violation of human rights. Furthermore, there has been limited attention given to gender issues in the health sector which has led to iniquities in accessing health services and interventions that are not gender-responsive. This manual is therefore designed to empower the duty-bearers and rights-holders with knowledge and skills to appreciate the importance of mainstreaming human rights and gender in health. The manual will also be used by trainers as a tool for delivering quality training to their audiences.

The Mainstreaming Human Rights and Gender Manual for the Health Sector is a result of joint efforts by the gender and human rights desk at the Ministry of Health (MOH) which brings together various stakeholders. The MOH wishes to acknowledge the contributions of the following organizations that supported the process technically and financially i.e. ACODEV, CEHURD, WHO, and IntraHealth Uganda.

I extend special thanks to the facilitators and trainers for their technical support in developing the first draft of the document, pre-testing the manual in various districts and refining the manual contents. I particularly recognise Acen Harriet from Action for Community Development (ACODEV), Moses Mulumba, Nakibuuka Noor Musisi, Nsereko Ibrahim, David Kabanda and Juliana Nantaba from the Center for Health, Human Rights and Development (CEHURD), Alice Nayebare from IntraHealth

Uganda, James Mugisha, Ally Walimbwa, Miriam Namugere, Wilberforce Mugwanya, Grace Ojirot, and Leah Goldmann from the Ministry of Health (MoH), Jane Ekapu, Nakyanzi, Innocent Tushabe, and Caroline Benda from The Ministry of Gender, Labour, and Social Development (MGLSD).

I implore all staff, health workers and especially the trainers to make use of this useful tool and improve their personal knowledge and practice and that of their clients and training audiences for better workforce management and improved health service delivery.



Dr. Diana Atwine
PERMANENT SECRETARY
MINISTRY OF HEALTH

INTRODUCTION

This manual is organised as two units in one module. Unit one focuses on human rights and health, and Unit Two discusses gender and health. The human rights Unit covers the existing international, regional, and national legal and policy frameworks and principles relating to health and human rights. Additionally, it includes steps on how to integrate the human rights-based approach to health programming and service delivery. Unit Two covers the key gender related concepts, gender analysis, gender responsive planning and budgeting, gender mainstreaming, sexual and gender-based violence, and sexual harassment. Additionally, there is an accompanying trainer's guide to support educators in delivering the material in an engaging and effective manner. Overall, the manual targets national, regional, local government, and facility level health professionals at service delivery points, managers and policymakers, as well as non-governmental institutions and others, in order to operationalize their professional codes of conduct, mainstream gender and human rights in policies and programs, and support communities in realizing their right to health.

BACKGROUND

The Ministry of Health is committed to facilitating the attainment of a good standard of health for all the people in Uganda by promoting human rights and gender equality to reduce inequality and promote fairness in accessing and receiving healthcare. In 2012, The Ministry of Health, in collaboration with the World Health Organization, Uganda County office and other partners began developing this training manual to enhance the capacity of health sector staff in mainstreaming gender and human rights in policies, plans, and programmes. The development of the manual used a participatory approach involving line ministries, local governments, CSOs, and NGOs. In 2013 and 2014, the manual was successfully pretested at three sites, whereby users found the manual practical, appreciated its content, and provided valuable feedback. In 2017, with support from IntraHealth Uganda, stakeholders incorporated feedback and updated its content. In the future, the Ministry of Health, in partnership with stakeholders, will develop a strategy to sensitize the community about their rights, roles, and responsibilities in realizing their right to health and reducing gender inequality in accessing and receiving care.

RATIONALE

There has been a knowledge and practice gap between duty bearers and rights-holders in health service delivery. This gap leads to limited service delivery and the violation of human rights, including the right to the highest attainable standard of health. In addition, there has been limited attention given to gender issues in the health sector which has led to iniquities in accessing health services and interventions that are not gender-responsive. This manual is therefore designed to empower the duty-bearers and rights-holders with knowledge and skills to appreciate the importance of mainstreaming human rights and gender in health.

OBJECTIVES

By end of the module, the trainees will be able to;

- Apply a human rights-based approach to health planning, implementation and monitoring and evaluation.
- Develop and implement gender responsive plans and interventions in health service delivery.
- Prevent and respond to SGBV (including sexual harassment) in health service delivery.

Although this training is supposed to be delivered in five days as per the training schedule below, it allows flexibility in terms of time depending on the capacity needs of the audience to be trained as well as the course content to be delivered. This schedule can be adapted with necessary modifications in accordance with the considerations above mentioned.

SCHEDULE FOR TRAINING

TIME	ITEM	RESPONSIBLE PERSON
DAY ONE		
8:00 – 8:30 am	Arrival, Registration, And Pre-Test	Secretariat
8:30 – 9:00 am	<ul style="list-style-type: none"> • Introductions • Expectations • Housekeeping • Objectives 	Facilitator
9:00 – 9:30 am	Official Opening Remarks	Organizer
9:30 – 10:30 am	Introduction To Human Rights	Facilitator
10:30 – 11:00 am	Health Break	Health Break
11:00 – 12:00 pm	Legal And Policy Framework	Facilitator
12:00 – 1:00 pm	Health And Human Rights	Facilitator
1:00 – 2:00 pm	Lunch Break	Lunch Break
2:00 – 3:00 pm	Possible Violations Of The Right To Health And Redress Mechanisms	Facilitator
3:00 – 4:30 pm	Group Work And Presentations On Violations And Redress	Participants
4:30 – 5:00 pm	Plenary Discussion	Facilitator and Participants
DAY TWO		
8:30 – 9:00 am	Registration	Secretariat
9:00 – 9:30 am	Recap of Day 1	Participant
9:30 – 10:30 am	Understanding the Human Rights-Based Approach In Health	Facilitator
10:30 – 11:00 am	Health Break	Health Break
11:00 – 1:00 pm	How to Integrate the Human Rights Based Approach in Planning And Implementation of Health Services	Facilitator
1:00 – 2:00 pm	Lunch Break	Lunch Break
2:00 – 4:00 pm	Group Work on The Application Of The Human Rights-Based Approach	Participants
4:00 – 5:00 pm	Presentations and Plenary Discussion	Facilitator And Participants
DAY THREE		
8: 30 – 9:00 am	Registration	Secretariat
9:00 – 9:30 am	Recap of Day 2	Participant
9:30 – 10:30	Gender and Health Service Delivery (Concepts And Importance)	Facilitator
10:30 – 11:00 am	Health Break	Health Break
11:00 – 12:00 pm	Gender Analysis in Health	Facilitator
12:00 – 1:00 pm	Exercises on Gender Analysis	Participants

1:00 – 2:00 pm	Lunch Break	Lunch Break
2:00 – 3:00 pm	Presentations on Group Work	Participants
3:00 – 5:00 pm	Gender Responsive Planning and Budgeting	Facilitator
DAY FOUR		
8: 30 – 9:00 am	Registration	Secretariat
9:00 – 9:30 am	Recap of Day 3	Participant
9:30 – 10:30 am	Gender Mainstreaming in the Health Sector	Facilitator
10:30 – 11:00 am	Health Break	Health Break
11:00 – 12:00 pm	Sexual and Gender-Based Violence (Forms, Magnitude, Consequences, Prevention, and Response)	Facilitator
12:00 – 1:00 pm	SGBV- Practical Exercises	Participants
1:00 – 2:00 pm	Lunch Break	Lunch Break
2:00 – 5:00 pm	Sexual Harassment Prevention and Response	Facilitator
DAY FIVE		
8: 30 – 9:00 am	Registration	Secretariat
9:00 – 9:30 am	Recap of Day 4	Participant
9:30 – 10:30 am	Action Planning	Facilitator
10:30 – 11:00 am	Health Break	
11:00 – 1:00 pm	Create Plans and Group Presentations	Participants
1:00 – 2:00 pm	Lunch Break	
2:00 – 3:00 pm	Post-training evaluation	Participants
3:00 – 4:00 pm	Way Forward, Award Certificates, and Closing Remarks	Facilitator
CLOSING		

UNIT 1: HUMAN RIGHTS IN HEALTH

Unit Preamble:

This module introduces you to existing international, regional, and national legal and policy frameworks and principles relating to health and human rights. Additionally, the module covers how to integrate the human rights based approach in planning, delivering, and monitoring of health services.

Rationale:

There has been a knowledge and practice gap between duty bearers and rights-holders in health service delivery. This gap leads to limited service delivery and the violation of human rights, including the right to health.

This module is designed to help service providers and decision-makers identify knowledge and practice gaps so that they can apply human rights into their day-to-day responsibilities and accord all service consumers and providers the right to health.

Unit Objectives:

1. Appreciate the legal and policy framework that details roles and responsibilities for state parties (duty-bearers) and citizens (rights-holders) in health service delivery,
2. Apply the human-rights based approach (HRBA) to planning and implementation in realizing the right to the highest attainable standard of health.

1.1 INTRODUCTION TO HUMAN RIGHTS

Introduction

Under this unit, participants will study human rights, norms and principles and the obligations created by human rights instruments.

Sub-Unit Objectives

By the end of this sub-unit, participants will be able to:

1. Explain the concepts related to Human Rights and Health ;
2. Discuss the origins and principles of human rights;
3. Outline the roles and obligations of duty bearers;
4. Discuss the human rights legal and policy framework applicable in Uganda;
5. Explain the implications of respecting and/or violating human rights for health care professionals.

1.1.1 Definition of Concept Terms:

Human Rights

Human rights are rights that every person is entitled to by virtue of being human. According to the Universal Declaration of Human Rights (UDHR), human rights are intrinsic values that give all human beings dignity.

Human rights are thus basic values that are essential to human dignity. Human rights are legally guaranteed by human rights law. They protect individuals and groups against actions that interfere with fundamental freedoms and human dignity. Human rights impose obligations on governments (who are the primary duty-bearers).

The UDHR further states that all human beings are born free and equal in dignity and rights and are endowed with reason and conscience and should act towards one another in a spirit of brotherhood. (Article 1).

Duty-Bearers

Those who have the obligation to respect, promote and realize human rights. State-actors and non-State actors can both act as duty-bearers depending on the context.

Rights-Holders

Those individuals who are entitled to such rights. Note that individuals are always rights-holders, but can also act duty-bearers simultaneously.

1.1.2 Origin of Human Rights

- Human rights are a 20th century phenomenon developed in response to the atrocities of World War II.
- The extermination of over six million Jews, Sinti and Romani (gypsies), homosexuals, and disabled persons by the German Nazi Party horrified the world.
- Governments then committed themselves to establishing the United Nations, with the primary goal of bolstering international peace and preventing conflict.
- This was to ensure that never again would anyone be unjustly denied life, freedom, food, shelter, and nationality.

1.1.3 Principles of Human Rights¹

Human rights are based on the following principles;

Universal and inalienable means that human rights apply to everyone, everywhere in the world regardless of their status, including their political, jurisdictional, or international status of the country or territory to which a person belongs;

Indivisible means that it is not sufficient to respect some human rights and leave out others. All rights have an equal status and cannot therefore be ranked or prioritized;

Inter-dependent and inter-related means that the realization of one right often depends, wholly or in part, upon realization of others. For instance, realization of the right to health may depend, in certain circumstances, on realization of the right to education, among others. A malnourished girl may be unable to perform in school and consequently be unable to realize her right to an education.;

Equality and non-discrimination: This principle requires eradication of any legal, institutional, interpersonal and structural discrimination. Additionally, public institutions should ensure representation of marginalized or excluded groups; that services are accessible and sensitive to all people; and appropriate judicial and administrative redress mechanisms;

Participation and Inclusion: This principle requires free, active, meaningful and inclusive participation in and contribution to policies, planning, and procedures in civil, economic, social, cultural and political development. This also calls for access to relevant information and building capacities of marginalized groups to formulate proposals;

Accountability and Rule of Law: This requires duty-bearers to comply with legal norms and standards enshrined in human rights instruments. Where duty bearers fail to comply, aggrieved rights-holders are entitled to seek appropriate redress. State institutions—independent human rights bodies, parliamentary committees, national human rights institutions, judges, courts and legal counsel—should be provided with sufficient resources and independent authority to address violations of human rights.

1.1.4 Nature of State Obligations Created by Human Rights

The Human rights system creates three major obligations on duty-bearers. These include the obligations to: respect; protect and fulfil. These obligations are also stated under Article 20 of the Constitution of the Republic of Uganda.

¹ UN system Staff College materials.

The obligation to respect: requires duty-bearers to refrain from interfering directly or indirectly with the enjoyment of human rights. States have the obligation to ensure that no government practices, policies, programs, or legal measures violate human rights, paying particular attention to the vulnerable and marginalized groups.

The obligation to protect: calls upon duty-bearers to prevent third parties from interfering with the enjoyment of the human rights. For example, this obligation calls upon government to prevent pharmaceutical companies and health insurance providers from infringing on human rights.

Example 1

Greenwatch vs. Attorney General & NEMA

In Center for Health, Human rights and Development (CEHURD) & Anor V. the Executive Director Mulago National referral Hospital and Attorney General civil suit No. 212 of 2013, Justice Lydia Mugambe noted that this obligation requires the state to ensure that non state actors such as multi-national corporations, local companies, private persons and armed groups do not violate economic social and cultural rights. This includes regulating and monitoring the commercial and other activities of non state actors that affect people's access to enjoyment of Economic social and cultural rights.

The obligation to fulfil: This requires the government to adopt appropriate measures towards full realization of the rights such as appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of human rights. This includes the obligation to provide accessible redress mechanisms where health rights have been infringed by the government or other actors.

Example 2

CEHURD CASE In Center for Health, Human rights and Development (CEHURD) & others V. the Executive Director Mulago National referral Hospital and Attorney General civil suit No. 212 of 2013, Justice Lydia Mugambe emphasized that measures under this obligation should be comprehensive, coordinated, transparent and contain clear goals indicators and benchmarks for measuring progress. She further noted that this obligation is a positive expectation on the part of the state to move its machinery towards the actual realization of the rights.

Responsibilities under Human Rights

For every single right, there is a corresponding responsibility. One's enjoyment of rights is subject to another person's rights; as a person enjoys their rights, they should respect the rights of others. The human rights system therefore makes everyone responsible in the realization of human rights.

For example, to meet the right of access to healthcare, one has the corresponding responsibility to share accurate information needed for their treatment and comply with the prescribed treatment or procedures.

1.1.5 What do Human Rights Mean for Health Professionals?

According to the UDHR, every individual and organ of society should strive through teaching and education to promote respect for these rights and freedoms. This therefore means that health

workers have various roles to play in the promotion and protection of the right to health. Specific duties of health workers have been clearly set out in certain international declarations and codes of ethics. For instance, basic principles of medical ethics include:

- **Respect of autonomy** requires health workers to ensure their patients' constitutional human rights to liberty and security of the person (safeguarded by an informed consent; freedom of conscience; thought and religion; privacy of property; and the confidentiality rule), are respected;
- **Nonmal eficence** requires health workers to ensure that patients are not subjected to any kind of torture and harm contrary to the patient's constitutional rights;
- **Beneficence** is the idea that medical actions should promote good;
- **Justice or fairness** requires health workers to ensure that their patients are not discriminated against. This can be divided into three categories- fair distribution of scarce resources (distributive justice), respect for people's rights (rights based justice) and respect for morally acceptable laws (legal justice); and
- **Welfare** of patients requires health workers to ensure that the methods to secure and maintain health services for the people is honoured by the public health facilities; health workers are specifically to stand up for the rights of their patients by putting the patient's rights first before those of any one else.

Industrial Action

Additionally, the Constitution of the Republic of Uganda provides for the right to practice one's profession and legal trade. To this end, every health worker has a right to collective bargaining and representation, and to withdraw his or her labour under Article 40 of the Constitution of Uganda 1995. This right has for example been severally exercised by the Uganda Medical Association each time they have withdrawn their labour.

1.2 LEGAL AND POLICY FRAMEWORK

Introduction

Under this sub-unit, participants will study the international, regional, and national legal and policy frameworks that enshrine the right to health and outline obligations and responsibilities of both duty-bearers and rights-holders.

Sub-Unit Objectives

By the end of this sub-unit, participants will be able to:

1. Explain international, regional, and national legal and policy frameworks regarding the right to health;
2. Discuss the roles and responsibilities detailed in Uganda's Patient's Charter; and
3. Discuss the limitations of human rights.

1.2.1 Key Concepts

Law

Law is a system of rules and guidelines which are enforced through social institutions to govern behaviour, wherever possible. It also refers to the system of rules which a country or community recognizes as regulating the actions /behaviours of its members and which it may enforce by the imposition of penalties. The laws elaborate rights and responsibilities in a variety of ways and every country has their own set of laws and each is unique to that country.

Health Policy

A policy is typically described as a principle or set of guidelines to guide decisions and achieve rational outcomes, it can also be considered as a "Statement of Intent" or a "Commitment". For that reason at least, the decision-makers can be held accountable for their Policy. It should be noted however that policies do not have a legal force, they simply act as statements and commitment and guidelines and can only be enforced by the use of the laws. A health policy is therefore about decisions, plans, and actions that are undertaken to achieve specific health care goals within a society.

Uganda has put in place policies and laws relating to the right to health. A combination of these is what we refer to as the legal and policy framework. While the policies outline the aspirations of government regarding health, the laws give the legal force to the policy provisions.

1.2.2 National Level

The Constitution of the Republic of Uganda

According to Article 2 of the 1995 Constitution of the Republic of Uganda (as amended), the Constitution is the supreme law of the country and is and has a binding force on all authorities and persons throughout Uganda. Thus if any other law or custom is inconsistent with any of the provisions of the constitution, the constitution prevails.

Chapter four of the Constitution provides for the protection and promotion of fundamental and other human rights and freedoms, otherwise known as the Bill of Rights.

List of rights under the Uganda Constitution:

- Equality and freedom from discrimination (article 21);
- Protection of right to life (article 22);
- Protection of personal liberty (article 23);
- Respect for human dignity and protection from inhuman treatment (article 24);
- Protection from slavery, servitude and forced labour (article 25);
- Protection from deprivation of property (article 26);
- Right to privacy of person, home and other property (article 27);
- Right to a fair hearing (article 28);
- Protection of freedom of conscience, expression, movement, religion, assembly and association (article 29);
- Right to education (article 30);
- Rights of the family (article 31);
- Affirmative action in favour of marginalised groups (article 32);
- Rights of women (article 33);
- Rights of children (article 34);
- Rights of persons with disabilities (article 35);
- Protection of rights of minorities (article 36);
- Right to culture and similar rights (article 37);
- Civic rights and activities (article 38);
- Right to a clean and healthy environment (article 39);
- Economic rights (article 40);
- Right of access to information (article 41);
- Right to just and fair treatment in administrative decisions (article 42); and
- General limitation on fundamental and other human rights and freedoms (article 43).

The Patient's Charter

Uganda's Patient Charter aims to empower health consumers to demand high quality health care, promote the rights of patients and improve the quality of life for all Ugandans. The Patients' Rights Charter lists both the rights and the responsibilities of duty-bearers and rights-holders in healthcare service delivery.

Rights provided for under the charter include:

- **The Right to Medical Care:** Every person in need of medical care is entitled to impartial access to treatment in accordance with regulations, conditions and arrangements obtaining at any given time in the government health care system;
- **In a medical emergency:** a person is entitled to receive emergency medical care unconditionally in any health facility without having to pay any deposits or fees prior to medical care. Should a medical facility be unable to provide treatment to the patient, it shall, to the best of their facility, refer him/her to a place where he/she can receive appropriate medical care;

- **Prohibition of Discrimination:** No health facility or health provider shall discriminate between patients on ground of disease, religion, political, disability, race, sex, age, social status, ethnicity, nationality, country of birth or other such grounds;
- **Participation on decision making:** Every citizen has the right to participate or be represented in the development of health policies and systems through recognized institutions;
- **Proper Medical Care:** A patient shall be entitled to appropriate health care with regard to both its professionalism and quality assurance based on clinical need;
- **Be treated by a named health care provider:** Everyone has the right to know the identity and professional position of the person providing health care;
- **Receiving visitors:** A patient hospitalized in a health facility is entitled to receive visitors at the times, and according to the guidelines provided by the facility management;
- **Informed consent:** Every patient has the right to be given adequate and accurate information about the nature of their illness, diagnostic procedures and proposed treatment. This should be communicated to the patient at the earliest possible stage in a manner that he/she is expected to understand in order to make a free informed, and independent choice;
- **Refusal of treatment:** A person may refuse treatment and such refusal shall be verbal or in writing provided that such refusal does not endanger the health of others;
- **Confidentiality and privacy:** Patients have the right to privacy in the course of consultation and treatment. Information concerning one's health may only be disclosed with informed consent, except when required by law or on court order;
- **The Patient's Right to Medical Information:** The patient shall be entitled to obtain from the clinician or the health facility medical information concerning himself/herself, including a copy of his/her medical records.

In addition, the charter spells out the following responsibilities:

- **Provision of information:** Every patient has the responsibility to provide the health worker with relevant complete and accurate information for diagnosis, treatment, rehabilitation or counselling purposes;
- **Compliance with instructions:** The patient has the responsibility to comply with the prescribed treatment or rehabilitation procedures meant to improve his/her health;
- **Refusal of treatment:** The patient takes responsibility for his/her actions if he/she refuses to receive treatment or does not follow the instructions of the health worker. In case of children below 18 years and the elderly who may depend on the decisions of the caretaker; the caretaker takes full responsibility;
- **Respect and consideration:** The patient has the responsibility to respect other patients and the rights of health workers by helping to prevent spread of diseases, control noise, smoke and the number of visitors and refraining from using verbal abuse or physical violence against health workers or other patients; and
- **Will:** The patient is free to advise the health care workers on his/her wishes with regard to his/her death including dying in dignity, spiritual support as well as organ support. This is a very important management tool of patients who are terminally ill and can make the patient fully satisfied before his/her death.

Relevant Health Policies

Vision 2040

Uganda's Vision 2040 provides development paths and strategies to operationalize Uganda's Vision statement which is "A Transformed Ugandan Society from a Peasant to a Modern and Prosperous Country within 30 years" as approved by Cabinet in 2007. It builds on the progress that has been made in addressing strategic bottlenecks that have constrained Uganda's socio-economic development since independence including gender inequality, human rights violations, and poor health outcomes.

National Development Plan II

This National Development Plan (NDPII) is the second in a series of six five-year Plans aimed at achieving the Uganda Vision 2040. The goal of this Plan is to propel the country towards middle income status by 2020 through strengthening the country's competitiveness for sustainable wealth creation, employment and inclusive growth. Focus on governance and education in NDPII are especially key to human rights, as inclusive governance and equitable education can lead to a more productive and efficient society.

The National Health Policy II (2010)

Among the aspirations of Uganda's Health Policy is a healthy and productive population that contributes to socio-economic growth and national development. Its aims include attaining a good standard of health for all people in Uganda to promote healthy and productive lives. In addition to the vision, one of the guiding principles of the policy is on gender-sensitive and responsive healthcare, which calls for mainstreaming gender in planning and implementation of all health programs.

The policy calls for professionalism, integrity and ethics in the ethical codes of conduct enforced by professional bodies to which health workers are affiliated. It further mentions that the Constitution of the Republic of Uganda and Uganda's Patients' Charter, will guide the implementation of the policy.

Health Sector Development Plan

The Health Sector Development Plan (HSDP) 2015/16 – 2019/20 is aimed at contributing to Uganda Vision 2040 of a healthy and productive population that contributes to socioeconomic growth and national development. The goal of this Plan is to accelerate movement towards Universal Health Coverage (UHC) with essential health and related services needed for promotion of a healthy and productive life. UHC makes it possible to ensure that all people receive essential and good quality health services they need without suffering financial hardship. The Plan's strategic objectives include addressing key determinants of health including gender and human rights.

Relevant Laws and Policies, among others:

Policies:

- Uganda Gender Policy 2007;
- Elimination of Gender Based Violence Policy 2016;
- Uganda National Equal Opportunities Policy 2007;
- National Employment Policy for Uganda, 2011;
- Ministry of Public Service Guidelines for Mainstreaming Gender Equality into Human Resources Management, 2011; and

- Guidelines for Mainstreaming Gender Equality into Human Resources Management in the Health Sector, 2016.

Laws:

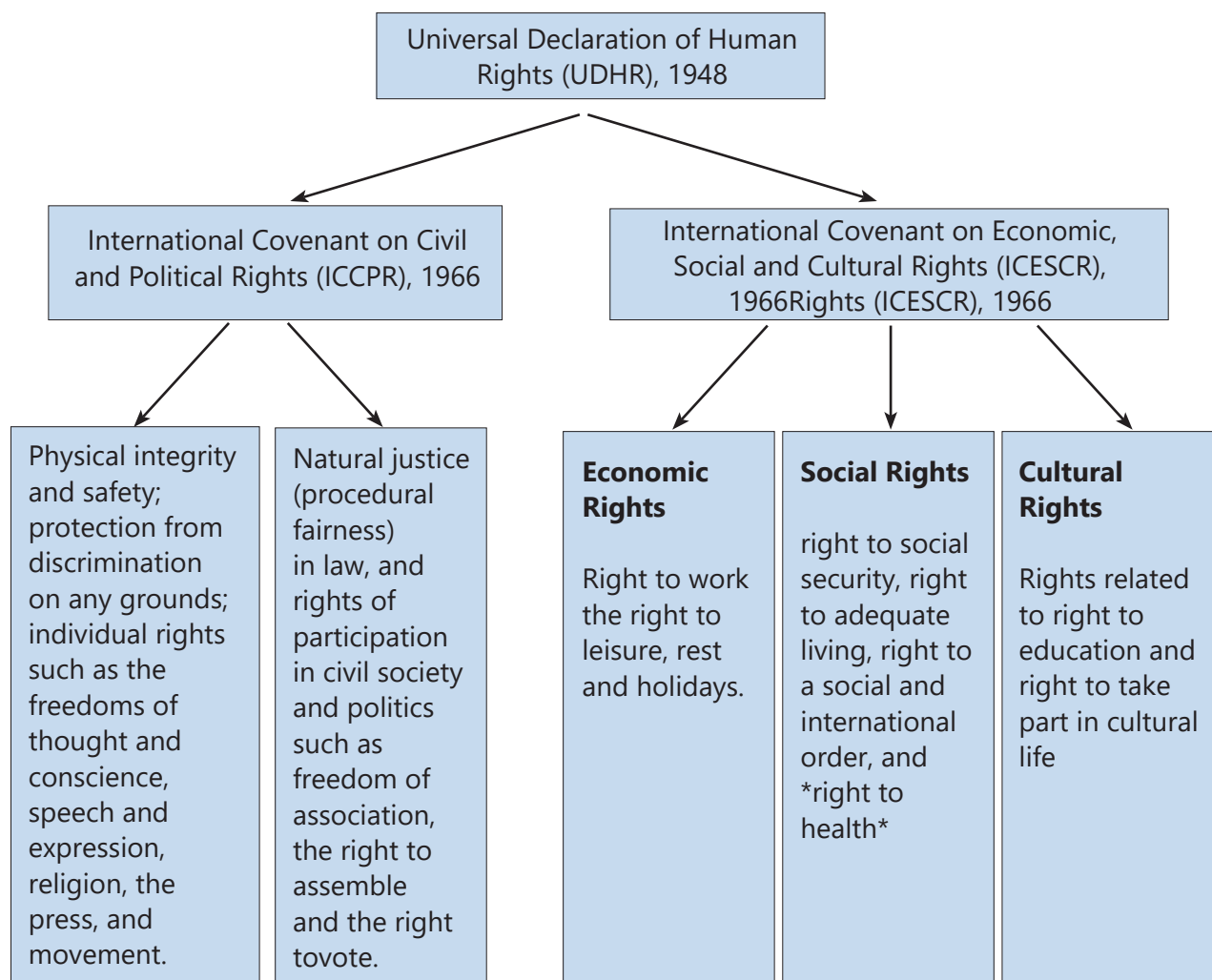
- The Domestic Violence Act 2010 and its Regulations 2011;
- The Prohibition of Female Genital Mutilation Act 2010 and its Regulations 2011;
- The Prevention of Trafficking in Persons Act 2009;
- The Penal Code Act, Cap 120;
- The International Criminal Court Act 2010;
- The Employment Act, 2006;
- The Employment Act, (Sexual Harassment Regulations 2012);
- The Public Finance Management Act, 2015;
- The Local Government Act, 1997;
- The HIV & Aids Prevention & Control Act, 2014;
- The Public Health Act 1935; and
- The Mental Health Act 2014.

1.2.3 Regional Level Instruments

- African Charter on Human and People's Rights (Banjul Charter) 1981;
- The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol) (July 2003);
- The African Charter on the Rights and Welfare of the Child (1990);
- The East African Community (EAC) Treaty (2000);
- AU Gender Policy (2009);
- The Common Market for Eastern and Southern Africa (COMESA) Gender Policy (2002);
- The Inter Government Authority on Development (IGAD) Gender Policy and Strategy (July 2004);
- The New Partnerships for African Development (NEPAD);
- The AU Heads of State Solemn Declaration on Gender Equality (July 2004); and
- The Regional Plan of Action to Accelerate the Implementation of the Dakar and Beijing Platforms for Action for the Advancement of Women (1999).

1.2.4 International Level

The modern era of human rights law began with the adoption of the Universal Declaration of Human Rights (UDHR) in 1948. In the last fifty years, the United Nations has adopted many general and thematic human rights conventions. The two key Conventions include the: International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR), otherwise known as the International Bill of Rights. By ratifying these Conventions, governments, including Uganda, recognize international norms in new areas of justice and social policy, including health.



The 1948 Universal Declaration of Human Rights (UDHR)

The UDHR represents the first global expression of rights to which every individual is entitled to and it enshrines both the civil and political, and the economic, social and culture rights.

The UDHR has 30 articles which outline various aspects of human rights. Article 25 for instance recognises that everyone has the right to a standard of living adequate for the health and well-being of oneself and of their family. It includes the right to access medical care, the right to security in the event of sickness and disability among other things.

To ensure the establishment of legally binding human rights norms, two international covenants on human rights were created:

The 1966 International Covenant on Civil and Political Rights (ICCPR)

Rights protected under this Covenant include: the right to life, the prohibition of torture and cruel, inhumane or degrading treatment, the right to liberty and security of person, the freedom of movement and choice of residence, equality before the law, the right to privacy in family, home and correspondence, the freedom of expression, the right to peaceful assembly, and the right to association. Civil and Political rights protect individuals' freedom from unwarranted infringement by government and private organizations, and ensures one's ability to participate in the civil and political life of the state without discrimination or repression.

Example 3

C v Australia (2002)

Mr C, an Iranian national, was detained as a 'non-citizen' in July 1992. In 1993 a psychologist recommended his release, because his mental health was rapidly deteriorating. Mr C was finally released in August 1994 with severe psychiatric problems. In 1996 he received a 3½ year prison sentence for aggravated burglary and making death threats to a relative. In 1997 the Immigration Department ordered his deportation as a criminal and non-citizen. Mr C complained that his detention by Australia had triggered the mental illness which was responsible for his criminal behaviour. He also feared persecution in Iran. The UNHRC concluded that Mr C's mandatory immigration detention was arbitrary because it was unnecessary, there was no individual justification and there was no chance of substantive judicial review: violating articles 9(1) and 9(4). The Committee also found Australia in violation of article 7 ('cruel, inhuman or degrading treatment or punishment') because it had continued to detain Mr C even after becoming aware that his mental deterioration was the direct result of his detention. The Committee also warned Australia that, having recognised the need to protect Mr C from persecution in Iran, to deport him would be another violation of article 7.

The 1966 International Covenant on Economic Social and Cultural rights (ICESCR)

This covenant is the only universal human rights instrument which deals exclusively with the entire range of economic, social and cultural rights, which includes freedoms, privileges, and entitlements that individuals and communities require to live a life of dignity. Article 12 of the ICESCR provides for the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and calls upon the states to take steps towards the realisation of the right to health.

Article 12 of ICESCR

1. The States Parties to the present Covenant recognize the right of every person to enjoy the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:
 - c. The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child;
 - d. The improvement of all aspects of environmental and industrial hygiene;
 - e. The prevention, treatment and control of epidemic, endemic, occupational and other diseases; and
 - f. The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Article 2 of the convention, legally obliges all ratifying states to respect, protect and fulfil economic, social and cultural rights and, take "progressive action" towards their fulfilment.

Example 4

Purohit and Moore v Gambia

The applicants alleged, amongst other things, that the legislative regime in The Gambia for mental health patients violated the right to enjoy the best attainable state of physical and mental health and the right of the disabled to special measures of protection in keeping with their physical and moral needs. It was held that the poverty that exists in many African countries makes it difficult to provide all the necessary amenities, infrastructure and resources needed to facilitate the enjoyment of the right to health. It was however recognized that even then, governments are required to take concrete and targeted steps, while taking full advantage of their available resources, to ensure that the right to health is fully realized in all its aspects without discrimination of any kind. The general lack of resources was not allowed as an excuse by government to realize its duty.

Note: General Comments to the treaties are normally put in place to advise and guide states/ governments on how to fulfil their rights obligations, deal with violations of rights and specify how international human rights treaties should be implemented. The Committee monitoring the implementation of the ICESCR has extensively elaborated on States parties' obligations in relation to article 12, which will be discussed in Section 1.2.4.

Other Human Rights Instruments

Besides the international instruments cited above, several other regional and international conventions and treaties recognize the right to health which have been ratified by Uganda. Some of these include:

Human Rights Instrument	Linkages to the Right to Health
The 1965 International Convention on the Elimination of All Forms of Racial Discrimination	Guarantees the right of everyone to public health, medical care, social security and social services without any form of discrimination
The 1979 Convention on the Elimination of All Forms of Discrimination against Women	<ul style="list-style-type: none"> • States must take all appropriate measure to eliminate discrimination against women in the field of healthcare...including access to health services and those related to family planning. • "States parties must ensure to women the appropriate services in connection with pregnancy, confinement and the post-natal period...and adequate nutrition during pregnancy and lactation"
The 1984 Convention against Torture, and other Cruel and Inhuman or Degrading Treatment or Punishment	Acts of torture which an individual has been subjected give rise to ill-health (physically or mentally) which violate their right to health.
The 1989 Convention on the Rights of the Child	<ul style="list-style-type: none"> • "The right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health." • "State parties shall strive to ensure that no child is deprived of his or her right to access such health services."

The 1990 International Convention on the Protection of the Rights of All; Migrant Workers and Members of Their Families	<ul style="list-style-type: none"> • “Right to receive, on the basis of equality of treatment with nationals, any medical care that is urgently required for the preservation of life and avoidance of irreparable harm to their health.”
The 2006 Convention on the Rights of Persons with Disabilities	<ul style="list-style-type: none"> • “persons with disabilities have the right to the enjoyment of the highest attain standard of health without discrimination on the basis of disability.”
The 1995 Beijing Platform for Action	<ul style="list-style-type: none"> • Several women and health objectives including: “increase women’s access throughout the life cycle to appropriate, affordable and quality health care, information and related services; strengthen preventive programmes to promote women’s health; undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health, promote research and disseminate information on women’s health, increase resources and monitor follow-up for women’s health.”

1.2.5 Limitations on Human Rights

There are non-derogable and derogable rights under the international, regional, and national human rights instruments. Non-derogable rights are those which can, under no circumstance, be taken away. Derogable rights are those which can be restricted under temporary circumstances.

Non-Derogable Rights include²:

- **ICCPR:** right to life; prohibition of torture, cruel, inhuman and degrading treatment; prohibition of medical or scientific experimentation without consent; prohibition of slavery, slave trade, servitude, prohibition of imprisonment because of inability to fulfil contractual obligation; prohibition of legality in criminal law; recognition everywhere as a person before the law; freedom of thought, conscience and religion.
- **ICESCR:** minimum essential food which is sufficient, nutritionally adequate and safe, to ensure freedom from hunger; essential primary health care, including essential drugs under the WHO’s Action Programme on Essential Drugs’ essential basic shelter and housing, including sanitation and the right not to be arbitrarily evicted from one’s house; access to the minimum essential amount of water, that is sufficient and safe for personal and domestic uses to prevent disease.

Derogable human rights can be restricted under some, temporary circumstances including protecting public health. For example, the government may restrict travel to and from an area experiencing an outbreak of a communicable disease.

When a government limits the exercise or enjoyment of a right, this action must be taken as a last resort and follow a criterion set out under the Siracusa principles. These principles require that the restriction [on human rights] must be:

- in accordance with the law;
- directed towards a legitimate objective of general interest;
- necessary to achieve the objective in question;

² <https://nhri.ohchr.org/EN/IHRS/TreatyBodies/Page%20Documents/Core%20Human%20Rights.pdf>

- the least restrictive means to reach this objective; and
- reasonable and non-discriminatory in its application.

These limitations have also been domesticated under the Constitution of the Republic of Uganda, 1995 as seen under Articles 43 and 44:

- Article 43- General Limitation on Fundamental and Human Rights and Freedoms.
In the enjoyment of one's rights, a person cannot interfere with the rights of others or the public interest. For example, while health workers have the right to engage industrial action, emergency health services should continue to be provided.

Public interest under this article shall not permit:

- Political persecution;
 - Detention without trial; and
 - Any limitation on the enjoyment of the rights and freedoms prescribed by the Bill of Rights beyond what is acceptable and demonstrably justifiable in a free and democratic society, or what is provided in the Constitution.
- Article 44- Prohibition of derogation from particular human rights and freedoms
Under this article, certain human rights and freedoms can never be taken away, including:
 - freedom from torture and cruel, inhuman, or degrading treatment or punishment;
 - freedom from slavery or servitude;
 - the right to fair hearing; and
 - the right to an order of habeas corpus.

Furthermore, certain rights listed under the Constitution have some qualifications, such as the right to information (Art 29 and 41), effect of laws enacted for a state of emergency (Art 46) and 47), personal liberty (Art 23), protection from slavery, servitude, and forced labour (Art 25), protection from deprivation of property (Art 26), and the right to life (Art 22), among others.

1.3 HEALTH AND HUMAN RIGHTS

Introduction

This sub-unit explains the right to health, and the linkages between health and human rights within a legal framework of government obligations. It will also review the roles of duty bearers within this framework.

Session Objectives

By the end of this session, participants will be able to:

5. Explain the concepts in Health and Human Rights;
6. Explain how Human Rights relates to health;
7. Discuss the criteria for assessing the Right to Health; and
8. Explain the obligations of the duty-bearers regarding the right to health.

1.3.1 Key Concepts in Health and Human Rights

Health

According to the World Health Organisation: "Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."

Right to health

According to WHO, "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, sex, political belief, economic or social condition". Thus;

- The right to health does not mean the right to be healthy,
- Poor governments must not put in place expensive health services for which they have no resources,
- However, governments and public authorities must put into place policies and action plans which will lead to available and accessible health care for all in the shortest possible time,
- The right to health is more than just seeking and accessing healthcare, but also includes the prevention of illness and promotion of healthy living,
- There are many social conditions and factors related to your standard of living that influence health³. For example, living in a healthy environment, having access to shelter, food, water and adequate sanitation are all important in maintaining good health.

3 (Learning Network, 2010)

1.3.2 How Human Rights Relate to Health

Human rights are interdependent, indivisible and interrelated. The right to health is dependent on, and contributes to, the realization of many other human rights.

Below is a chart illustrating the different ways in which health and human rights are related.

The relationship between health and human rights is explained under four scenarios:

9. Violation of human rights affects health

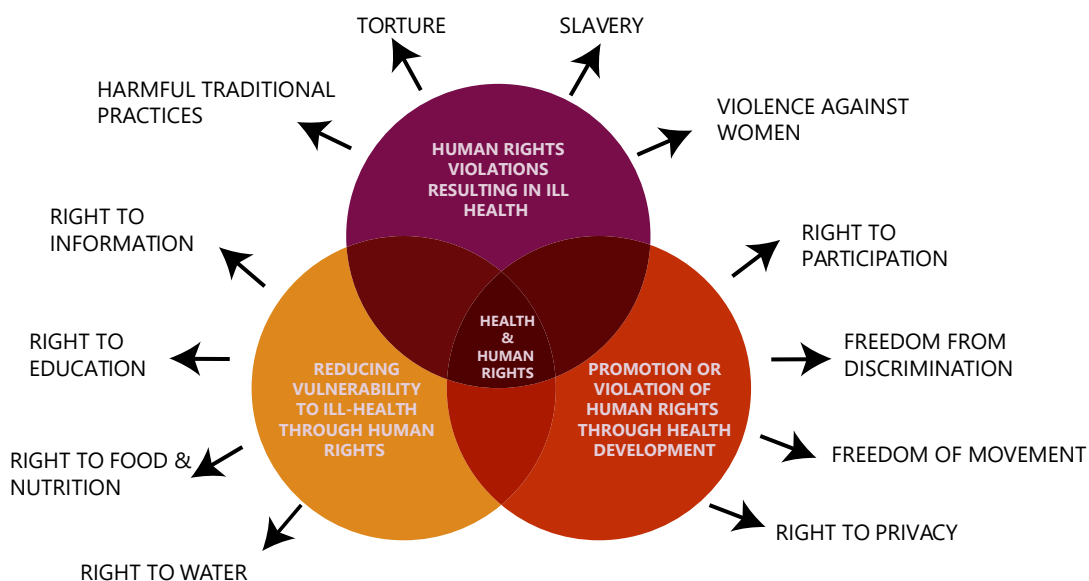
- When people are denied the right to access to clean water, it could result in illnesses like diarrhoea or cholera.
- When a health worker denies clients/patients correct information about the disease/condition and treatment, this may lead to poor adherence and poor health. (Freedom of Expression, Article 29 of the Ugandan Constitution of 1995).
- The lack of protective gear at the healthy facility, can expose the clients or health workers to potential health risks.
- A polluted environment, such as improper disposal of medical waste, can cause health problems.

10. Health conditions can lead to violation of rights

- People who are deaf are discriminated against when health services do not provide adequate translation for them, interfering with their access to appropriate health care. (Freedom from discrimination, Article 21, of the 1995 Constitution of Uganda).

11. Health conditions can lead to a failure to claiming other rights

- If a child is severely tortured, battered and beaten, this can lead to mental and health complications hence affecting their other rights such as the right to education.



(Right to Education, Article 30 of the 1995 Constitution of Uganda).

- A person who is HIV positive may be discriminated against by a potential employer, thereby denying him/her the right to work (Freedom from discrimination, Article 21, of the 1995 Constitution of Uganda).

12. Poor health policies and programs can deny rights to certain people

- One health policy is to encourage routine HIV testing in health facilities. If the health personnel are over-enthusiastic in testing people for HIV without their consent, then patients' rights to bodily integrity, autonomy, and privacy are violated. (Right to Privacy, Article 27 of the 1995 Constitution of Uganda).

1.3.3 Criterion for Assessing the Right to Health:

The right to health includes the four elements of availability, accessibility, acceptability and quality(AAAQ Framework) that are central to the realization of the right to health. General Comment 14 of IESCR provides guidelines to understand how to assess if the right to health has been met, as stated below:⁴

Availability

Functioning public health and health care facilities, goods, and services, as well as programmes, must be available in sufficient quantity.⁵

Criterion	Available? (Y/N)
Functioning health-care facilities (hospitals, clinics, enough staff) goods (drugs, equipment) and services (mental health care, family planning, immunisation), as well as programmes available in sufficient quantity to all communities.	
Access to the underlying conditions upon which health depends, such as safe and potable drinking water and adequate sanitation facilities.	
Availability of urgent medical care for accidents and disasters.	
Trained medical and professional personnel.	
Access to essential drugs, as defined by the WHO Action Programme on Essential Drugs.	

Example 5

Les Témoins de Jehovah v. Zaire

There was an alleged gross mismanagement of public finances by the government leading to degrading conditions, shortages of medicine, education and basic services. The government allegedly failed to provide these services, impairing its people from obtaining adequate medical treatment and from accessing basic education. Indeed there was a two year long closure of universities and secondary schools. The claim was brought by four NGOs against former Zaire (now Democratic Republic of the Congo). It was held the failure of the government to provide basic services such as safe drinking water and electricity and the shortage of medicine constitutes a violation of the right to enjoy the best state of physical and mental health.

Accessibility

Accessibility should be non-discriminatory, physically accessible, economically accessible, and information accessible. This focuses on physically accessible, economically accessible, accessible in a non-discriminatory way, accessibility of information.

4 (Learning Network)

5 (Comment 14)

Criterion	(Y/N)
Existence of services at community level;	
Health facilities, goods and services have to be accessible to everyone without discrimination (especially the vulnerable);	
Health care is distributed equitably (resources allocated according to need);	
This includes physical accessibility (access for disabled, distance to facility, opening hours);	
Facilities should be affordable for everyone;	
Information should be accessible (simple explanations, health information, access to health records, people being spoken to in the language they understand).	

Example 6

Minister of Health and Others v Treatment Action Campaign and Others.

In 2000 the anti-retroviral drug Nevirapine was offered to the South African Government for free for five years. The drug offered the potential of preventing the HIV/AIDS infection of 30,000 – 40,000 children per year. However, the South African Government announced it would introduce Mother-To-Child-Transmission (MTCT) only in certain pilot sites and would delay setting these up for a year, thereby denying most mothers access to treatment. The Treatment Action Campaign (TAC) launched a constitutional challenge, arguing that by not making MTCT available to everyone constituted a violation of the constitutional right to have access to adequate health care. The Court ordered the Government to extend availability of Nevirapine to hospitals and clinics, to provide counsellors; and to take reasonable measures to extend the testing and counselling facilities throughout the public health sector. Court noted that the State's policy not to make Nevirapine available to everyone was unreasonable and, therefore, fell short of meeting its obligation to devise and implement within its available resources a comprehensive and coordinated programme to realize progressively the rights of pregnant women and their new born children to have access to health services to combat woman-to-foetus transmission of HIV.

Acceptability

All health facilities, goods and services must be respectful of medical ethics, culturally appropriate, sensitive to gender and life-cycle requirements, as well as designed to respect confidentiality and improve the health status of those concerned⁶.

6 (General Comment 14)

Criterion	(Y/N)
Responsive and sensitive attention to patient needs, fostering a culture of dignity;	
All health facilities, goods and services must be respectful of medical ethics (informed consent);	
Must be culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities;	
Translation/interpretation should be available as a standard service;	
Sensitive to gender and age;	
Designed to respect confidentiality/privacy and improve the health status of those concerned.	

Quality

Health facilities, goods, and services must be scientifically and medically appropriate and of good quality. This requires skilled medical personnel, scientifically approved and unexpired medicines, and hospital equipment⁷.

Criterion	(Y/N)
Goods and services must also be scientifically and medically appropriate and of good quality (safe, timely, patient-oriented);	
Standards for treatment are enforced and there is quality control;	
Measured by how well the programme meets health needs;	
Skilled and trained medical personnel;	
Scientifically approved and unexpired drugs and hospital equipment;	
Quality of buildings;	
Safe and potable water, and adequate sanitation.	

1.3.4 Obligations of the duty-bearers regarding the right to health

Duty bearers must be familiar with the general obligations that the right to health imposes on them. These obligations include: respect, protect, and fulfil the right to health.

Health professionals, as agents of government, need to be familiar with the obligations that the right to health imposes on governments. This includes the obligation to protect the rights of health workers. The right to health – like all human rights – imposes three levels of obligations on governments: to respect, to protect, and to fulfil the right to health.

⁷ (Comment 14)

Respect

The obligation to respect implies a duty of the state not to violate the right to health by its actions. Examples under this include:

- The state must refrain from denying or limiting equal access to health care for all persons, including prisoners, detainees, minorities, asylum seekers and illegal immigrants;
- The state must refrain from censoring, withholding or intentionally misrepresenting accurate health-related information, including sexual health education and information.

Protect

The obligation to protect implies a duty on the state to prevent violations of the right to health by others. It must take measures which prevent third parties from interfering with or violating the right to health. Examples here include:

- The government must introduce and enforce appropriate controls for the marketing of medical equipment and medicines by third parties;
- The government must ensure that medical practitioners and other health professionals meet appropriate recognised standards of education, skill and ethical codes of conduct.

Fulfil

The obligation to fulfil means that governments must act in order to ensure that rights can be enjoyed, examples under this include:

- The government must focus on rectifying existing imbalances in the provision of health facilities, goods and services by allocating sufficient public resources to the most deprived regions or groups in the country;
- The government must promote activities that benefit good health and ensure the dissemination of appropriate information;
- Governments are also under an obligation to put in place policies to progressively realise the right to health.

These Core obligations require immediate and effective measures and are not subject to progressive implementation.

In the case of healthcare, governments must provide the following as core:

- Immunization against immunisable diseases;
- Measures to prevent, treat and control epidemic and endemic diseases;
- Government develops an essential medicines' list in reference to WHO's action programme on essential medicines;
- Reproductive, maternal (pre-natal and post-natal) and child health care;
- Essential Primary Health Care as described in the Alma-Ata declaration;
- Access to health facilities without discrimination;
- Equitable distribution of all health facilities, goods and services; and
- Governments must also adopt and implement a national public health strategy and action plan, based on epidemiological evidence, which takes into account the health concerns of the population.

The Uganda National Minimum Health Care Package (UNMHCP), under the second National Health Policy 2010-2014 (NHP II), consists of the most cost-effective priority health care interventions and services addressing the country's high disease burden. The package includes:

- i. Health Promotion, Disease Prevention and Community Health Initiatives, including epidemic and disaster preparedness and response;

- ii. Maternal and Child Health;
- iii. Nutrition;
- iv. Prevention, Management and Control of Communicable Diseases;
- v. Prevention, Management and Control of Non-Communicable Diseases.

Since the core obligations require immediate implementation, government must provide whatever it takes to enable health workers the abovelisted services. System failures leading to inability to provide the stated services amounts to a violation of the right to health of health consumers and a violation of the rights of health workers.

1.4 VIOLATIONS OF THE RIGHT TO HEALTH

Introduction

Under this unit, we look at the circumstances under which the rights to health are violated and the redress mechanism available.

Performance objectives

By the end of the session, participants should be able to:

1. Identify the circumstances under which violations of the right to health may occur;
2. Identify relevant mechanisms for addressing violations of the right to health; and
3. Outline procedures for redress of violations of the Human Rights.

1.4.1 Possible violations of the right to health by the government

The right to health is violated when duty-bearers do not meet their obligations in respecting, protecting, fulfilling and promoting the right to health, for example:

- Inability to provide access to health care facilities, goods, services (distant facilities); shortage of qualified health workers; inadequate medicines, medical supplies and equipment;
- Failure to enforce laws, policies and regulations intended to prevent violations of health rights; a situation where a Health Center IV does not have an aesthetic assistant or provide basic maternal health commodities;
- Failure to enforce laws that promote safe environment; for example policies on sanitation in relation to disposal of waste;
- Failure to regulate medical practice; for example a situation where prescriptive medicines are accessed over the counter;
- Failure to ensure provision of quality health care services, e.g. failure to train, recruit, retain and motivate human resources for health;
- Non-provision of sufficient resources for health in the national budget;
- Failure to ensure that essential medicines are available at health care facilities;
- Failure to educate the population about their health rights, responsibilities, and procedures for redress of violations of the right to health.

Not every situation of wrongdoing, failure or bad service by a government authority or health care worker is a violation of health rights. There is a difference between complaints about health care services (e.g. nurses forbidding patient access to toilets in the facility) and violations of health rights (e.g. absence of health service in a rural town, which is a violation of the right to have access to health care).⁸

Additionally, there may be valid reasons why a government authority or a health care worker is unable to meet their duties related to health rights. Here, it is important to note the difference between the government being unwilling to meet its obligations and being unable to meet these obligations. Sometimes the state does not have the resources (financial, infrastructure, human) to meet its obligations.

⁸ (SA, Toolkit, 2011)

Retrogression: the violation of the right to health can take place when the government takes steps backwards. For example, closing of existing health care facilities, stopping treatment of HIV positive people with ARVs, or a reduction in budgetary allocation to health.

1.4.2 Possible violations of the right to health by health service providers

Health service providers may violate the right to health. Some examples include:

- *Unfair provision of health services.* For instance, health facility policies where a woman who comes with her spouse is served before those that have not come with a spouse goes against the policy of firstcome, first serve.
- *Unprofessional conduct,* e.g. absenteeism, discrimination, asking for illegal payments, breaching confidentiality, abusing patients, service without safety gear for example drugsetc.
- *Deliberately withholding health information that is vital for prevention or treatment.* For example, where a patient has died and attendants require information relating to the death.

1.4.3 Procedures for redress of violations

It is important to address violations of the right to health by holding perpetrators accountable. Uganda has two primary formal redress mechanisms: legal and policy frameworks and institutional frameworks. Additionally, civil society plays an important role in holding duty-bearers accountable.

The courts of Law

Under Article 50(1) of the constitution, any person who claims that a fundamental or other right or freedom guaranteed under this Constitution has been infringed or threatened, is entitled to apply to a competent court for redress which may include compensation.

The article further provides that any person or organisation may bring an action against the violation of another person's or group's human rights, and that any person aggrieved by a decision of the court may appeal to the appropriate court.

Furthermore, Article 137 of the Constitution says any person or group can go to the Constitutional Court for questions of interpretation of the constitution.

Example 8

In the case of Center for Health, Human rights and Development and another V.V Nakaseke District Local government Civil suit No. 111 of 2012, CEHURD challenging the violation of the fundamental rights of Nanteza Irene, deceased, who died from Nakaseke District Hospital after she had failed to access health services at the hospital while in labour. The case was for declaratory orders and damages on the grounds that the failure of the deceased to access health services in a public health facility mandated to provide such services to all women violated her fundamental rights and freedoms including the inter alia the right to health. Court ruled that the district local government was vicariously liable for the death of Nanteza Irene as it failed to play its administrative and supervisory role to Nakaseke Hospital. Further that the human and maternal rights of the deceased and the rights of the children and spouse arising under the Constitution were violated. Court concluded that access to emergency obstetric care is a right.

The Uganda Human Rights Commission (UHRC)

Article 51 of the Constitution provides for the establishment of the UHRC and Article 52 empowers the UHRC to ‘investigate, at its own initiative or on a complaint made by a person or group of persons against the violation of any human rights.’”

The UHRC has the powers of the High Court— it can summon witnesses and issue relevant orders against the state, its agencies and private persons in matters involving violations of human rights. The UHRC can use its mandate to protect socio-economic rights generally and particularly, the right to health.

The UHRC mandate extends to:

- Receiving complaints regarding the violation of human rights;
- Investigating and reporting on human right violations;
- Giving people assistance when their rights have been violated or finding solutions to remedy violations of rights;
- Conducting research on human rights issues;
- Having public hearings (where people can talk about violations of their rights) to gather information on specific rights issues;
- Reporting to Parliament on matters relating to human rights;
- Regularly publishing reports on government departments’ performance on realizing socio-economic rights;
- Making recommendations to government to improve the carrying out of human rights; and
- Creating awareness of human rights.

UHRC has established a tribunal which handles human rights complaints against both the state and individuals. Specifically, UHRC has a “right to health” unit to handle complaints regarding violations of the right to health.

Example 9

WANJALA BOAZ ABUNGU AND REGISTERED TRUSTEES OF MENG0 HOSPITAL - COMPLAINT UHRC No. 620 OF 1999

Wanjala testified that on February 10, 1999 he went to Mengo Hospital Eye Clinic for an operation to remove a cataract from his eye and upon admission he was asked to pay a sum of U.Shs.20,000 as a deposit. The balance of U.Shs.101, 000 was to be paid on February 16, 1999 when he reported back for review. He further said that upon being discharged the hospital security guards arrested and confined him in a cell. He remained in the cell until March 16, 1999 when he was released upon paying the balance of U.Shs.101, 000. Wanjala testified that while in the cell he was mistreated: he was denied food and beddings and he was confined with some patients suffering from infectious diseases. He said that he was traumatized when one of the patients died within the cell. He also said that he did not bathe for the first week until he requested for water from the guards. The Commission Tribunal found that Mengo Hospital unlawfully arrested and detained Wanjala for failure to pay the balance of U.Shs.101, 000. It also found that Wanjala was confined in a filthy, dark and smelly room and that he was denied beddings which amounted to cruel, inhuman and degrading treatment. The Tribunal ordered Mengo Hospital to pay to Wanjala a sum of U.Shs.500, 000 and instructed the hospital to devise a lawful policy of recovering money from defaulting patients without recourse to awarding itself extra-judicial redress.

Equal Opportunities Commission (EOC), Article 32

The EOC monitors, evaluates and ensures that policies, laws, plans programs, activities, practice, traditions, and cultures are compliant with equal opportunities and affirmative action in favor of marginalized groups.

Directorate of Public Prosecutions (DPP), Article 120, 121

DPP's functions include: direct the police to investigate any information of a criminal nature, institute criminal proceedings and take over any criminal proceedings instituted by any other person/authority.

Uganda Police Force, Article 221, 212

Uganda Police Force's functions include: protect life and property, and preserve law and order.

Inspector General of Government, Article 223. Art 225

The IGG's mandate is to eliminate corruption and abuse of public officers and investigate acts of omission by public officers.

Health Professional Regulatory Authorities/bodies

The regulatory bodies created for professional self-regulation are responsible for ensuring members are competent and act in the public interest in providing the services that society has entrusted to them.

Health professionals in Uganda are regulated by four main health profession regulatory authorities established under the law. These professional bodies emphasize the importance of observing human rights and ethical standards by health professionals. These authorities are:

The Medical and Dental Practitioners Council (UMDPC)

UMDPC supervises and maintains control over professional medical and dental standards by providing for firm and fair disciplinary sanctions against practitioners who behave unethically in their work. The UMDPC has a central office and regional representatives to supervise on behalf of UMDPC and receive complaints. UMDPC has a Professional Code of Conduct and Ethics (MDP-Code) that can be used to protect the rights of patients in a health care setup.

The Nurses and Midwives Council;

The UNMC maintains control over professional nursing and midwifery standards. Like UMDC, UNMC has a Professional Code of Ethics and Conduct for Nurses and Midwives which express provisions on human rights of patients as the MDC-Code.⁹

The mandate of this UNMC includes: regulating the standards of nursing and midwifery in the country, regulating the conduct of nurses and midwives, and to exercising disciplinary control over them.

The Allied Health Professionals Council (AHPC)

AHPC is charged with the regulation, supervision and control of allied health professionals, which include all other professionals in the health sector other than the medical and dental practitioners, nurses and midwives and pharmacists. The Council has a Disciplinary Committee which investigates and considers allegations of professional misconduct.

9 Part 2, Principles of the Code, p 4 of the NMC Code of Ethics and Conduct for Nurses and Midwives

The Pharmacy Board

In addition to registering and licensing pharmacists, The Pharmacy board which is responsible for setting up a Disciplinary Committee relating to the professional conduct of pharmacists.

Civil Society

Members of civil society are any groups that are not affiliated with government or with business such as: non-profit organisations, unions, educational institutions, community-based organisations, advocacy or religious groups. Civil society organisations can play a critical role in dealing with rights violations in a variety of ways: educating communities of their rights, assisting vulnerable groups to join forces in protesting against violations of rights and holding the state responsible to its human rights obligations. Some organizations in Uganda are involved in provision of free legal services to those whose rights are violated and sensitizing the population on their rights.

1.4.4 Redress at the Health Facility

The Patient Charter under Section 19 provides for the right to redress in case of a health right violation. This charter requires that every health facility designate a person or a committee to be responsible for the observance of patient rights, whose duties should include:

- Give advice and assistance to a patient as to the realization of her/his rights spelt out in this document.
- Receive, investigate, and process patient's complaints. Complaints regarding the quality of medical care shall be referred to the attention of the facility in-charge.
- Educate, and instruct all medical and administrative staff in the facility in all matters regarding the patient's rights.

1.5 THE HUMAN RIGHTS-BASED APPROACH IN HEALTH

Introduction

In units 1-3, we have analysed the basic knowledge of human rights norms, obligations and responsibilities they impose on duty-bearers in the health system. In this unit, we will examine and apply the human rights based approach to health planning, implementing and monitoring.

Performance Objectives

By the end of this session, participants will be able to:

1. Explain the meaning of Human Rights-Based Approach (HRBA);
2. Explain the importance of Human Rights-Based Approach;
3. Explain the principles of HRBA;
4. Outline the differences between Basic needs approach and HRBA;
5. Explain how to Integrate Human Rights-Based Approach in Planning and Implementation Of Health Services¹⁰; and
6. Apply a human rights-based approach to health planning, implementing and monitoring.

1.5.1 Introduction to the Human Rights-Based Approach

A human rights-based approach (HRBA) empowers people to know and claim their rights, and increases the ability and accountability of individuals and institutions who are responsible for respecting, protecting and fulfilling human rights.

HRBA uses the conceptual and analytical framework of international human rights standards to analyse and address various forms of vulnerability, poverty, inequality, political, social and economic exclusion. HRBA does not only identify these instances, but also seeks to address them by actions aiming at respecting, protecting and fulfilling human rights.

HRBA identifies duty-bearers, those who have the obligation to respect protect and fulfil human rights; and rights-holders, meaning those individuals who are entitled to such rights. Using a human rights-based approach builds capacity of duty-bearers to fulfil their obligations and the capacity of rights-holders to claim their rights.¹¹

For example:

- Where prescriptive medicines are provided over the counter, the government is the duty bearer because of its obligation to regulate and enforce provision and accessibility of such medicines.
- In a situation where a health worker fails to provide a service to a patient/client, yet has all the necessities to do so, the health worker will become the duty bearer.

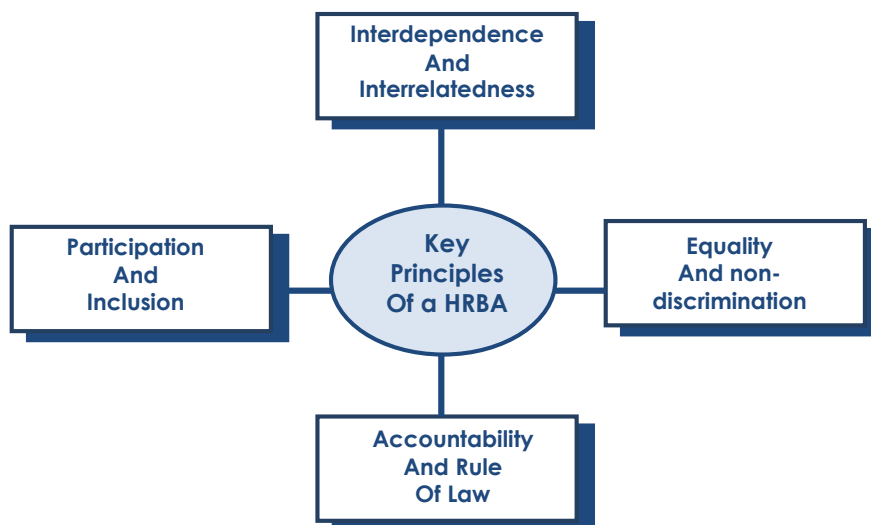
NB: The primary duty-bearer is the government however; it has individuals, agents, organs and institutions that have the responsibility to ensure protection of human rights (Article 20, Constitution of Uganda).

¹⁰ WHO Presentation

¹¹ World Health Organisation (WHO): A Human Rights-Based Approach to Health, http://www.who.int/hhr/news/hrba_to_health2.pdf

1.5.2 Principles of HRBA

Key human rights principles in HRBA include:



- a. **Inter-dependent and inter-related.** The realization of the right to health may depend on the realization of the right to education, the right to information, the right to food and nutrition, the right to safe water and sanitation etc.
- b. **Equality and non-discrimination:** Health programs must be designed and implemented with a lens of non-discrimination.
- c. **Accountability and Rule of Law:** The duty-bearers in the health sector must comply with legal norms and standards enshrined in national and international human rights instruments. If duty-bearers fail to comply, there should be appropriate laws, policies, institutions, administrative procedures and mechanisms of redress in order to realize the right to health.
- d. **Participation and inclusion:** Decision-making processes must include free, meaningful, and effective participation of beneficiaries of health development policies or programs that affect them. This entails empowering people to articulate expectations towards the State and other duty-bearers, and take charge of their development.¹²

Importance of HRBA

The HRBA is important for the following reasons:

- It promotes multi-stakeholder ownership of the development process through measures that put beneficiaries in charge through empowerment and active participation;
- It enhances accountability as it identifies and holds accountable duty-bearers and rights-holders in the process;
- It safeguards against intentional/unintentional harm by ensuring that potentially harmful, rights-violating policy action is avoided;
- It provides assessment indicators and benchmarks, and gives policies and programmes aspiration but claimable right. When benchmarks are expressed as human rights, actions to achieve them become legal obligations of the state;

¹² (WHO MODULE 3 Pg. 7)

- It recognises the notion of the democratic state, in which Government is bound by a social contract to its citizens. Government (chosen by and accountable to the people) exercise certain key functions on behalf of the people, including providing access to social, public goods and services, on the basis of rights;¹³
- HRBA application is required by law under Uganda’s Constitution and international human rights standards;
- It stresses values and standards found in major human rights instruments central to development efforts which Uganda has ratified;
- It has clear standards of achievement based on human rights norms and standard that planners and policy makers should strive to achieve;
- It transforms legal instruments from rhetoric to reality by bringing human rights principles to the forefront of thinking and action that underpin the daily work of planners and policymakers.

Integrating the Human Rights-Based Approach (HRBA) in health sector programming—including planning, implementation and monitoring—introduces a new way of achieving equity goals and improving health service delivery. To do this, planners, managers, service providers and community members must know how to apply the HRBA.

1.5.3 Basic needs approach versus HRBA¹⁴

The basic needs approach defines the absolute minimum resources necessary for long-term physical well-being, usually in terms of consumption of goods.

Although the basic needs approach and the human rights approach differ, the needs complement one another; oftentimes, human rights cannot be realized without fulfilling basic needs.

BASIC NEEDS APPROACH	HUMAN RIGHTS APPROACH
Needs are met or satisfied and fulfilled.	Rights are realized (respected, protected, fulfilled).
Needs do not imply duties or obligations, although they may generate promises.	Rights always imply correlative duties or obligations.
Needs are not necessarily universal.	Human rights are always universal.
Basic needs can be met by goal or outcome strategies, outcomes and process.	Human rights can be realized only by attention to both.
Needs can be ranked in a hierarchy of priorities.	Human rights are indivisible because they are interdependent; there is no such thing as "basic rights".
Needs can be met through charity and benevolence.	Charity and benevolence do not reflect duty or obligation.
It is gratifying to state that "80% of all children have had their needs met to be vaccinated."	In a human rights approach, this means that 20% of all children have not had their right to be vaccinated realized.
The government does not yet have the political will to enforce legislation to iodize all salt.	The government has chosen to ignore its duty by failing to enforce legislation to iodize all salt.

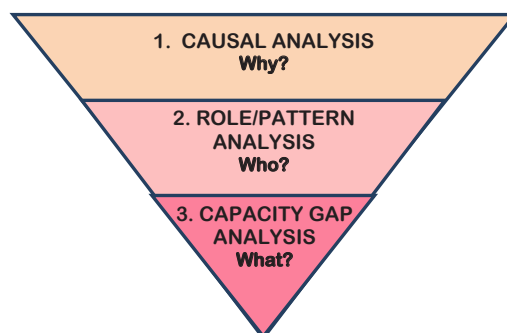
¹³ (UHRC 2008, guidelines on HRBA, pg 3)

¹⁴ (WHO Module 3 Pg.3)

1.5.4 How to Integrate Human Rights-Based Approach in Planning and Implementation Of Health Services

Programme design using HRBA involves a situation analysis in three perspectives:

5. Causal analysis;
6. Role/pattern analysis; and
7. Capacity gap analysis.

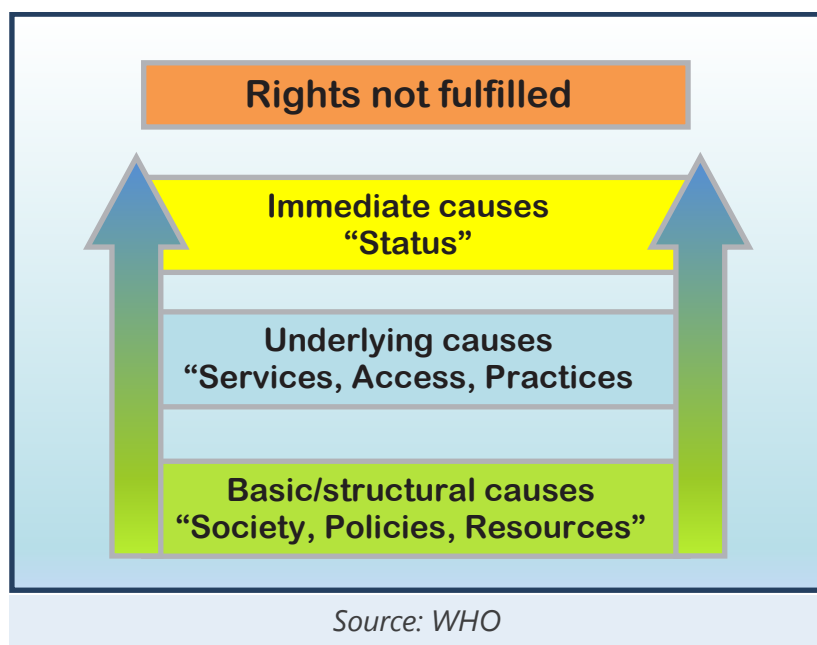


1) **Causal analysis**

A causal analysis is a tool which is commonly used in the design of human development programmes. It will identify the root causes for the non-realisation of health-related rights as well as the systematic patterns of discrimination.

From a human rights-based perspective, a causal analysis of the health situation in a country should:

- Differentiate between the immediate causes, the underlying causes and the root causes of the health situation in a country, or of specific diseases;
- Identify which groups are most affected by ill-health and why; and
- Link the identified health problems with rights which are unfulfilled, are being violated or are at risk of being violated.

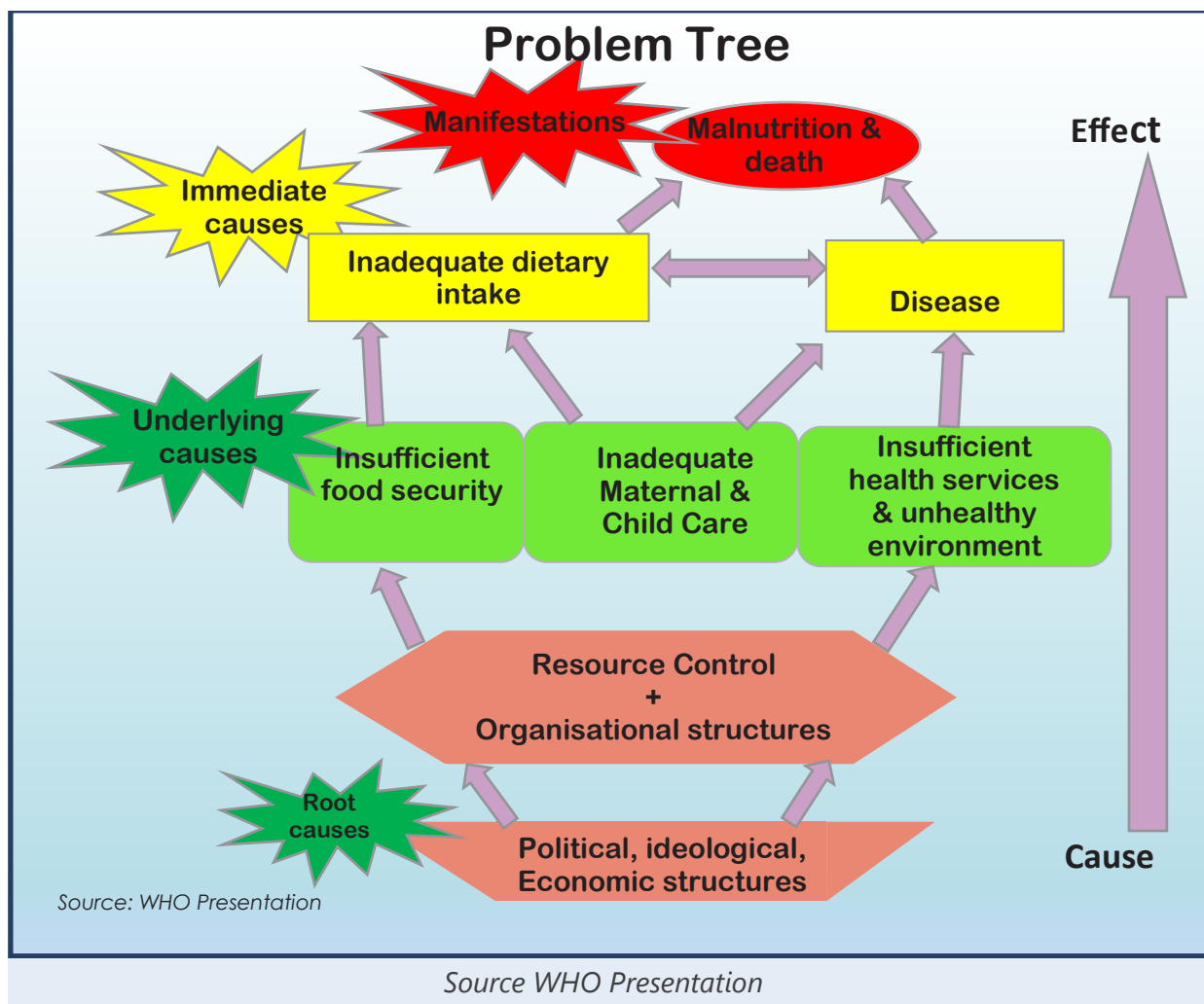


At all levels of the analysis, causes should be linked to human rights. This allows clear identification of the rights-based goals of the strategy and of the changes needed to achieve these goals. For example, high maternal mortality is linked to the right to life.

Problem Tree

A problem tree is one tool to perform a causal analysis. The problem tree explains key problems and their respective cause and effects, in order to develop clear strategies for addressing the issue.

Immediate causes are those that directly affect individuals and households, and underlying causes normally involve service delivery and behaviour. Root causes include tradition, economic resources, and ideology, among others.



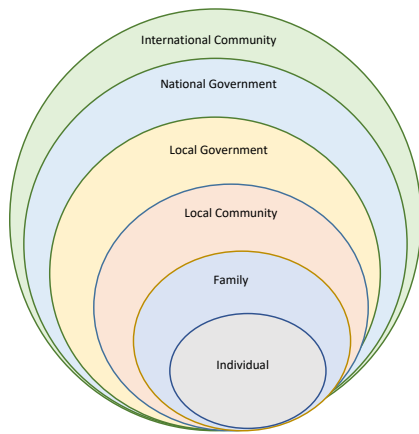
2) The Role/Pattern Analysis

The role/pattern analysis looks at the relation between rights-holders who have rights to be fulfilled and duty bearers who have the obligation to fulfil the rights of rights-holders at all levels. The analysis should consider actors that are immediately and directly affecting the ability of the rights-holder to enjoy his or her rights.

For achieving optimal results, it is necessary to focus on those duty-bearers who are essential for the realization of the right to health.

The role/pattern analysis identifies the following:

- Who are the rights/claim-holders?
- What are their health-related rights?
- Who are the duty bearers?
- What are their duties? What should they do to protect, respect and fulfil the right to health?
- Who owes what obligations to whom?



According to human rights law, all people are rights-holders. However, specific attention should be given to those rights-holders who are most deprived of their right to health. The state is the primary duty-bearer in respecting, protecting and fulfilling the right to health. However, individuals or organizations, beyond the government, have responsibilities in fulfilling their own rights and those around them. Depending on the context, a person can have both duties in relation to somebody else's right and claims in relation to another right.

3) A Capacity Gap Analysis

A capacity gap analysis is a process of measuring:

1. The ability of duty-bearers to fulfil their obligations and responsibilities;
2. the ability of rights-holders to demand their rights and under their responsibilities.

A capacity gap analysis will identify:

- What capacities are lacking for the right-holders to demand their rights?
- What capacities are lacking for these institutions and/or individuals to carry out their duties as duty-bearers?
- Strategic interventions to close the gaps of right-holders and duty-bearers.

As you do your analysis and consider how to respond to the problems, remember the key human rights principles:

- **Participation:** Are the perspectives of rights-holders and duty-bearers integrated into all phases and steps of the analysis?
- **Equality and non-discrimination:** Is the situation of the most vulnerable and disadvantaged reflected in all phases and steps of the analysis?
- **Accountability:** What procedures and mechanisms can be established to ensure accountability?
- **Capacity building:** What skills can be strengthened for health workers, institutions, policies, and/or legislation?

Rights Holder:	Claim:	Capacity gaps:
Duty-bearer (1):	Obligations:	Capacity gaps:
Duty-bearer (2):	Obligations:	Capacity gaps:
Duty Bearer (3):	Obligations:	Capacity gaps:

A capacity gap analysis requires an understanding of the following elements:

- **Knowledge:** This refers to the knowledge and skills that rights-holders and duty-bearers need to claim their rights and fulfil their obligations. Have duty-bearers and rights-holders recognized the key problems and rights at stake? For example, do they understand the right to health and its implications?
- **Responsibility/motivation/leadership:** This refers to the key characteristics that duty-bearers should recognize about their roles in order to carry out their obligations. Example: a health worker posted to a health facility, - needs a job description (jobs/tasks), schedule, etc.
- **Authority:** This refers to the legitimacy of an action, when individuals feel or know that they can act. Laws, formal and informal norms and rules, tradition and culture largely determine what is or is not permissible.
- **Access to and control over resources:** The access to and control of resources at all levels of society often has a direct impact on the roles and capacities of duty-bearers and rights-holders to fulfil and claim the right to health. If district health authorities do not have the required budget or staff to supervise health facilities, they may not be able to comply with their obligations. If women do not take part in the decisions on how to spend the household income, they may not be able to seek and receive necessary health care.
- **Gaps in national protection systems:** The capacities of individuals to demand and fulfil the right to health are affected by legal and policy frameworks prevailing in a country. Also, assessments should be done to measure the strength of a system's protection mechanisms in the case of a violation of rights.

Program Design:

Using the gaps identified, propose possible interventions:

The Gap	Root cause	Interventions	Responsible person	Indicator of progress	Time frame

Note that for any intervention design and implementation to be human rights-based, there must be participation and substantive input from the rights-holders.

Monitoring and Evaluation

The Human Rights-Based Approach (HRBA) calls for monitoring:

- Programme performance (achievement of targets, inclusion of human rights and gender issues in programming activities),
- Programme process (participation, accountability and non-discrimination),
- Programme context (laws, policies and institutional mechanisms).

The key principles of a HRBA (interdependence and interrelatedness, equality and non-discrimination, accountability and rule of law, and participation and inclusion) should also be reflected in the M&E processes. The following text depicts an example of community based monitoring which served to reinforce both participation and accountability.

Uganda Human Rights Commission’s Human Rights-Based Approach Guidelines include an indicative matrix on HRBA implementation tool of right to health, as seen below:

Output	Verifiable indicators	Means of verification	Duty bearers involved
All people access adequate and affordable primary healthcare	<ul style="list-style-type: none"> • Life expectancy at birth. • % age of public expenditure on primary health care. • No. of primary healthcare units. • No. of doctors per thousand of people % of poor with access to essential drugs. 	Household surveys Health facility surveys IGA programme reports DHH reports Background to the budget.	MoH, MGLSD, District Administration and leadership parliament, MoFPED, UBOS, private sector, UHRC, CSOs, NGOs.
Eliminate avoidable maternal and child mortality	<ul style="list-style-type: none"> • No. of under five mortality. • Infant mortality rates. • % age of immunised children. • %age of births attended to by skilled personnel. • % age of mothers access pre and postnatal care facilities. • Maternal mortality ratio. • % age of health units providing basic and comprehensive obstetric care. 	DDHS/District health Office reports. Health survey. Health centre records. Sub-county registers. Death records. Periodic reports. Inventory records.	MoH, MGLSD, District Administration and leadership parliament, MoFPED, UBOS, private sector, UHRC, CSOs, NGOs.
Eliminate HIV/AIDS and other communicable diseases	<ul style="list-style-type: none"> • % age of HIV/AIDS prevalence among pregnant mothers. • % age of condom use. • No. of children orphaned by HIV/AIDS. • % age of people with access to safe and clean water. • % age of people with access to adequate sanitation. • % age of people immunised against communicable diseases. 	Assessment inquiry results. Resource tracking study Ministry sector plans DAC reports. Records from UAC DDHS/District Health Office reports. Population based surveys. OVC programme reports. Background to the budget Procurement record.	MoH, MGLSD, district administration and leadership parliament, MOFPED, UBOS, MWLE, DWD, Private Sector, UHRC, CSOs, NGOs.

UNIT 2: GENDER AND HEALTH

Introduction

Gender plays a crucial role in health service access and delivery. Health professionals should understand how gender inequality and discrimination, such as access to information, impede full realization of the right to health, and are obligated by the human rights instruments to address these inequalities. The health sector is responsible for developing and implementing health interventions that are gender-responsive to reduce such gender inequalities, in order to create a more equitable system. This Unit details the relationship between gender and health, and how mainstreaming gender into policy planning, implementation, monitoring, and evaluation can reduce poor health outcomes, and promote gender equality and compliance with human rights for both clients/patients and health workers.

Unit Objectives

1. Discuss the relationship between gender and health service delivery;
2. Mainstream gender into health sector policies, plans, and programs; and
3. Apply SGBV prevention and response strategies in decision-making and service delivery.

2.1 GENDER AND HEALTH SERVICE DELIVERY

Sub-Unit Objectives

1. Explain key concepts on gender and health;
2. Explain the relationship between gender and health; and
3. Describe the importance of gender and health services delivery.

2.1.1 Key Concepts

Sex:

Sex refers to the biological characteristics that distinguish males and females. These include: anatomy (e.g. body parts/organs, size and shape) and physiology (e.g. hormonal activity or functioning of organs). Sex is universal, such that factors related to sex are the same in humans and generally unchanging.

Gender

Gender can be defined as the socially ascribed characteristics of males and females of a given society which include the social and cultural construct of roles, responsibilities, attributes, opportunities, privileges, status, access to and control over resources and benefits between women and men, boys and girls in a given society.

Gender is:

- Relational – Gender refers to the relationships between men and women, and how these relationships are socially constructed.
- Hierarchical – The differences established between women and men attribute importance and value to “masculine” characteristics, which often results in unequal power relationships.
- Historical – Gender and gender norms are nurtured by factors that change over time and space, and can therefore be modified through interventions.
- Contextually specific – Variations in gender relations depend on ethnicity, age, religion, etc.
- Institutionally structured – Social relations are often embedded and reinforced in values, legislation, religion, etc.
- Culturally determined – Gender is shaped by learned beliefs, values, behaviours and the way of life shared by the members of a society at a particular time and place.

In summary, what can be changed represents gender and what cannot be changed represents sex differences. This can be summarized in the table below:

<p>Sex is: Biological Given by birth Therefore Is static For example Only women can give birth Only men can make women pregnant</p>	<p>Gender is: Cultural learned through socialization Therefore is dynamic For example: Women and men can work as teachers, engineers, lawyers, doctors Women and men can take care of children, the sick, and the elderly.</p>
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Sex roles:

Sex roles are functions or tasks that are biologically determined. For example, it is a women's role to bear children.

Gender Roles:

Gender roles refer to social and behavioural norms that, within a specific culture, are widely considered to be socially appropriate for individuals of a specific sex. These often determine the traditional responsibilities and tasks assigned to men, women, boys and girls. Gender-specific roles are often conditioned by household structure, access to resources, specific impacts of the global economy, occurrence of conflict or disaster, and other locally relevant factors such as ecological conditions. Like gender itself, gender roles can evolve over time, in particular through the empowerment of women and transformation of masculinities.¹⁵

Gender norms, roles and relations have a powerful influence on the way health services are delivered (i.e. how health providers perceive their clients, how clients access the services) and ultimately the degree to which health services respond effectively to clients' needs. Gender roles and responsibilities can have a far-reaching impact on disease patterns and the effectiveness of prevention and control efforts.

Patriarchy

Means 'Rule of father' and refers to the current male dominated social relations, ownership and control of power at many levels in society. It is thought to be the root cause of the existing system of gender discrimination.

Gender issues

Arises when there is inequality, inequity or differentiated treatment of an individual or a group of people purely on the basis of social expectations and attributes of gender.

Gender-blind

This is failure to recognize that gender is an essential determinant of social outcomes. It therefore impacts on project planning and implementation.

Gender-sensitivity

This is the ability to perceive existing gender differences, issues and equalities, and incorporate these into strategies and actions.

¹⁵ <https://trainingcentre.unwomen.org/mod/glossary/view.php?id=36&mode=letter&hook=G&sortkey=&sortorder=asc&fullsearch=0&page=1>

Gender mainstreaming

This is a process of ensuring that gender analysis is used to incorporate women's and men's needs, constraints and potentials into all stages of planning, implementation and evaluation of development interventions.

Gender needs

Since men and women have different gender roles, do different types of work, have different degrees of access to services and resources, and experience unequal relations, the needs of men and women are different. The practical and strategic gender needs concepts are used to identify and address gender needs.

Practical gender needs-necessities such as adequate living conditions, drinking-water, health care and employment. Meeting women's practical gender needs, for example, is essential to improving women's status in society. Examples of practical gender needs include providing health care, food, shelter or income.

The characteristics of practical gender needs include:

- short-term, such as health care, food, shelter and income;
- can be identified by women and men when asked; and
- Direct, tangible action such as installing water pumps and building schools or health facilities can address these needs.

Strategic gender needs- Addressing strategic gender needs challenges predominant gender systems such as the gender-based division of labour. Examples of strategic needs include engaging men in domestic responsibilities such as child care and ensuring that women have control over their own bodies through laws and in practices such as consent for health interventions.

The characteristics of strategic gender needs include:

- long-term, such as changing laws and policies related to gender-based violence;
- more difficulty to identify these needs when asked, as they are often less tangible than practical gender needs; and
- Usually common across groups of women, as they relate to vulnerability to physical violence, restricted legal protections and other social resources such as education.

Gender and diversity:

Gender differs from one community/culture to another in roles, responsibilities and activities, therefore, taking diversity into consideration as we deliver services is key to achieving our intended outcomes and outputs. Some examples of diversity are; age, ethnicity, physical abilities, race, education background, geographical location, income, marital status, parental status, religion, etc.

Gender Equality:

Gender equality is the absence of discrimination based on a person's sex in the allocation of resources or benefits or in access and/or control of services or resources.

There should be equal treatment of women and men in laws, policies, opportunities, access to resources and services in families, communities and society.

When gender equality and gender equity are applied to health, the following distinctions are important:

- Gender equality does not mean making sure that disease patterns are evenly distributed among women and men.
- Gender equality in health means that women and men have equal conditions to realize their full rights and potential to be healthy, contribute to health development and benefit from the results.
- Achieving gender equality will require specific measures designed to support groups of people with limited access to such goods and resources.

Gender Equity:

Gender equity refers to fairness and justice in the distribution of benefits and responsibilities between women and men. It recognizes and encourages the fair and just involvement of both women and men in roles and responsibilities.

Remember that fairness may mean different things in different cultures. International human rights principles and standards provide us with the tools and frameworks necessary to arrive at a common understanding of fairness with respect to women and men all over the world.

Gender equity in health

Gender equity in health is the process of being fair to women and men with the objective of reducing unjust and avoidable inequality between women and men in health status, access to health services and their contributions to the health workforce.

The goal of equal opportunity and equal enjoyment of rights by women and men, boys and girls, resources and rewards.

Exercise: Equality vs. Equity

The Story of the Fox and the Crane (Equal treatment does not mean the equitable treatment)

The Fox invited the Crane to dinner and served soup on a wide bowl. The Crane, with her long, narrow beak could not eat. The Crane watched as the fox, able to fit its snout in the bowl for eating, lapped up the soup with ease.



Later, the Crane invited the Fox to dinner and served rice in a long thin tin. Her Crane friends its could easily dip their long, thin beaks into the tin, to peck away at the delicious rice. The fox, hard as it tried, could not get its snout past a certain point on the tin.

What does this story tell us about equality and equity? How do you see the different between equity versus equality in your work?

Both friends had an equal opportunity for nourishment, but each time one of them could not take advantage of this opportunity. The development challenge in every case is to identify barriers to the opportunities that exist, and custom design the adjusted interventions that will lead to equality of outcome.

Affirmative Action

A policy or programme of taking steps to increase the representation of certain designed groups seeking to redress discrimination or bias through active measures in education and employment.

Affirmative Action in Uganda

According to the Local Government act, at least one third of boards, commissions, etc must be comprised of women. Additionally, It is mandatory for any girl joining higher institutions of learning she is given an additional 1.5 points. Women MPs in parliament and different sectors have designed their own policies for affirmative action.

Gender-based discrimination:

Gender-based discrimination refers to distinction, exclusion or restriction made based on socially constructed gender roles and norms, which prevents a person from enjoying full human rights. The following are points to remember:

- Gender-based discrimination is often based on traditional beliefs about women and men.
- Gender-based discrimination can be direct or indirect; in other words, either through overt prejudicial treatment (direct discrimination) or through "neutral" laws and policies that may result in unequal treatment between groups (indirect discrimination).
- Gender-based discrimination may not always be intentional – it results from normalized beliefs and practices in many instances. This does not, however, make it excusable!
- Normalized beliefs and traditions may be passed from generation to generation without any question as to their validity or fairness.
- Women's limited access to and control over resources is often the result of gender-based discrimination.
- Health programmes and policies must respond to instances of gender-based discrimination when they pose potential or real harm to the health of males or females at any age.
- Public health workers must understand how gender-based discrimination may influence health to be able to develop sound responses. They also need to know some of the strategies to counteract discrimination that might be incorporated in their programmes.

Gender Stereotyping:

The assigning of roles, tasks and responsibilities to a particular sex.

Exercise- What are some examples of gender stereotypes in Uganda?

Traditional woman	Traditional man
- dependent - weak - emotional - lazy	- independent - strong - decision maker - leader

Sexual and Reproductive Health¹⁶

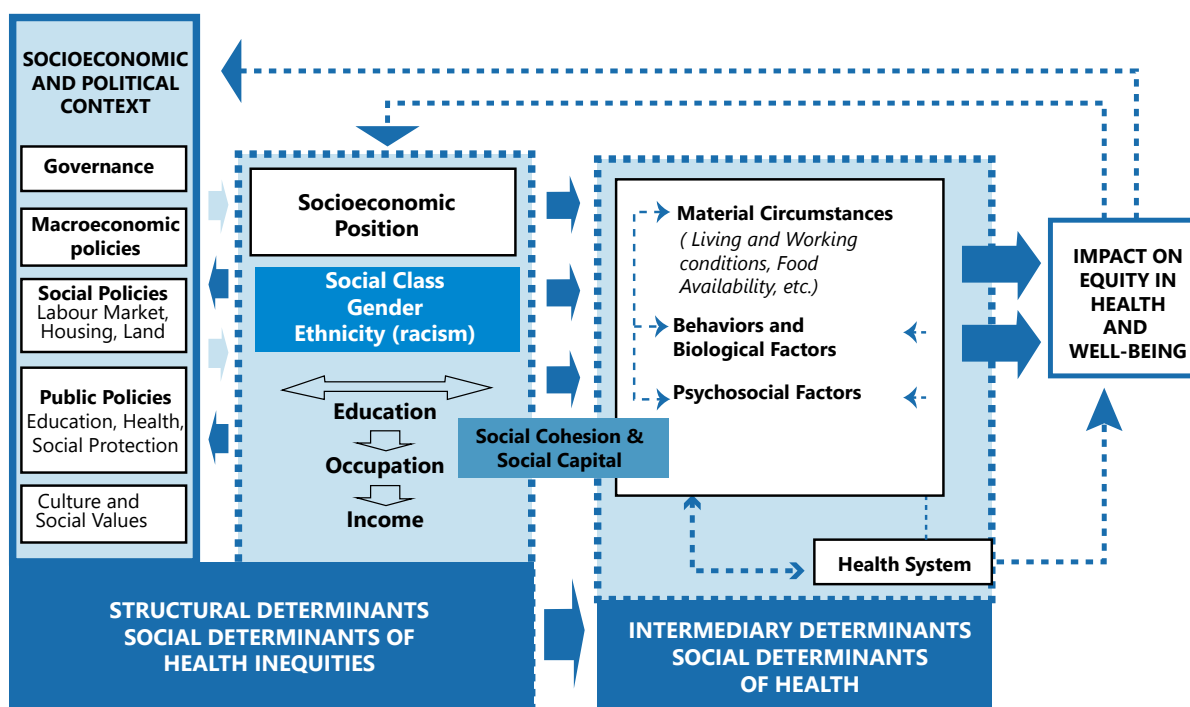
Good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so.

Sexual and reproductive health is a gender issue; SRH problems are a leading cause of ill health and death for women and girls of childbearing age. Impoverished women suffer disproportionately from unintended pregnancies, unsafe abortion, maternal death and disability, sexually transmitted infections (STIs), gender-based violence, and other related problems.

Determinants of health:

There are other factors apart from gender inequalities that affect access to health by both women and men. These are explained in the flowchart below.

Various factors including gender inequalities, affect access to health services by both men and women as explained in the framework below.



Source: WHO, 2008.

Also Available at: <www.treatmentactiongroup.org/sites/default...>

2.1.2 Importance of Gender on Health Services Delivery

Contemporary public health mandates include addressing a wide range of determinants of health such as sex, gender, and equity. This sub-unit focuses on gender as a determinant of health for women and men and the particular ways that gender equality contributes to better health outcomes for women and men.

Gender is an important determinant of health with two important dimensions.

- 1. Gender inequality** puts the health of millions of women and girls at risk globally. Addressing gender equality helps to counter the historic burden of inequality and deprivation of rights faced

16 <http://www.unfpa.org/sexual-reproductive-health>

by women and girls in households, communities, workplaces and healthcare settings. Addressing gender equality in health enables important work dedicated towards improving the health of women.

2. Addressing **gender norms, roles and relations** enables better understanding of how socio-cultural identity construction (male and female), attribution of rights and unequal power relations can affect (among other things) risk and vulnerability, health-seeking behaviour and – ultimately – health outcomes for men and women of different ages and social groups.

How do gender roles affect health service access and utilization?

What men do and what women do affects their access to health services because of their different roles.

Roles of Men	Roles of Women
Building a house Looking for money Paying school fees	Cooking Taking care of the children Fetching water Cleaning the house

The above roles differ across religions, cultures, education levels, technology availability, and more. Although the activities expected from men and women differ, they consume their time and affect their access to and utilization of health services. Women may delay seeking health care because of their multiple household and societal roles which can take priority. Men may delay seeking health care due to social and cultural norms that view them as a stronger sex.

How else do gender roles affect health service delivery?

2.2 GENDER ANALYSIS IN HEALTH

Introduction

This topic introduces participants to gender analysis. It covers why health professionals should conduct a gender analysis and how to do it. Gender analysis explores what activities are being done by men and women in society, and the problems and opportunities that each face in doing those activities. It helps understand how gender relations will affect an intervention's ability to achieve its intended results. The analysis covers how gender relates to certain health problems i.e. health risk and vulnerability, ability to access health services, experiences with health services and health care providers, health seeking behavior of an individual, prevention and treatment options, responses to treatment and rehabilitation, and outcome of health problems.

Lesson Objectives

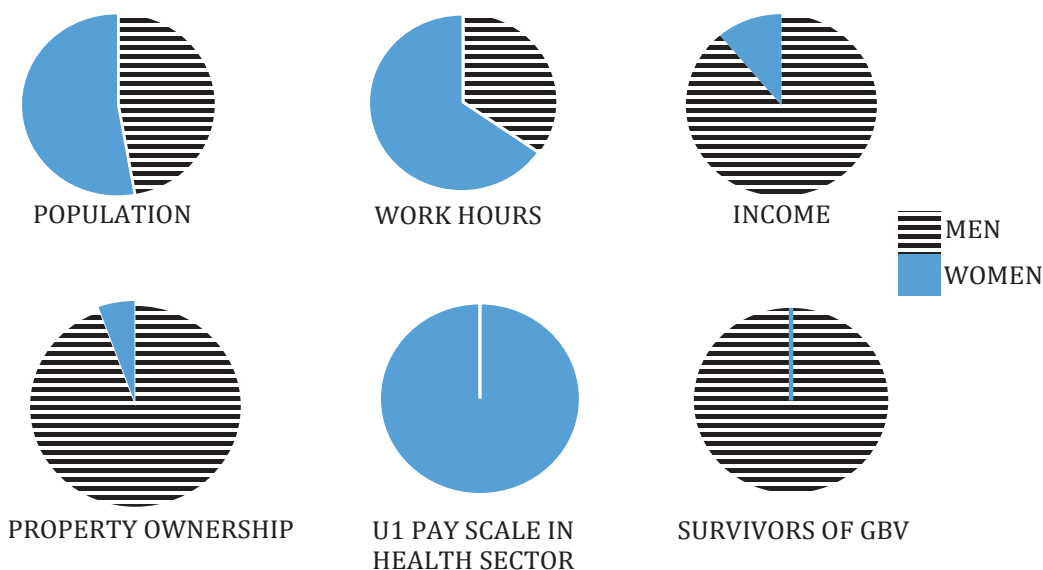
1. Define Gender Analysis;
2. Explain the importance of gender analysis in health; and
3. Explain the tools used to conduct gender analysis.

2.2.1 Gender Analysis

Gender analysis is a systematic methodology for examining the differences in roles and norms for women, men, girls and boys; the different levels of power they hold, ; their differing needs and constraints, and opportunities, and the impact of these differences on their lives.

Gender analysis must be informed by data gathered from multiple sources, including consultations with diverse groups of women and men. Surveillance, monitoring and health research activities should be based on both quantitative and qualitative methods. Available data must be disaggregated by the variables used in gender analysis. Disaggregation by sex is the bare minimum required.

Gender analysis, as the first step in gender mainstreaming, requires sustained commitment and attention to attain results in the short- medium- and long-term.



The figure above shows inequalities in the society between men and women, the lighter shade represents women and the darker shade represents men. Gender inequalities can be identified in population, working hours, income, ownership of resources and formal education.

Gender analysis alone does not address practical and strategic gender needs.

To avoid sprinkling gender salt on top of existing efforts information from gender analysis should inform every stage of health planning and programming. This means that the actual work of addressing gender inequality in health begins with analysis but requires action.

2.2.2 The Importance of Gender Analysis in Health Service Delivery

Gender Analysis in health looks at the consequences of gender inequality with respect to health and well-being, and contributes to understanding health differences and disparities among and between groups of women and men in the following areas:

- Risk factors and vulnerability;
- Patterns of disease, illness and mortality; and
- The health effects of policies, legislation or programmes.

Gender analysis in health contributes to the understanding of;

- differences in risk factors and manifestations or diseases among men and women;
- differences in the severity and frequencies of disease among men, women, boys and girls; and
- the responses of the culture, society and health system to these health problems.

Gender analysis highlights differences in access to and utilization of;

- health care and resources for promoting health and prevention diseases among men and women;
- transport, information, communication, education services for men and women which are key in promoting health; and
- decision making: it highlights the inability of women and disadvantaged groups in many societies to make appropriate decisions for their health.

In health, gender analysis can be applied to:

- health policies, legislation, programmes, services and research;
- specific health conditions and problems; and
- Planning: human resource planning, budgeting and operational planning.

Diverse types of evidence are needed to understand how gender operates as a determinant of health.

- Sex disaggregated data- sex disaggregated data is quantitative statistical information on differences and inequalities between women and men. It might reveal, for example, quantitative differences between women and men in morbidity and mortality;
- Gender analytical information is qualitative information on gender differences and inequalities. Gender analysis is about understanding culture, e.g. the patterns and norms of what men

and women, boys and girls do and experience in relation to the issue being examined and addressed.

Where patterns of gender difference and inequality are revealed in sex-disaggregated data, gender analysis examines why the disparities are there, whether they are a matter for concern, and how they might be addressed:

- **Health risk and vulnerability;** this refers to factors that put an individual at increased risk, or a potential threat to one's health e.g. risk of getting HIV from an infected needle or sexual abuse during war situations or low economic status.
- **Inability to access health services;** women and men can fail to access health services even when they are available for various reasons like; lack of money, time, decision making.
- **Experience with health services and health care providers;** negative responsiveness of the health system can influence the individual's choice about seeking health care e.g. absence of health workers, limited time for health services and negative attitude.
- **Health seeking behaviour of an individual;** Men's health seeking behaviour differs from that of women. Men tend to seek health services at a later stage than women do.
- **Preventive and treatment options,** responses to treatment and rehabilitation; options for prevention, treatment and rehabilitation are not always obvious to individuals who have less knowledge about their condition and less resources to address them because these options tend to be heavily influenced by availability of resources. Access to and control of resources determines preventive, treatment responses to and rehabilitation options for women and men.
- **Outcome of health problems;** health outcomes relate to recovery, disability or death. Gender considerations often influence how these outcomes influence a family or individual. E.g. a woman disabled by disease may be neglected by a husband or vice versa.

Gender Analysis and Adolescent health

Adolescent health is a priority in many countries and regions and marks an important transition in the life cycle. Inequality in children's mortality tends to relate to household income and the fact that girls and boys experience childhood diseases differently for a variety of reasons including biological advantages for girls, preferential treatment for boys and/or harmful practices towards girls. In adolescence, however, biological advantages for girls seem to decrease. Both biological and social factors contribute to increased sexually transmitted infections, including HIV (associated with forced or consensual sexual debut) and adolescent pregnancy among girls. The availability of sex- and age-disaggregated data has enabled different patterns of health risks to be identified for girls and boys.

When broader determinants of health, such as gender norms, roles and relations, are included in analysis methods to interpret such data, the distinct needs and risks among girls and boys become strikingly apparent. Applying gender analysis to adolescent health data has identified specific gendered risk factors for adolescent girls, such as:

- Having access to, enrolling in and completing primary and secondary education;
- Child marriage, which could contribute to early childbirth and unintended pregnancy;
- Sexual exploitation and trafficking, which could lead to unintended pregnancy and higher rates of HIV infections;

- Harmful practices such as female genital mutilation;
- Unequal sexual relationships; and
- Barriers to contraception and/or other measures to protect their sexual health.

Based on these risk factors, practical needs such as clean and safe water and food can be identified for their differential effects on young girls and boys. Strategic needs such as broader protective mechanisms to prevent sexual exploitation and harmful practices (through legal and policy frameworks, for example) have also been identified – with a clear emphasis on the specific needs girls may have due to gender norms, roles and relations. As a result, global, regional and national responses (within and beyond the health sector) have been developed to protect and promote the health of adolescent girls.

Example- DREAMS Partnership

Girls and young women account for 74% of new HIV infections among adolescents in sub-Saharan Africa. The DREAMS Partnership combines evidence-based approaches across multiple sectors to address structural drivers that directly and indirectly increase girls' HIV risk, including poverty, gender inequality, sexual violence and lack of education.

DREAMS is the result of an extensive gender analysis, through collection and disaggregation of HIV data by sex and age, as well as an in-depth analysis of the various sectors that have a direct and/or indirect affect on opportunities for girls and young women to thrive.

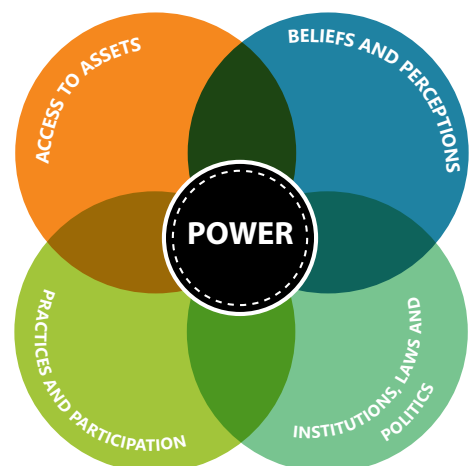
2.2.3 Gender Analysis Frameworks

Frameworks are approaches used to generate data and information during gender analysis. They serve different purposes depending on the situation and what is being analyzed.

Four Domains of Gender Analysis

Gender analysis should aim to encompass the following four domains, with power as a cross-cutting issue:¹⁷

- 1. Access to assets-** how gender relations affects access to resources necessary for a person to be a productive member of society and includes tangible assets (land, capital, and tools) and intangible assets.
- 2. Practices and Participation-** The norms that influence men and women's behavior also structure the type of activities they engage in and their roles and responsibilities. This dimension of the framework captures information on men and women's different roles, the timing and place where their activities occur, their capacity to participate in different types of economic, political, and social activities, and their decision-making.



¹⁷ *Jhpiego gender Analysis Toolkit for Health Systems*

3. Beliefs and Perceptions- draws from a cultural belief system or norms about what it means to be a man or woman in a specific society. These beliefs affect men and women’s behavior, dress, participation and decision-making capacity. They also facilitate or limit men and women’s access to education, services, and economic opportunities.

4. Institutions Laws and Policies- This dimension focuses on information about men and women’s different formal and informal rights, and how they are dissimilarly affected by policies and rules governing institutions, including the health system.

Note: Power pervades all domains– it informs who has, can acquire and can expend the authority to acquire and expend assets. It determines if an individual can take advantage of opportunities, can exercise rights, move about and associate with others, enter into legal contracts, and run for and hold office. Power also determines the way men and women are treated by different types of institutions, policies, and laws. The way in which people are treated forms an important part of what it means to be socially marginalized and disempowered. Providers’ discriminatory attitudes, for instance, reinforce and deepen inequalities. Providers, particularly lower-level women providers, may also experience discrimination and mistreatment in their workplaces, as a result of gendered hierarchies.

Example Frameworks

The following are the commonly used gender analysis frameworks that cover one or some of the four domains mentioned above:

- Harvard gender analysis framework;
- Gender planning in the third world countries (By Caroline Moser);
- Gender equality and empowerment framework (By Sarah Longwe);
- People orientated planning (UNHCR);
- Social Economic of Gender Analysis (SEGA);
- Gender Analysis Matrix (GAM);
- Social relations approach; and
- Capacities and Vulnerabilities Analysis framework.

Harvard gender analysis framework

Harvard gender analysis framework is one of the early frameworks of analysis and was developed by researchers at Harvard Institute for International Development in USA. It is based on the understanding that women and men are affected by development activities differently. The framework emphasizes the role on data and information because provision of data makes women and men to be more visible in projects.

1. Daily Activity schedule- The below tool describes how women, men, boys and girls spend their time during a typical 24 – hour day. The purpose of this tool is to analyze the roles women, men, boys and girls are involved in so that it can be taken into consideration when planning and implementing projects.

Women /Girls		Men/Boys	
Time	Activity	Time	Activity

The tool below is used in categorizing activities as productive, reproductive or communal. It shows who does them, when and where. It helps to understand the gender division of labour.

Type of activity	Who (Gender/age)	Where	How often	When	How	Why
Production Activities						
Reproductive Activities						
Community management work						

2. Access and control profile - This tool enables users to list what resources people use to carry out the tasks identified in the Activity Profile. It indicates whether women or men have access to resources, who controls their use, and who controls the benefits of a household's (or a community's) use of resources. Access simply means that you can use a resource; but this says nothing about whether you have control over it. For example, women may have some access to local political processes but little influence or control over which issues are discussed and the final decisions. The person who controls a resource is the one ultimately able to make decisions about its use, including whether it can be sold.

	ACCESS				CONTROL			
	FC	FA	MC	MA	FC	FA	MC	MA
RESOURCES								
Land								
Equipment								
Cash								
Education								
Labour								
BENEFITS								
Outside income								
Asset ownership								
Basic needs								
Education								
Political power								
KEY								
Female Child (FC) Female Adult (FA)				Male Child (MC) Male Adult (MA)				

Gender Analysis Matrix

The framework analyzes the different impacts of development interventions on women and men by providing a community-based technique for the identification and analysis of gender differences. Secondly, it assists the community to identify and challenge their assumptions about gender roles in a constructive manner. It may be used for different purposes, for example, transformative gender training or as a participatory planning tool.

The analysis is conducted at four levels of society: women, men, household and community.

Categories of analysis	Labour	Time	Resources	Culture
Women				
Men				
Household				
Community				

Outcomes of gender analysis

- Understand the differences in roles of men and women;
- Understand the power and decision making in relationships between men and women;
- Understand implications development processes e.g. service delivery in health. Gender analysis will highlight factors which influence status of health of men and women;
- Understand Social norms, which value women and men differently and expect different behaviours from them; and
- Empowers health workers and enables to build networks and their confidence to be able to deal with root causes of harmful behaviour and ultimately develop interventions to address those Gender inequalities.

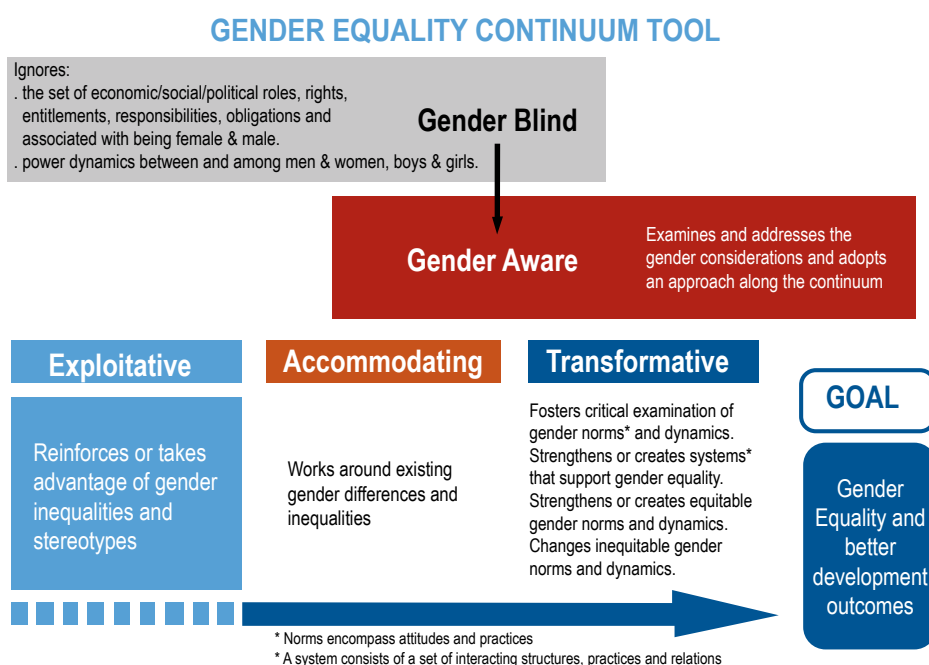
2.3 GENDER AND EQUITY RESPONSIVE PLANNING AND BUDGETING

Lesson Objectives

1. Explain and apply the gender equality continuum tool;
2. Explain gender-responsive planning and budgeting and its importance in health service delivery; and
3. Develop a gender-responsive plan and budget.

2.3.1 Gender Equality Continuum Tool

The Gender Equality Continuum Tool¹⁸ is a useful framework to understand the continuum of gender-responsive programming and policies, from gender-blind to gender aware. Gender awareness is often the result of a pre-program/policy gender analysis, as we learned to carry out in the previous section.



Source: URC media recreation of IGWG Gender Equality Continuum Tool. USAID ASSIST PROJECT (2017). Available at: <www.usaidassist.org/photo-gallery/gender-equality-continuum-tool>

Gender Blind

Ignores gender norms, roles and relations and very often reinforces gender-based discrimination. It ignores differences in opportunities and resource allocation for women and men and is often constructed based on the principle of being “fair” by treating everyone the same. In reproductive health programming.

Gender-Aware

Policies and programs examine and address the set of economic, social, and political roles, responsibilities, rights, entitlements, obligations and power relations associated with being female and male and the dynamics between and among men and women, boys and girls.

18 Interagency Gender Working Group, 2013

Gender Exploitative

Policies and programs intentionally or unintentionally reinforce or take advantage of gender inequalities and stereotypes in pursuit of health and demographic outcomes.

Gender Accommodating

Policies and programs acknowledge but work around gender differences and inequalities to achieve project objectives. Although this approach may result in short term benefits and realization of outcomes, it does not attempt to reduce gender inequality or address the gender systems that contribute to the differences and inequalities.

Gender-sensitive

Considers gender norms, roles and relations and does not address inequality generated by unequal norms, roles or relations. It indicates gender awareness, although often no remedial action is developed.

Gender Transformative

Programs that transform harmful gender norms, roles and relations in order to promote equity as a means to reach health outcomes.

EXERCISE

Mr. and Mrs. ABC live in country P, in which residents need private health insurance or pay out of pocket to get health care. Mr. ABC is unemployed, but his wife works as a primary school teacher. However, in country P, the national policy entitles men but not women to include dependents on employment benefits such as health insurance.

Therefore, the only person in the ABC household who has health insurance is Mrs. ABC. Her husband and children are not covered. If Mrs. ABC were a man, a wife or children would be covered under health insurance. But since she is a woman, no one in the household has any health insurance through employment benefits.

Questions:

Where would this policy fit on the gender continuum?

2.3.2 Gender-Responsive Planning

Gender should be integrated at all levels of the planning process. Planning objectives and strategies should be designed in such a way that they address gender inequalities identified during the analysis process. Gender responsive planning therefore, helps you to plan activities and allocate resources in a more appropriate manner according to the needs of men and women.

When developing plans, we must ensure that gender issues are addressed. A gender-responsive plan should be able to identify gender gaps, constraints and potentials for development.

Why	An intervention/a measure/ a project is carried out	Who will benefit?	Goal
What	The project is expected to achieve/to change	Utilization of services	Purpose
What	The project will deliver/hand over	Service provided	Outputs/results
How	The project is going to achieve its outputs/results	Measure execute	Activities
Which	External factors are crucial for the success of the project	Risk and frame conditions	Assumptions
How	One can assess the success	Specifications	Indicators
Where	To find the data required to assess the success	Monitoring	Means of verification

Steps in gender-responsive planning:

Step 1: *Carry out a gender analysis and identify causes of problems/gaps.*

Make use of the available information/data such as the health facility records, Health Management Information System (HMIS) reports, census reports and enrich it with your observations from the community and focus group discussions with the community. It is important to note that problems are unmet needs of the population and not absence of preconceived solutions. The HMIS records could reveal a higher number of STI cases in women in a community and the preconceived solution to the problem could be setting up an STD clinic at health center III, however, the reasons for this high numbers could be due to different reasons such as lack of knowledge among the women, late presentation of the condition etc.

Step II: *Identify goals, objectives and theory of change*

Every community aims at reducing their problems; therefore the goals of a health worker should be what the community would benefit from the services offered to address the identified problems. Ideally goals should aim at promoting equity, clarifying rights, and empowering women and men. Example: for the problem of higher STI rates among women, our goals should be to reduce the STI rates among women. The benefit to the community will be having fewer women with STI.

To achieve goals of reducing the STI rates among women there are some practices that the community needs to change. This is the reason why services are delivered. The example of the higher STI rates among women could be solved through change of practices such as; having safer sex, use of condoms and seeking of health care.

For the community to change their practices, health workers must help them by delivering services. The services we deliver are our outputs. For example, if we want to increase the number of women being attended to for STIs, we may have to include comprehensive health promotion activities e.g. outreach services, which are providing health education, treatment and distributing condoms. The numbers of outreach programmes we provide are our outputs.

In this step, determine the theory of change based on the gender analysis, identify the objectives and goals, identify the beneficiaries and programme participants, consider constraints and opportunities in setting of objectives, and identify stakeholder roles and responsibilities. See Section 2.5.6 for a summary table of on the planning stage.

Step III: *Plan of action*

Plans must be translated into actions as to schedule activities that will enable their implementations. It is important that the activities you selected are able to produce intended gendered outputs. For

example community activities planned during the planning season may fail to meet their desired objectives.

During this step, it is important to:

- Design the approaches to meet objectives;
- Ensure the mainstreaming of all gender issues throughout all possible entry points in the planned interventions;
- Identify the activities to meet the objectives especially addressing the gender gaps and constraints;
- Design interventions and methods to address the prioritized problems; and
- Identify gender-sensitive ways and means of achieving the objectives.

2.3.3 Gender and Equity Responsive Budgeting

2.3.3.1 Introduction

Budget: a plan of financial operation that consists of an estimate of proposed expenditures for a financial year and the proposed means of financing them. A budget can also be understood as a statement of resource allocation and a tool that helps to communicate goals, coordinate actions and provide benchmarks for measuring performance throughout the financial year.¹⁹

Gender and Equity Budgeting (GEB) is a process of addressing gender and equity concerns in the budget. Such concerns arise out of inequalities and inequities amongst regions, socio-economic groups as well as women, men, boys and girls.²⁰

In Uganda, GEB involves analyzing disaggregated data (by gender, age, disability and geographical location) to identify inequalities and inequities in access to, participation in, and/or benefit from government programmes and budgets as well as designing appropriate interventions to address the inequalities and inequities by allocating funds during the budget process. GEB has over the years transformed from a CSO advocacy led campaign to a legally backed obligation of MDAs whose knowledge and skills is a major requirement in government planning and budgeting.

2.3.3.2 Gender and Equity Budgeting Benefits

Gender and Equity Budgeting has a host of benefits that include:

- i. Promoting equitable distribution of growth, public expenditure and access to services, markets and opportunities for women, poor men, youth, orphans, the unemployed, prisoners, children, persons with disabilities (PWDs), informal sector workers, the elderly, ethnic minorities, people in conflict areas etc.²¹
- ii. Facilitating all vulnerable groups to access and benefit and effectively utilise government programmes, hence the choice of Gender and Equity Budgeting.
- iii. Drawing attention of all stakeholders on how public resources are allocated.
- iv. Seeking political and administrative commitment to Gender and Equity.

¹⁹ Republic of Uganda (2005) *How to Prepare a Budget Framework Paper that Addresses Gender and Equity Issues: Users Manual*, Kampala, MoFPED.

²⁰ SURGE Team (2016) *"A Background Paper for a Political Economy Assessment"*, Kampala, October.

²¹ Republic of Uganda (2012) *"Equity Promotion Strategy Paper"*, Kampala, MoGLSD.

Key learning points

- GEB enhances equitable distribution of growth, public expenditure and access to services, markets and opportunities for excluded categories;
- GEB has normative justification;
- GEB has evidence based justification.

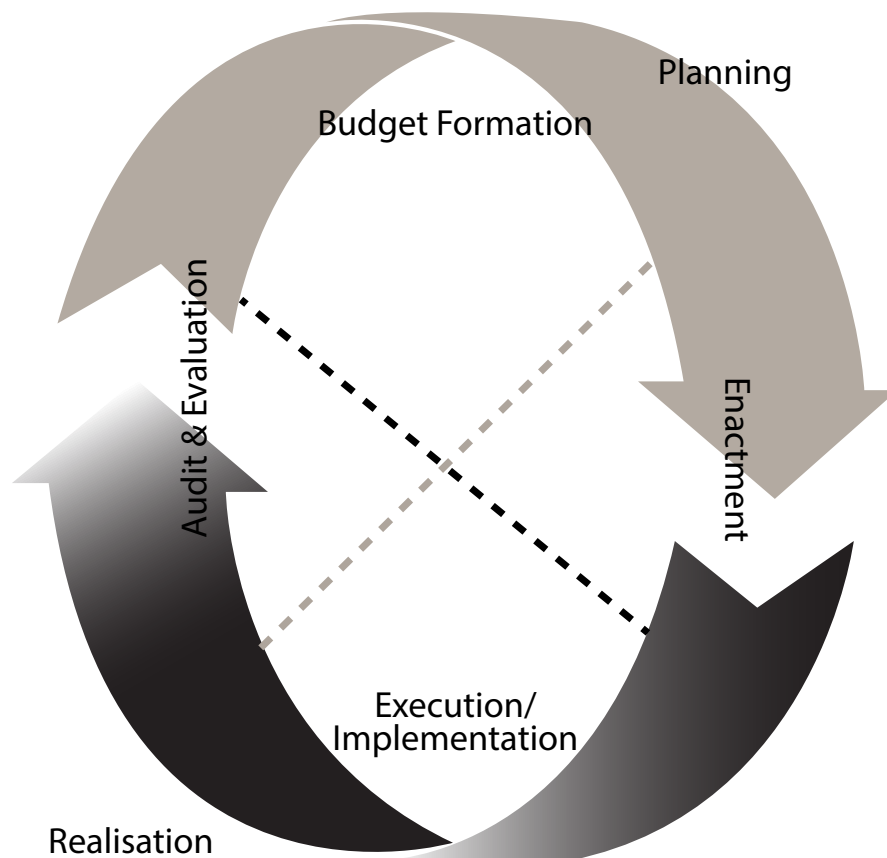
2.3.3.3 Gender and Equity Budgeting Criterion

Criteria	Score 0-1-2
G&E analysis concepts are used to analyse the situation (e.g. gender division of labour, access to, and control of resources and benefits, practical gender needs, strategic gender interests, recognition of rights of girls/women which may be suppressed by social norms, etc.).	
Goals towards increased gender equality and equity are clearly reflected or indicated in programme design.	
Policy/programme objectives specifically address G&E practical and strategic needs.	
Document objectives are disaggregated by G&E.	
Documents use G&E sensitive language that includes women, men, boys, girls, PERSON WITH DISABILITIES, youth, the elderly, persons from remote/poor geographical locations, and ethnic minorities.	
Document references to G&E are substantive and central to the document, not just a marginal add on.	
Strategies and activities are designed specifically around G&E needs to address G&E asymmetries.	
Community-level programmes specifically G&E strategic interests.	
Programmes are designed with the participation of community groups. If so, women's, Person With Disabilities, youth groups were explicitly included in this.	
Implementation arrangements are G&E conscious.	
M&E mechanisms are G&E focused.	
Total score for reviewed sector plan.	Average score for the reviewed sector plan: total/ number of assessment criteria (e.g. 22/11 = 2).

2.3.3.4 Gender and Equity Budgeting in the Budgeting Process

Figure 5²² visualises the budget cycle, which is formed of four core stages: drafting/design; Legislation/ approval; execution/implementation; and audit an evaluation. The cyclical graphic emphasises the interconnectedness among the four stages, whereby one is feeding into another.

²² Taken from Sharp, R., 2003. *Budgeting for Equity: Gender Budget Initiatives within a Framework of Performance Oriented Budgeting*.



In reality, the stages can also be running concurrently, with ongoing evaluation throughout the implementation phase, etc. Due to the protracted and ongoing nature of the budget cycle, several cycles are normally running at the same time (e.g. implementation of a budget for the forthcoming FY begins in July, which is when the auditing/evaluation stage of the past budget begins).

To ensure full accountability over how G&E is addressed in the budgeting process, it is important that it becomes part of the full cycle, from formulation to evaluation (and feeding the findings to the formulation of the next budget). Throughout the budget process in Uganda, there are multiple decision making entry points when gender and equity dimensions should be addressed to ensure that the government does not fall through on its critical G&E responsive objectives and policies.

It is important to identify the various entry points to promote G&E in budgeting. The table below highlights some of the key entry points for addressing G & E in Uganda.

Table 5.1: Entry points for addressing G&E in the budget cycle

Budget cycle stage	Entry points for addressing G&E	Key activities for addressing G&E within Uganda's budget calendar/processes
Budget formulation	<p>This is a crucial stage for addressing G&E in budgets. This is when Sector/Vote priority policy directions and programme-based allocations for the medium term are articulated – it is important that during this process, which includes discussions within Sector Working Groups and consultations with the private sector and development partners, among others, G&E responsive (targeted and universal) interventions are selected and included; G&E responsive outcomes, outputs, inputs and robust indicators at all levels are selected (and further formulated if required); and appropriate budget allocations are made for their implementation. It is important to ensure that this process is effectively communicated in key budget documents – BFPs and MPSs, which are assessed by the EOC for G&E compliance.</p>	<p>Statement of Multi-Year Commitments (Sector-Line Ministries) and submission of strategic investment plans by MDAs/Local Governments.</p> <p>Provision of Macro Framework and Resource Envelope for FY 2017/18 by Directorate of Economic Affairs.</p> <p>Draft Budget Strategy Paper.</p> <p>Cabinet Retreat on the Budget Strategy/OPM Retreat on Annual Government Performance Report of the previous year & National Budget Conference.</p> <p>Discussions with the Presidential Advisory Committee on the Budget.</p> <p>Issue of Budget Call Circulars.</p> <p>Consultations with Local Governments (LGBFP regional workshops) (MoFPED).</p> <p>Development Committee Meetings (Budget Directorate and MDAs).</p> <p>Private Sector Working Group Consultations.</p> <p>Sector Working Groups Consultations.</p> <p>Inter-Ministerial Consultations (Technical and Policy Levels).</p> <p>Submission of Sectoral Budget Framework Papers to MOFPED and EOC.</p> <p>Submission of the Final Detailed Budget Estimates by MALGS to MoFPED.</p>

<p>Legislation and Approval</p>	<p>National BFP, MPSs and subsequently the Annual Budget are presented to the Parliament, where they are interrogated (in sectoral committees and on the floor of the House), amended if required and subsequently approved. At this time G&E should be fully addressed in key budget documents, which will be assessed and questioned.</p> <p>The presentation of the Annual Budget, supported by the Budget Statement, is a time of increased civil society and media scrutiny – it is important that G&E issues and decisions around the specific budget allocations are debated and receive sufficient coverage (advocacy will be further addressed in module 9).</p>	<p>Submission of the National Budget Framework Paper by MoFPED to Parliament and its approval.</p> <p>Presentation of the Ministerial Policy Statements to Parliament.</p> <p>Submission of the Final Detailed Budget Estimates by MoFPED to Parliament.</p> <p>Presentation of the Annual Budget Committee of Supply considers the Budget.</p> <p>Presentation of the Budget Speech in Parliament.</p>
<p>Execution/ Implementation</p>	<p>At this stage it is important to continuously monitor government performance against its G&E responsive commitments. This should focus on monitoring both financial and physical performance of G&E responsive outputs and outcomes, which informs audit and evaluation.</p> <p>The role of civil society during this phase is critical as budget execution watch dogs.</p>	<p>Submission of Quarterly performance reports by Votes.</p> <p>Preparation and Submission of half year financial statements to Accountant General.</p>
<p>Audit & evaluation</p>	<p>At this stage the focus is on the evaluation of G&E results (delivery of G&E responsive outputs and achievement of G&E responsive outcomes) and of the fiscal performance of specific G&E responsive budget allocations. The evaluation is based on the fiscal and technical performance information collected during the implementation phase.</p> <p>Evaluation results will be outlined in the next financial year budget documents as an assessment of past performance and will inform the budget formulation phase for the following FY.</p>	<p>Submission of ABPR by OPM.</p> <p>Submission of Project Reviews by Accounting Officers/Heads of Public Corporations and Enterprises.</p> <p>Preparation and Submission of Consolidated Annual Statements to MoFPED and Auditor General.</p> <p>Submit report to Parliament on Fiscal Performance.</p> <p>Repayment of unexpended money to the Consolidated fund.</p>

2.4 GENDER MAINSTREAMING IN THE HEALTH SECTOR

Lesson Objectives

1. Explain the concept of gender mainstreaming;
2. List the steps taken to mainstream gender;
3. Explain the purpose of the Gender Mainstreaming in the Health Sector;
4. Describe the strategies for effective gender mainstreaming; and
5. Develop gender sensitive indicators for monitoring, evaluation and reporting.

2.4.1 What is gender mainstreaming?

- It is process of integrating a gender equality perspective into the development process at all stages and levels.
- Gender mainstreaming is a strategy for the achievement of gender equality.
- What is gender integration? Integration occurs when issues and interventions related to gender are introduced into a project, program or policy context as a broad component or content area, without analysis and identification of gender concerns and their implications.
- Gender mainstreaming is an internationally accepted strategy that aims to institutionalize gender equality across sectors.
- It is the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels.
- It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated.
- Gender mainstreaming is a government framework initiative for redressing gender imbalances, which is meant to be undertaken by all government agencies, including local governments.

2.4.2 Purpose of the Gender Mainstreaming in the Health Sector

Gender mainstreaming makes it possible for programs/projects to:

- Address gender-based barriers to accessing services;
- Address providers' gendered attitudes which can affect service provision;
- Improve health communication (and avoid inadvertently promoting negative gender norms/stereotypes); and
- Engage men as clients, partners and agents of change.

Ideally, gender should be integrated into programs from the very beginning. Just as gender norms influence health behaviour, gender norms are also an important determinant in fulfilling the rights of client.

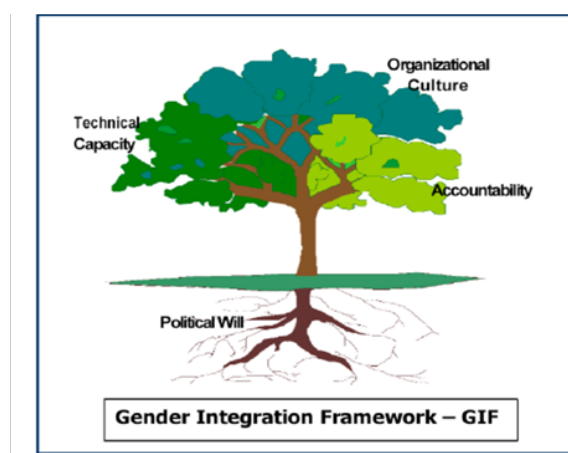
2.4.3 Strategies for Promoting Gender Mainstreaming in Health Sector

Political will- ways in which leaders use their position of power to communicate and demonstrate their support, leadership, enthusiasm for and commitment to working toward gender equality within the organisation and in the organisation's programs and research. For example, the Ministry of Health has guidelines on Mainstreaming Gender in the Health Sector.

Technical Capacity- level of ability, qualifications, and skills individuals in an organization need to carry out the practical aspects of gender integration for enhanced program quality, and level of institutionalization of gender equitable organizational processes for program implementation and monitoring including research and information dissemination on gender issues, sex-disaggregated data, and practical coordination of all gender mainstreaming activities.

Accountability- mechanisms by which an organization determines the extent to which it is "walking the talk" in terms of integrating gender equity in its programs and organizational structures, including job descriptions, performance evaluations, program reporting requirements and evaluation systems. Gender audits can be a useful tool for accountability, as well as developing mechanisms for redressing sexual harassment in the workplace.

Organizational culture- norms, customs, beliefs and codes of behaviour in an organization that support or undermine gender equality- how people relate; what are seen as acceptable ideas; how people are "expected to behaviour" and what behaviours are rewarded by the organization. For example, is sexual harassment prevalent in the work environment.



2.4.4 Methods used in gender mainstreaming

- Carrying out a gender analysis regularly;
- Carrying out participatory training;
- Consultative meetings and feedback fora;
- Preparation and dissemination of Information, Education and Communication (IEC) materials;
- Creation of data banks and resource centre on gender mainstreaming and support services;
- Creation of membership associations of people and organizations involved in gender advocacy;
- Participation of member associations in trade shows and exhibitions; and
- Media and publicity programs.

2.4.5 Monitoring, evaluation and reporting in gender mainstreaming.

Monitoring is the systematic and regular tracking of progress during planning and implementation of gender mainstreaming. It involves continuous observation, reflection and making decisions regarding activities implemented. Evaluation, on the other hand, refers to the periodic assessment of expected results in relation to specific objectives of the implementation of gender mainstreaming. It is important to determine who needs what type of information, for what purpose and how often. Appropriate instrument to be used for data collection should be designed. In Sub-Unit 3, Monitoring and Evaluation, will go into further detail on monitoring and evaluating human rights and gender.

What needs to be monitored and evaluated?

- Inputs, activities, results and context;
- What tools should be used in monitoring and evaluation?
- Work plans, budgets, reports and projects documentation.

Reporting involves collection and documentation of information relating to the implementation of gender mainstreaming. Such reports provide feedback and sharing of information for planning and decision – making.

Indicators must be gender-sensitive. See the table below to inform the creation of gender-sensitive indicators for the health sector:

- Have process and outcome indicators been included in monitoring and evaluation frameworks and activities?
 - » When selecting or creating indicators, ensure that they are disaggregated by age and sex (as a minimum) and when appropriate.
 - » Ensure that the health status indicators used in both monitoring and valuation and situation analysis development include morbidity and mortality trends, disaggregated by sex and age at the very minimum.
- What are the sources of information for monitoring and evaluation?
 - » Rely on a mix of indicators from various sources to analyse the social, economic, political, and cultural influences on health.
- Does the program monitor progress on gender equality and health equity?
 - » Ensure that measures are included and analysed on empowerment of women and of the community.
 - » Use progressive measures of gender equality and health equity as evaluation criteria.
 - » Include both process and outcome indicators for gender mainstreaming.
 - » Socio economic measures include both productive and reproductive roles of women.
 - » Examine the differential impact of the programme or policy outcomes on both women and men of different ages and across other socio-economic and socio-cultural divisions as feasible.
 - » Use the information collecting from monitoring and evaluation activities to inform amendments, corrective action or subsequent cycles of programmes or activities.
- Have women and men participated equally in the monitoring and evaluation stages – both as beneficiaries and as programme staff members?
 - » Include community members (men and women) and other local stakeholders in designing the monitoring and evaluation strategy and activities.

Types of reports

- Narrative / qualitative.
- Quantitative A sample table which can be used for monitoring and evaluation is attached below.

Examples of indicators

Uganda's National Priority Gender Equality Indicators for the Health Sector and Indicators for Human Rights align with the Sustainable Development Goals (SDGs). Examples include, but are not limited to, the following:

NDP II	SDG	NPGEIs
Ratio of doctors to population	3.C.1 Health worker density and distribution.	3.1 Ratio of practicing medical officers (doctors) by sex. 3.4 Ratio of practicing midwives to population. 3.5 Ratio of practicing midwives to women.
Children stunting as percent of under 5s	2.2.1 Prevalence of stunting (height for age <-2 standard deviation from the median of the WHO Child Growth Standards among children under 5 years of age).	3.7 Proportion of mothers who are able to breastfeed exclusively for six months (%). 3.9 Prevalence of stunting in children under 5 years of age by sex.
Maternal mortality rate per 100,000 live births	3.1.1 Maternal mortality ratio.	3.15 Maternal deaths per 100,000 live births (MMR) (number).
Birth attended by skilled health personnel	3.1.2 Proportion of births attend by skilled health personnel.	3.16 Proportion of births attend by skilled health personnel.
Contraceptive prevalence rate	3.7.1 Proportion of women of reproductive age (15-49 years) who have their need for family planning satisfied with modern methods.	3.21 Contraceptive prevalence rate in reproductive age group (15 to 49). 3.22 Adolescent contraceptive prevalence rate.
	5.6.1 Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care.	3.23 Proportion of women (aged 15-49 (who make their own sexual and reproductive health decisions.
	5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual, or psychological violence by a current or former intimate partner, in the previous 12 months, by form of violence and age.	5.2 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual, or psychological violence by a current or former intimate partner, in the previous 12 months, by form of violence and age.
	5.2.2 Proportion women and girls aged 15 years and older subjected to physical, sexual, or psychological violence by a current or former intimate partner, in the previous 12 months, by age and place of occurrence.	5.3 Proportion of the population aged 15+ subjected to sexual violence by persons other than an intimate partner, since age 15 by sex.
	5.3.1 Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18.	5.5 Percentage of the population aged 20-24 who were married or in a union before age 18 (i.e. child marriage) by sex.

2.4.6 Summary of Gender Mainstreaming Process

Project/program cycle stage	What is involved at this level	Key guiding questions	Expected output
Assessment (situation analysis)	<ul style="list-style-type: none"> define the program related gender issues that are country and community specific and related to the kind of intervention that will be undertaken. Identify needs of men and women and priorities to be addressed in the project/ plan. Conduct the gender assessment/analysis. 	<ul style="list-style-type: none"> Does plan have data, facts on men and women?. Have gender issues/ inequalities and their causes been identified. 	<ul style="list-style-type: none"> Data on men and women (a situation analysis.
Planning	<ul style="list-style-type: none"> Determine the change of theory based on the gender analysis. Identify the objectives and goals that address the gender issues identified above. Identify of the beneficiaries/ programme participants. Consider the constraints and opportunities in setting of objectives. Identify stakeholder roles and responsibilities. 	<ul style="list-style-type: none"> Do the objectives address the gender issues identified? Are there objectives in line with achieving gender equality? Do the goals and objectives include the reduction of gender inequalities? Do they address the specific gender issues and needs of men and women? 	<ul style="list-style-type: none"> Gender-sensitive goals and objectives.
Design	<ul style="list-style-type: none"> Design the approaches to meet objectives. Ensure the mainstreaming of all gender issues throughout all possible entry points in the planned interventions. Identify the activities to meet the objectives especially addressing the gender gaps and constraints. Design interventions and methods to address the prioritized problems. Identify gender-sensitive ways and means of achieving the objectives. 	<ul style="list-style-type: none"> How will the programme activities benefit men and women? What strategies will ensure both men and women and men? What interventions have been put in place to address the identified gender needs? Are there specific Programmes targeting women or men? 	<ul style="list-style-type: none"> Identified gender issues and interventions/ activities to address them set.

Implementation	<ul style="list-style-type: none"> • Translate the approved plan/program/project and budget into outputs (actual undertaking of the planned activities and Programmes). • Address gender issues as you execute the activities / interventions. • Continue to analyse for gender issues as you implement and address them. 	<ul style="list-style-type: none"> • How many women and men are participating in the implementation? • Are gender-related constraints to participation and benefits being addressed? • Are gender guidelines in place to guide gender-focused implementation? 	<ul style="list-style-type: none"> • Involvement of both men and women. • Interventions that address gender inequalities implemented.
Monitoring and Evaluation	<ul style="list-style-type: none"> • Track progress with regards to achieving gender targets and objectives of the planned governance intervention. • mid-term review to evaluate if gender programme goals and objectives are on course and to redesign the programme to address any serious challenges impeding the effective implementation of the gender strategy. • Also checks the impact of the implemented interventions. • Develop monitoring indicators. • Design gender sensitive indicators& data collection tools. • Evaluate programme progress in achieving gender equality objectives. • Evaluate the effectiveness of the adopted gender strategy. • Evaluate the impact of the programme on beneficiaries. • List lessons learnt, identify key areas that influence programme success or failure and document best practices. 	<ul style="list-style-type: none"> • Is there baseline data, were clear and measurable gender sensitive indicators been designed? • Have appropriate data collection tools been prepared? • Were gender responsive indicators developed? • Were gender related interventions implemented? • Were the allocated funds released? • Ensure participation of women and men in monitoring? 	<ul style="list-style-type: none"> • Gender sensitive indicators and tools. • A final gender sensitive program/ project report.

2.5 GENDER-BASED VIOLENCE

Lesson Objectives:

6. Explain the meaning and forms of GBV;
7. Discuss the magnitude of GBV in Uganda;
8. List the contributing factors and consequences of GBV;
9. Outline the response and prevention mechanisms of GBV in the health sector; and
10. Explain the referral pathway of sexual harassment in the workplace.

2.5.1 Definition

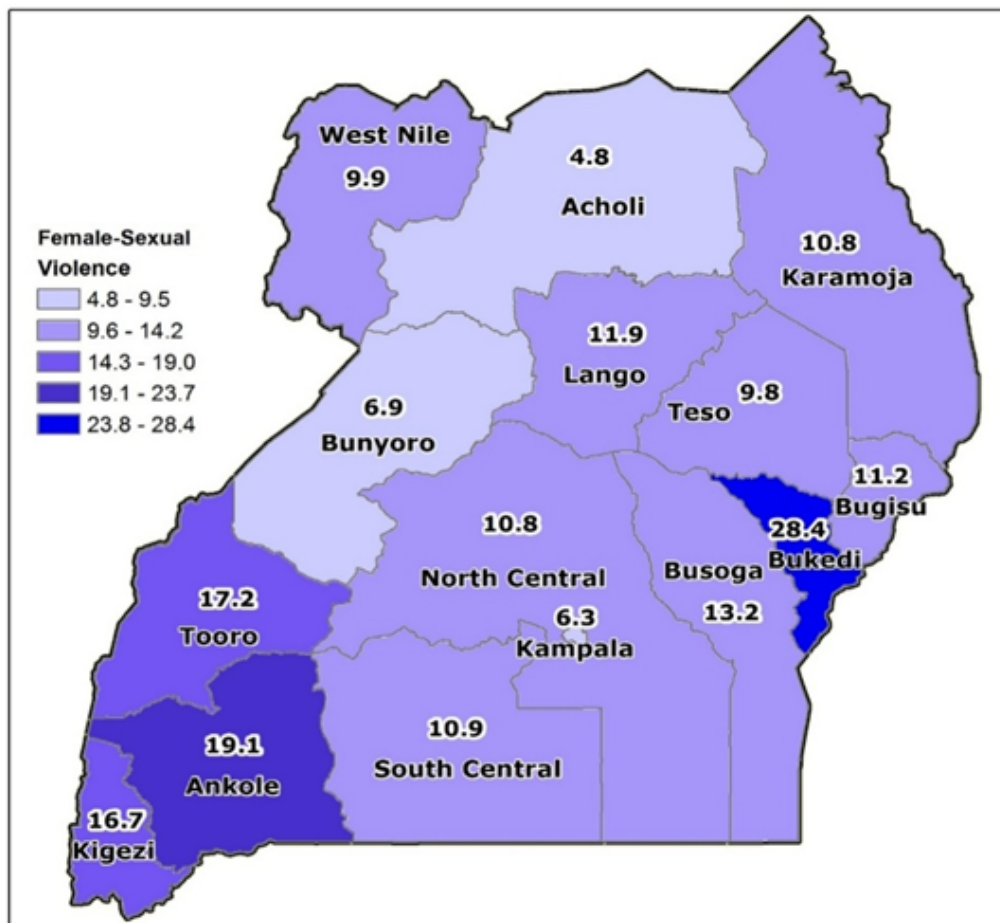
The National Policy on Elimination of Gender Based Violence (GBV) in Uganda defines GBV according to United Nations Declaration on the Elimination of Violence Against Women (DEVAW), which is “any act of gender-based violence which results in or is likely to result in physical, sexual, or psychological harm, or suffering to women including threats of such acts, coercion, or arbitrarily deprivation of liberty, whether occurring in public or private life.”

The policy also recognizes that men can also be victims of gender-based violence. Over time, GBV has become an umbrella term for any harm that is perpetuated against a person’s will on the basis of unequal relations between women and men as well as through the abuse of power.

2.5.2 Magnitude of GBV in Uganda

Gender based violence occurs in families, communities, workplaces and institutions. GBV occurs at every stage of Life (Pre-birth, Infancy, Childhood, Adolescence, Reproductive age, Elderly). GBV within families is often hidden from public sight and those who bear the burden usually suffer in silence.

According to the UDHS indicator report (2016), women in Uganda are more than twice as likely to experience sexual violence compared to men, with 22% of women age 15-29 experiencing sexual violence at some point in their life and 8% of men. Young women age 15-19 are less likely to report a recent experience of sexual violence compared to older women, 5% and 13-16%, respectively. To the right, you can see the regional prevalence of women who have experienced sexual violence.



Source: UBOS

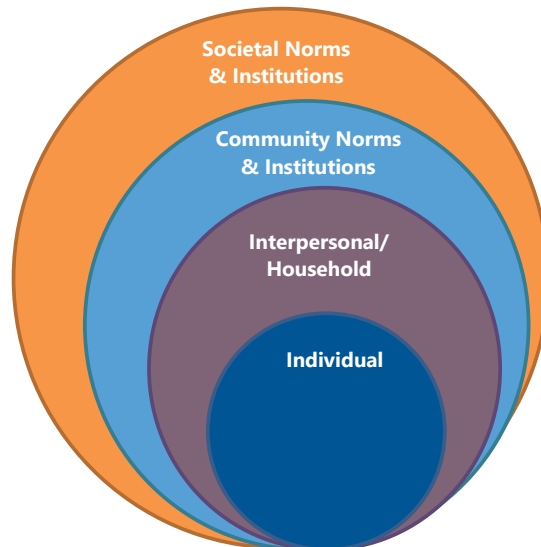
2.5.3 Root Causes and Contributing factors of GBV

The root causes of SGBV are:

1. Gender inequality;
2. Failure to respect human's rights; and
3. Unequal power relations.

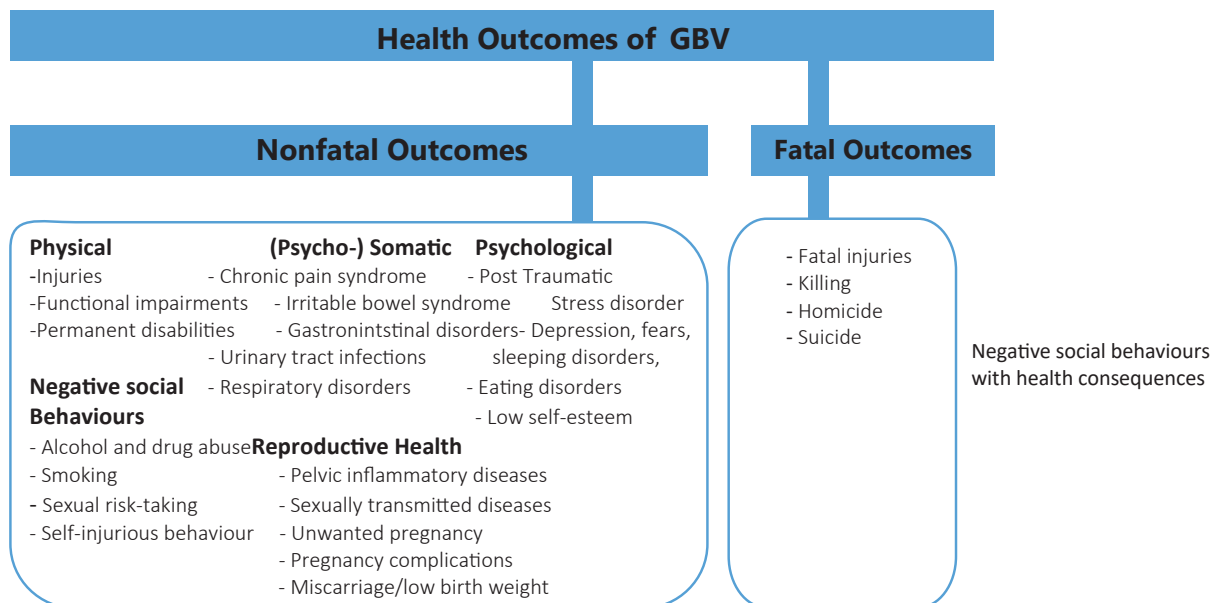
Contributing factors of gender-based violence can be understood using the social-ecological framework.

- Patriarchy
 - Discriminatory gender norms
 - Conflict
 - Globalization
- Cultural beliefs
 - religious practices
 - Policies and laws
- Poverty
 - Urbanization
 - Family traditions
- knowledge of rights
 - personal security
 - access to services
 - control of resources
 - disability
 - alcohol and drug abuse



2.5.4 Consequences of GBV

The consequences of GBV are far-reaching, affecting health, social, and economic circumstances. The below chart²³ describes health outcomes of gender-based violence, included fatal outcomes and nonfatal outcomes.



Source: Nellbernd et al 2004, CHANGE 1999, all cited in PRO TRAIN 2009, Available at: <www.health-gender violence>

Intergenerational and social economic consequences

Just like the contributing factors of GBV, the consequences of GBV operate at the individual level, household, and societal levels. Some intergenerational and socio-economic consequences are seen in the table below:²⁴

Effects on children raised in violent homes	<ul style="list-style-type: none"> • Higher rates of infant mortality. • Behaviour problems (Self-withdrawal, delinquency). • Anxiety, depression, attempted suicide. • Poor school performance. • Experiencing or perpetrating violence as adults. • Lost/low productivity in adulthood.
Effects on families	<ul style="list-style-type: none"> • Inability to work. • Lost wages and productivity. • Loss of basic needs (food, shelter, etc). • Family breakdown.
Social and economic effects	<ul style="list-style-type: none"> • Costs of services incurred by victims and families (health, social, justice). • Lost workplace productivity and costs to employers. • Perpetuation of violence.

Violence Against Children

It's important to recognize the linkages between violence against women, specifically intimate partner violence (IPV) and violence against children (VAC). Children who witness and/or experience violence in childhood are more likely to perpetuate or normalize violence as adults. A study done in December

²³ Hellbernd et al 2004, Change 1999, all cited in PRO TRAIN 2009

²⁴ Source: Amin, A. (2012, March 8). "Violence against women & children: health & other consequences." PowerPoint lecture presented at the Chester Beatty Library for International Women's Day.

2015 by Raising Voices in Kampala²⁵ revealed that IPV and VAC co-occur and create cycles of abuse in the family. Secondly, IPV and VAC are often committed as a way to enforce expected gender and childhood roles. Thirdly, despite widespread acceptable and use of violence, both children and adults would like to see a violence-free relationship between parents/partners. Lastly, perspectives justifying VAC were found to be more entrenched than those regarding IPV, with some participants speaking out against IPC, but none clearly rejecting VAC.

2.5.5 Addressing SGBV in the Health Sector

Understanding and addressing such causes of ill health and inequity enables appropriate and adequate policies and programmes in the health sector.

Referral Pathway

The table below explains the National Referral Pathway for Prevention and Response to GBV in Uganda (2013) for healthcare providers.

Service Provider	Service Package	GBV Referral Pathway
<p>Report to Medical/health practitioner</p> <p>Note:</p> <ul style="list-style-type: none"> The victim/survivor in critical condition should be taken for medical care before reporting to police or any other service provider. At the same time, there should be collaboration to have Police form 3 and 24A filled. In case of rape/defilement, the victim/survivor should not wash before medical examination. The victim/survivor must be medically examined, treated and provided with PEP and ECP within 72 hours/3 days to prevent HIV infection to avoid pregnancies. The service providers should follow up the cases. 	<ul style="list-style-type: none"> Medical/health practitioner receives victim. Medical/health practitioner offers required medical assistance to the victim/survivor including provision of pep/ECP. If medical/health practitioner suspects GBV, she/he accurately documents the visit of the victim, including filling out Police Form 3. Inform the victim/survivor of options available within the support system. Makes herself/himself available to testify in court regarding the case where necessary. 	<pre> graph TD A[Medical care, health units I, II, III, IV, general hospital, Referral hospital] --> B(Shelter, Counseling, Legal Aid) A --> C(Police) C --> D(Magistrates Court) </pre>

Prevention Strategies

The National Policy on Elimination of Gender-Based Violence in Uganda (2016) identifies the following multi-sectoral priority intervention areas to prevent gender-based violence:

- Sensitization of all people to promote understanding of the forms, causes and effects of GBV;
- Sensitization of parents, guardians and caregivers on creating GBV free family environment;
- Create awareness among the people at risk particularly the girl child to be able to detect and protect themselves against GBV;
- Promotion of male involvement in elimination of all forms of gender based violence in the family, community, schools and institutions as well as workplace;

25 http://raisingvoices.org/wp-content/uploads/2017/05/LP7.PotentialPathwaystoPrevention.FINAL_May2017.pdf

- Integration of strategies to eliminate GBV in the education curricular at all levels of education so as to foster attitudinal change among pupils, students and teachers;
- Enhancing economic empowerment of women in order to reduce poverty and economic dependence;
- Promoting participation of faith-based, cultural, civic political and other opinion leaders as champions in ending GBV;
- Building and strengthening media partnership on GBV interventions;
- Promotion of legal education and awareness on existing laws addressing GBV;
- Enacting and/or reviewing laws addressing GBV;
- Domesticate and implement regional and international instruments on elimination of GBV;
- Integrate GBV in the National Planning framework, legislation, policies, sectoral and Local Government plans and programmes;
- Developing programmes to increase the capacity of vulnerable groups to protect themselves against GBV and reinforce economic empowerment; and
- Designing and implementing programs aimed at addressing the major root causes of GBV incidences such as patriarchal attitudes, behaviors, and practices.

2.5.6 Sexual Harassment in the Workplace

Harassment frequently involves an abuse of power where the targets can experience difficulties in defending themselves. Harassment at the workplace is any unwelcome or offensive action, repeated or unreasonable act, addressed to a worker or a group of workers that causes difficulty in the performance of an assigned job or causes a worker to feel that he/ she is working in a hostile working environment. This can also cause risk to the health and safety of the worker. The following is from the 2018 Policy Implementation guidelines on Prevention and Response to Sexual Harassment in the Health Sector, a joint initiative by Ministry of Health and IntraHealth Uganda.

2.5.6.1 What is Sexual Harassment?

For purposes of these guidelines, Sexual Harassment shall refer to unwelcome, offensive, unwanted behavior by its nature, singular or through persistent conduct by the supervisor, peer to peer, manager, in-charge, service provider that may be verbal or nonverbal to a supervisee, junior staff, or clients of a sexual nature that has a negative and harmful effect of that person's dignity as well as their employment, career, job performance or job satisfaction and access to services that may be direct or implicit.

There are two categories of sexual harassment:

1. Hostile Work Environment is conduct that creates an intimidating, hostile, degrading or humiliating work environment for the recipient.
2. Quid Pro Quo ("this for that" exchange) is a demand by a person in authority, for sexual favours in exchange for work related benefits (e.g. a wage increase, a promotion, training opportunity, a transfer or the job itself).

Hostile Work Environment and Quid Pro Quo can manifest in a variety of ways, including:

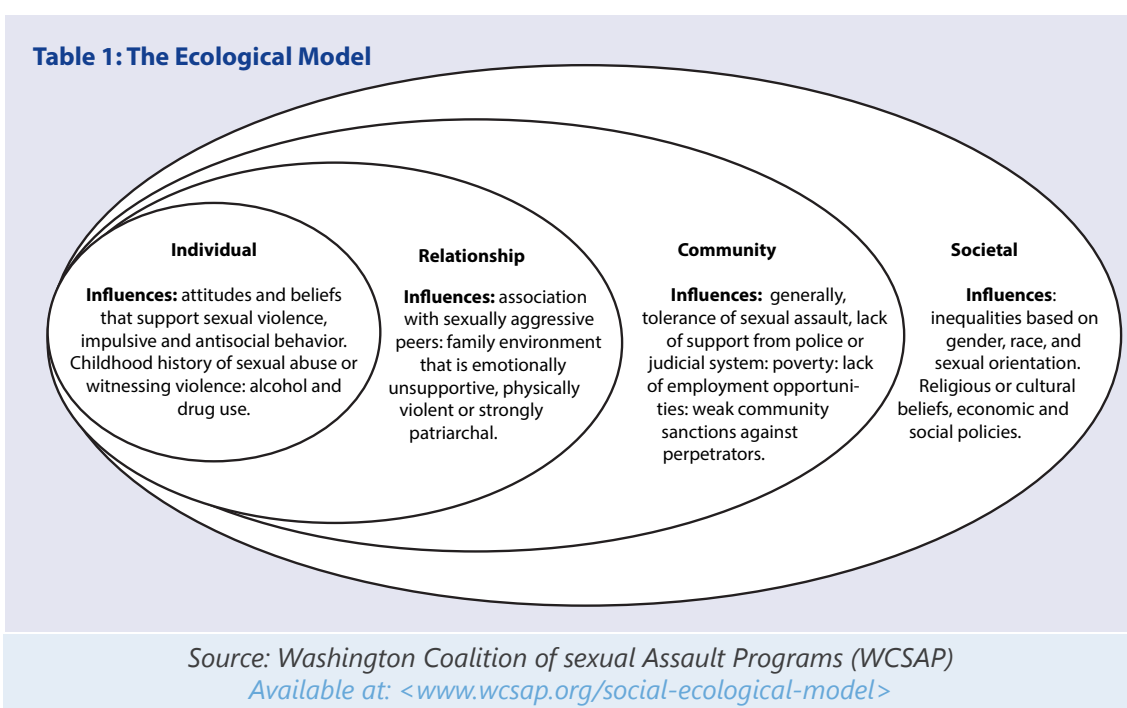
- **Physical harassment** includes unwelcome and/or unnecessary touching in a sexual manner such as kissing, patting, pinching, glancing and staring with lust; inappropriate medical examinations.
- **Verbal harassment** includes unwelcome comments about a person’s private life, body parts or appearance, sexually suggestive jokes, innuendos and comments; suggestive or insulting sounds; outright demand for sex; use of vulgar language.
- **Gestural harassment** includes sexually suggestive body language and/or gestures, repeated winks, licking lips.
- **Written or graphic harassment** includes displays of objects of sexual nature (such as pornographic materials, sexually explicit pictures, screen savers or posters) and harassment via emails and other modes of electronic communication.
- **Psychological/emotional harassment** consists of persistent proposals and unwelcome requests, unwanted invitations to go out on dates, insults, taunts, and innuendoes of a sexual nature.

2.5.6.2 Magnitude of Sexual Harassment in Uganda’s Public Health Sector

According to a 2012 Uganda Ministry of Health Gender Discrimination and Inequality Analysis (GDIA) revealed that 32.1% of employee survey respondents (or almost one-third of the staff surveyed) reported that sexual harassment involving manager/supervisor expectations of sexual favors in order (for staff) to get a good evaluation, a promotion, or a salary raise (i.e., quid pro quo sexual harassment) were either “somewhat common” or “very common.”

2.5.6.3 Causes of Sexual Harassment

Refer to Section 2.4.2 to identify the root causes of GBV. The socio-ecological model below explains factors at the individual, relationship, community and societal level that influence the likelihood of sexual harassment occurring.



2.5.6.4 Consequences of Sexual Harassment

Victims	<ul style="list-style-type: none"> • HIV/STDs/abortions/unwanted pregnancies • Depression • Loss of respect for manager/supervisor/harasser • Fear to work with harasser/avoidance • Late salary • Favors granted if comply/not granted if don't comply • Demotion • Unwanted or forced transfers • Poor performance • Poor performance appraisal, failed promotion • Loss of job • Loss of self-confidence • Legal costs • Secondary trauma • Forced marriages
Perpetrators	<ul style="list-style-type: none"> • HIV/STDs • Being avoided/feared to work with • Conflict with victims • Loss of respect • Tainted reputation • Loss of job • Civil claims • Criminal charges • Incurrence of legal costs • Poor performance appraisal, failed promotion
Health services/ Organizational	<ul style="list-style-type: none"> • Absenteeism • Attrition (dismissal, resignation, transfer) • Lower productivity level • Not promoted/demoted • Professional dissatisfaction • Hostile, tense environment • Disrupted team work • Avoidance of harasser • Supervisor authority undermined • Violation of patient/community trust • Poor quality of care (barrier to use) • Tainted reputation • Clients coming late for services • Poorer client health • Poorer health seeking behavior • Incurrence of legal costs through industrial actions • Criminal charges • Civil claims
Societal	<ul style="list-style-type: none"> • Decreased productivity • Decreased GDP • Reinforcement of patriarchal norms • Poorer health of citizens • Violation of human rights which brings negative consequences for both the state and individuals

2.5.6.5 Prevention Strategies

The most effective weapon against sexual harassment is prevention. If it is not prevented, sexual harassment cannot disappear on its own without taking deliberate interventions to address it. These include;

a. Stakeholder Induction

The management should ensure that all newly recruited staff are inducted and oriented on nature, magnitude and effects of sexual harassments on individual workers and service delivery. The staff should also be oriented on reporting and management procedures of sexual harassment cases. This will require inclusion of a session on sexual harassment in the induction programme.

b. Integrating sexual harassment into curriculum for Pre-service and in-service training/ continuous professional development for all health workers.

Sexual harassment should be integrated into curriculum of pre-service and in-service training and continuous professional development for all health workers so as to create awareness.

c. Issuing Administrative Circular on Sexual Harassment

The Ministry of Health in collaboration with the Ministry of Public Service, should regularly issue out Administrative Circular to all Local governments, Health Departments and Health Institutions including Private not for Profits to provide guidance and mechanisms and systems to prevent and combat sexual harassments.

d. Evidence and Action-based research on Sexual harassment

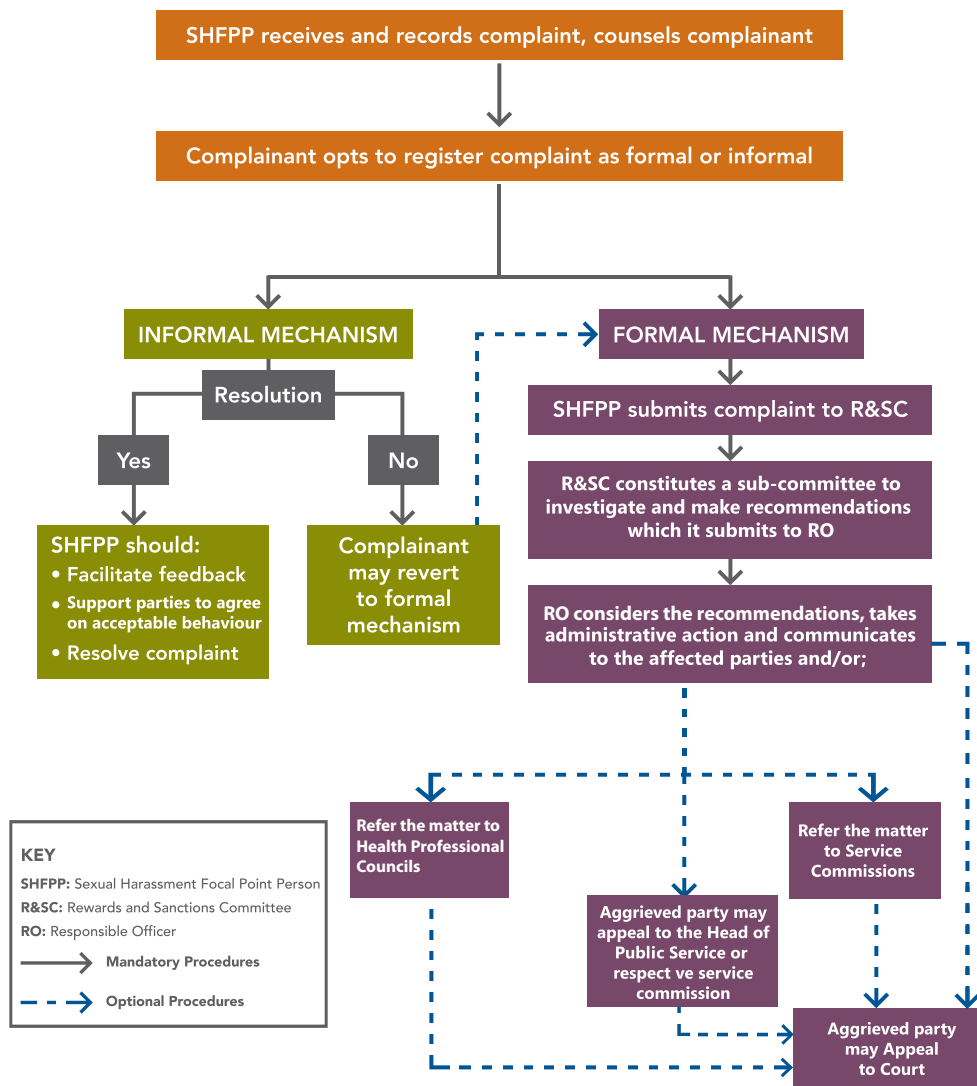
The MOH and stakeholders should continuously conduct evidence and action based research that highlights the root causes and complexities of sexual harassment and developing a culture that is responsive to diversities. MOH in collaboration with partners and stakeholders (MGLSD) should build capacity of national, regional hospitals and district local governments to conduct action research at respective levels.

e. Regular reviews of preventive mechanisms put in place

The MOH should conduct reviews of the preventive strategies implemented and evaluate their effectiveness with a view of addressing the new emerging and dynamic challenges.

2.5.6.6 Reporting and Response mechanisms

This outlines a step by step process and procedures of reporting, investigating, determining and providing appropriate remedies of the cases reported.



Source: Guidelines to Implement the Policy on Prevention and Response to Sexual Harassment

Reporting Mechanisms

Complainant can use the following mechanisms to report cases of sexual harassment:

a. Sexual Harassment Focal Point Person

There will be a Sexual Harassment Focal Point Person (FPP) designated to receive and handle complaints of sexual harassment at all levels of health service delivery. Any person who is sexually harassed may report directly to the FPP.

b. Ministry of Health Call Center (0800-100-066)

The MoH has a central call center that receives all complaints and inquires on health issues. All calls with complaints of sexual harassment shall be directed to a focal point person for further management.

c. Suggestion Box

The Ministry of Health shall ensure there are suggestion boxes at all institutions within the health sector. When sexual harassment complaints are received, the complaint shall be directed to the Sexual Harassment Focal Point Person for further management.

d. Other

In addition to the above, in circumstances where the complainant is uncomfortable issuing their complaint to the SH FPP, he/she can report directly to:

- i. PS/CAO/HOSPITAL DIRECTOR/HOSPITAL DIRECTOR, Supervisors, Human Resource Officers, District Health Officers, and other relevant authorities.
Upon receipt of the complaint, these officials shall follow the procedure outlined in these guidelines.
- ii. Health Professional Councils, Equal Opportunities Commission, Inspectorate of Government, Uganda Human Rights Commission, and Police.

Response Mechanisms

i. Informal Complaints Procedure

Informal procedures emphasize early intervention to address violations before problems escalate. The hallmarks of the informal procedures are clear communications of expectations, a focus on future behavior, and maintaining confidentiality to protect the privacy of everyone involved.

A victim/survivor of sexual harassment who does not want to go through the formal system may opt for informal complaints procedure which must be settled within 7 working days, with the aim of resolving the complaint through deliberation.

The victim/survivor shall be at liberty to choose between the supervisor/manager or the SH FPP to mediate/facilitate the informal complaint. This facilitator (for conflicts of interest, see the note in section 5.2.2B "roles of duty bearers within the response mechanism") may address the complaint using some or all of the following actions:

1. Encourage formation of peer-to-peer groups to handle and resolve complaints of sexual harassment, should the concerned parties be willing. The peer group can guide the parties in reaching an amicable settlement which may include: apology, a commitment for non-reoccurrence, compensation as they may deem fit, among others. The peer-to-peer groups must be knowledgeable about sexual harassment and must give feedback to the FPP to determine the course of action.
2. It may be sufficient for the complainant/harassée or victim/survivor concerned to have an opportunity to explain to the offender that their conduct is not welcome.
3. The complainant/harassée or victim/survivor concerned may seek confidential advice on possible solutions from a supervisor, trusted colleague or an officer trained to deal with harassment issues.
4. The complainant/harassée or victim/survivor concerned may request a supervisor or relevant officer to privately and informally speak with the offender on their behalf.

By lodging an informal complaint, the complainant shall not be barred from seeking formal redress to the complaint.

ii. Formal Complaints Procedure:

The formal complaint process shall be no longer than 30 days from receipt of complaint to resolution.

A complainant/harassée shall not be required to exhaust all informal attempts of resolution before choosing to lodge a formal complaint.

Formal Investigation starts at two fronts: 1) when there is a disagreement at the informal level and the complainant/harassée decides to lodge a formal complaint or 2) when, from the start, the complainant/harassée indicated s/he wanted to lodge a formal complaint.

1. Upon receipt of the formal complaint, the FPP will (10 working days):
 - i. Document the complaint in detail;
 - a. In case of complaint of physical injury, the FPP shall immediately refer the claimant to the hospital or health facility for examination and treatment;
 - ii. Inform the PS/CAO/Facility In-Charge of the investigation;
 - iii. Conduct full investigation using Forms B1 and B2;
 - iv. Forward full investigation report to the R&S Sub-Committee.
2. R&S Sub-Committee will convene and review the investigation report (within 7 working days), and forward The Report of Findings (in Form C) the PS/CAO/Facility In-Charge with its findings and recommendations for consideration.
3. Upon receipt and consideration of the Report of Findings, the PS/CAO/Facility In-Charge will make final decision and communicate to the parties involved about the decisions and sanctions to be taken; (3 working days).
 - Where the parties are satisfied with the decision of the PS/CAO/Facility In-Charge, the complaint will be considered settled.
 - Where any of the parties is aggrieved, he/she may appeal.

iii. Patient/Client Sexual Harassment

In cases where there is sexual harassment between a patient/client and health worker:

- **Patient/client sexually harasses health worker:** The health worker shall report to the PS/CAO/Facility In-Charge in case the matter requires administrative response and where it is of a criminal nature shall, s/he is at liberty to take the matter to police.
- **Health worker sexually harasses patient/client:** The patient/client who is harassed is at liberty to report through any of the mechanisms outlined in section 5.2.2 or the police, among others.

iv. Substantiating a Claim of Harassment

The balance of probability should be sufficient to substantiate a claim, requiring that the dispute be decided in favor of the party whose claims are more likely to be true.

To substantiate a claim of sexual harassment, the R&S Sub-Committee must determine if the claim is a criminal offence warranting reference to the criminal justice system or if the conduct is calling for administrative redress. If the complaint is of a criminal nature such as rape, defilement, sexual or indecent assault, the case should be referred to the administrators of criminal justice system for further management. However, if the claim is not criminal in nature, the R&S Sub-Committee must determine if it is hostile work environment or quid pro quo, following the criterion below:

a. Hostile Work Environment:

The harassment is severe and regular enough to interfere with a complainant/harassée's ability to do their job and creates an offensive work environment. Some considerations include, among others:

- i. Whether the conduct was verbal or physical or both;
- ii. frequency of conduct;
- iii. whether the conduct was hostile, intimidating, and/or offensive;
- iv. whether the alleged harasser was a co-worker or a supervisor; and
- v. whether the victim feels the conduct interferes with their job performance.

Note: that isolated incidents of harassment may be sufficient to constitute a claim of sexual harassment.

b. Quid Pro Quo Sexual Harassment:

At least one instance of an individual extorting sexual favors in exchange for professional benefits has occurred. Given the power differential and coercive nature of quid pro quo sexual harassment, a complainant/harassée's compliance in providing sexual favors does not negate a claim of sexual harassment.

In determining if a claim of sexual harassment can be substantiated, the sub-committee should consider the different ways that individuals (men and women) may perceive sexual harassment. Evidence shows that women are more likely to view a situation as sexual harassment than men, particularly in instances of hostile environment sexual harassment. While an alleged perpetrator may not consider their conduct offensive, the complainant/harassée's perception of the behavior should be paramount in making a final decision.

v. Unsubstantiated Claims

If the complaint of sexual harassment is found to be unsubstantiated, the complaint will be dismissed.

vi. Retaliation

All parties involved in an investigation who acted in good faith will be protected from retaliation. Reminders of this prohibition against retaliation will be made during the investigation. If at any time anyone involved in the investigation, either as a complainant/harassée or as a witness, feels they have been retaliated against, they are encouraged to report it to the FPP or a supervisor, so it can be addressed immediately.

vii. Possible Sanctions

If the R & S Committee substantiates the claim of sexual harassment and recommends disciplinary sanctions to be imposed by the Responsible Person against the perpetrator, such sanctions should be proportional to the severity of the harassment. These sanctions will be determined in accordance with the existing laws and policies including, but not limited to: Employment Act (Sexual Harassment) Regulations, Public Service Standing Orders and Public Service Code of Conduct.

Some of the administrative sanctions may include: written warning or disciplinary measures in employees file; verbal warning and feedback on prohibited behavior; a “stay away” letter or restraining order; suspension of employment or of certification to practice; demotion; transfer of harasser with a report of the reason for transfer; termination from employment in the public health sector; and/or voluntary transfer of victim that avoids unintended, negative professional consequences. For cases which cannot be handled administratively, they will be referred to the criminal justice system especially when a criminal offence such as rape, defilement, indecent assault, molestation etc. has been committed.

Note: Instituting a criminal case against the perpetrator is not a bar to commencement of the administrative procedures. The two procedures can go on concurrently should the victim so choose.

The PS/CAO/Facility In-Charge shall ensure that the sanctions imposed on the perpetrator be implemented. The R & S sub-committee shall conduct regular checks to ensure that disciplinary sanctions imposed are being implemented. Additionally, the R & S Committee shall make annual reports to the PS/CAO/Facility In-Charge detailing the status of compliance with these guidelines.

viii. Appeal Procedure

Appeals shall be available to both parties, whether or not the complaint is confirmed or dismissed. Appeals are available up to 14 days after initial determination of the complaint. The aggrieved party shall notify the PS/CAO/Hospital Director of the intention to appeal in writing.

There are two appeal procedures:

1. Internal Appeal Procedure;

- b. The aggrieved party may appeal to the Public Service Commission, Health Service Commission or the District Service Commission for redress.
- c. The concerned Service Commission must hear and determine the appeal within 30 days.

4. External Appeal Procedure;

- e. The aggrieved party may appeal to the Commissioner Labor, District Labor Officer or the Industrial Court.
- f. In compliance with the Employment (Sexual Harassment) Regulations, 2012, the Commissioner Labor, District Labor Officer or the Industrial Court shall hear and determine the appeal.

More content and further reading on this sub-unit can be obtained from the Ministry of Health’s “Prevention and Response to Sexual Harassment: Facilitators’ Guide, 2018” developed by the Ministry of Health. Also refer to the Guidelines to Implement the Policy on Prevention and Response to Sexual Harassment for the Health Sector, 2018.

CONCLUSION

Investing in human rights and gender mainstreaming produces the double dividend of benefiting women and children and is pivotal to the health and social development of families, communities and nations. Gender equality and human rights-based approach aim to support better and more sustainable health outcomes. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction based on race, religion, political belief, economic or social condition. This right cannot be enjoyed fully when the socially marginalised groups are not taken into consideration. Thus, health managers, decision and policy makers, health sector workers and stakeholders are implored to ensure human rights approach and gender equality in health service delivery.



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