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Implementing rights-based accountability for sexual and reproductive health and rights in humanitarian settings

Issue Brief

Good-practice case study from Adjumani district, northern Uganda

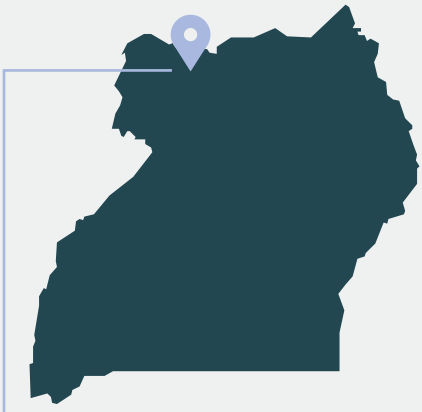
La Consult, 2021

The Accountability for SRHR pilot launched by the Center for Reproductive Rights and CARE International in Uganda promotes rights-based accountability through participatory, community-led mechanisms to improve the delivery of quality sexual and reproductive health services.

I. BACKGROUND

An estimated 35 million women of reproductive age and 29 million adolescents and young people require humanitarian assistance, and both need and have equal rights to essential and lifesaving sexual and reproductive health (SRH) services that are often limited and deprioritized in humanitarian settings.[1] Fragmented health systems, entrenchment of systemic inequalities and discrimination, and increased risk of gender-based violence (GBV), including sexual

International Health



Pagirinya refugee settlement Adjumani district

245,071 refugees
237,400 host population

violence, negatively impact access to SRH services, and undermine women's and girls' full enjoyment of human rights.[2]

International human rights law, including sexual and reproductive health and rights (SRHR), continues to apply in situations of armed conflict and is complementary to and mutually reinforcing of other bodies of international law, including international humanitarian law.[3] Incorporation and application of human rights standards within the humanitarian program cycle can strengthen accountability for access to SRH services in these settings.[4]

To realize accountability for SRHR, States are required to provide reparations when these rights are violated. Reparations must address root causes of violations including, inter alia, guarantees of non-recurrence and rehabilitation such as provision of medical services, including SRH information and services.[5] Indeed, without ensuring accountability for the SRHR of women and girls in humanitarian situations, key global and regional rights-based commitments cannot be achieved, including the Sustainable Development Goals and the African Union Agenda 2063.

The UN Technical Guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity sets out a circle of accountability to promote multiple forms of oversight, monitoring, and review at all stages of the humanitarian policy and program cycle, including through administrative, legal, political, and social accountability strategies. A circle of accountability centers the effective participation of rights-holders and focuses on building or strengthening existing accountability mechanisms to realize human rights.[6]

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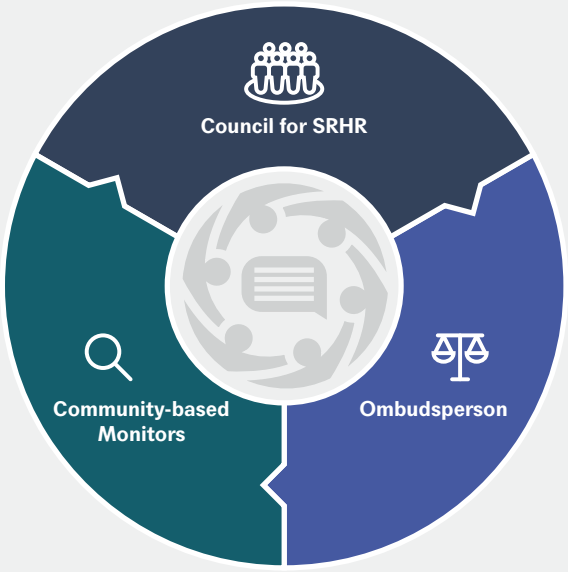
To address gaps in accountability for access to SRH services in humanitarian settings and advance innovative approaches to implement a circle of accountability for SRHR, the Center for Reproductive Rights and CARE International in Uganda piloted a rights-based community-led accountability model to document and remedy accountability deficits for SRHR in refugee response and post-conflict contexts in northern Uganda.

Community-led accountability mechanism to advance sexual and reproductive health and rights in northern Uganda

The Center for Reproductive Rights, in partnership with CARE International in Uganda, developed a rights-based social accountability model for collecting, reviewing, and ultimately remedying SRHR complaints in Pagirinya refugee settlement. The following model is comprised of three community-led structures and is implemented to monitor meaningful actions and outcomes related to SRHR.



Council for SRHR

Community representatives trained to inform their community of their rights and collect and review complaints

Ombudsperson

Independent third party selected by local government and humanitarian health system actors to review Council directed complaints and facilitate a meaningful response

Community-based Monitors

A network to relay decisions back to complainants and the community, ensures implementation of the redress measures happen and remain sustainable over time

II. OPERATIONALIZING RIGHTS-BASED ACCOUNTABILITY FOR SRHR IN NORTHERN UGANDA

The rights-based social accountability mechanism was integrated into existing humanitarian response and SRHR programs in Adjumani district, northern Uganda, one of the largest refugee hosting districts in the world. Guided by human rights standards and principles, the aim was to work inclusively with rights-holders (refugee and host community women and girls) and duty-bearers (district government and humanitarian health system actors) to establish a context-specific and responsive accountability mechanism for the collection, review, and response of service users' SRHR-related complaints and feedback.

The mechanism also provided access to an effective remedy when rights were not respected; resourced community-led monitoring of response plans; and guided changes to government and humanitarian actor policy and practice in line with a commitment to non-repetition of violations. While other rights-based accountability models may use different strategies, this case study is based on the refugee and post-conflict setting in northern Uganda and establishes an integrated three-part community-led structure.

Implementing human rights-based approaches at the level of response and bringing refugee and host women and girls closer to decisions that impact their lives, provides a pathway to solutions for complex SRHR issues in humanitarian settings. Evidence from the pilot program demonstrates that:

Intersectional Discrimination Undermines Access to SRH Services and Disproportionately Impacts Those Most Marginalized

Most SRHR-related complaints made to the Council for SRHR came from refugee women about experiences of disrespect and abuse during antenatal care (ANC) and delivery services at the settlement

health center. Women reported poor quality of basic obstetric care and being verbally abused. The Council also received complaints regarding arbitrary requirements for patients to purchase essential medicines and commodities out of pocket to receive services. Moreover, refugees reported to the Council and ombudsperson how structural barriers, such as lack of transportation or errors on refugee attestation cards, impeded timely access to the facility.

Complaints collected after the onset of COVID-19 highlighted the gendered and intersectional implications of the pandemic. There was a rapid increase in complaints regarding high unintended pregnancy and exposure to harmful practices, including early and forced marriage. Closure of schools in Uganda resulted in reduced access to menstrual hygiene dignity kits for girls; and girls outside the formal school system complained to the girls' representative on the Council for SRHR that existing dignity kit distribution did not meet their needs.

Access to Quality SRH Services and Information Contributes to an Effective Remedy When Rights Are Not Respected

The program supported rights-holders to understand human rights standards and navigate systems to claim their rights; and duty-bearers to meet their international, regional, and national obligations. Through the program, the district level government committed to increased oversight and monitoring of SRH services and outcomes in coordination with the integrated community structures.

Through the program, inaccessible medical equipment was remedied for women with disabilities by installing supportive timber lifts on delivery beds in one health center and resourcing the change through a formal budget audit process.

During peer-group workshops, adolescents frequently reported to the adolescent representative on the Council for SRHR a lack of confidential services and acceptable adolescent-centered information at health centers. In coordination with the adolescent representative on the Council for SRHR, health system actors revised clinic scheduling to include an adolescent block, where services and counselling were reserved for young persons. The facility also revised policies and practices within the medical supplies dispensing unit to reduce wait times for adolescents, which addressed confidentiality being maintained throughout their time at the facility.

The community accountability mechanism also enabled access to forms of restitution when services were denied, thereby protecting rights to equality and non-discrimination. For example, a district policy that limited access to anti-retroviral treatment (ART) for incoming refugees was reversed. The policy was revised to make ART available free of charge to all persons from the refugee community, with no distinction based on duration of registration in Uganda.

Full, Effective, and Meaningful Participation at All Stages of Policy and Planning Is Critical for Accountability

Inclusion and meaningful participation of refugee and host women and girls was vital for all stages of the program. Representatives across refugee and host communities (including adolescents and people with disabilities) served as members of the Council for SRHR, led identification of SRHR issues and challenges, and supported the conceptualization and design of the intervention. They built the trust and legitimacy needed for rights to be realized through the accountability mechanism. Meaningful participation strategies were designed for and by refugee and host women and girls, including adolescent and disability community solidarity groups that used song, drama, radio, and other approaches to sensitize information about human rights and SRH service access.

Engaging trusted and independent intermediaries is a promising approach to document and address complaints. Stigmatization of SRHR issues and a fear of reprisal prevented women and girls from raising rights violations through existing public forums, or feedback boxes, which often lack confidentiality, require levels of literacy, and tend not to close the accountability circle leaving complainants uncertain if their issue was heard, let alone addressed. Moreover, these approaches are often led by actors responsible for providing the basic needs and rights of refugees and marginalized women and girls.

Institutionalizing Accountability Mechanisms at the Level of Response Strengthens Humanitarian and Host Health Systems

Health system actors affirmed that by holding duty-bearers accountable for monitoring complaints and availing remedies through the pilot program, larger scale health systems improvements were achieved. Examples given by duty-bearers included "informing planning, building the capacity of the [health service delivery] staff, helping the community realize their rights, and having the coordination to bring on board different stakeholders." These results reflect some of the key building blocks of health systems strengthening (HSS) and demonstrate how integrating community-led accountability mechanisms within refugee response health systems may be instrumental in realizing HSS goals.

Ultimately, the community accountability mechanism was integrated into established processes such as quarterly district government

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> "Our role in the community is to make sure we give awareness of sexual and reproductive health and that women are aware of their rights... (we) are now empowered in leadership. When we collect the complaints from the community, now they go to the ombudsperson. As a result, our complaints are always collected and feedback given."
>
> *—Women's representative on Council for SRHR*

> "Through the accountability mechanism people knew their rights, so they could demand services at the health facility and for the services to be of quality… and when problems were being addressed, the clients were able to increase in number in accessing the SRH services."
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> *—Pagirinya refugee settlement duty-bearer*

> “Article 20(1) declares hu-man rights as including those that are inherent and not granted by the state. Specifically, Article 20(2) imposes a duty on all government organs, agencies, and persons to respect, promote and uphold every human right including health related ones. This is the premise for the implementation of the constitutional right to health as it creates obligations for both public and private duty bearers.”
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> *—Centre for Human Rights and Development (CEHURD) in the Regional Network for Equity in Health in East and Southern Africa (EQUINET), Review of constitutional provisions on the right to health in Uganda, 2018*

reporting, resource allocation decision-making through Health Management Units, humanitarian implementing partners’ operational budgets, and multi-actor technical sub-working groups on SRHR. Moreover, based on the acceptability and effectiveness of the model, a leading health service delivery partner adopted core components of the piloted complaints mechanism for expansion in two additional health centers.

III. LEGAL FRAMEWORK

The Constitution of Uganda “is the supreme law of Uganda and [has] binding force on all authorities and persons throughout Uganda.”[7] Notably the Constitution enshrines rights that are relevant to health and reproductive health, including the right to life (Article 22), respect of human dignity and freedom from torture, cruel, inhumane and degrading treatment (Article 24), the right to a clean and healthy environment (Article 39), the right to found a family (Article 31), and access to information (Article 41).

The right to health is enshrined in the national objectives and directive principles of state policy (hereinafter “NODPSPs”). Specifically, NODPSP XIV which mandates the government to fulfil the right to health services and NODPSP XX which requires the state to take all practical measures to ensure the provision of basic medical services to the population.

A 2005 amendment of the Constitution of Uganda introduced Article 8A that “requires the state to be guided by national objectives and directives of state policy in applying or interpreting the constitution.”[8]

Uganda has ratified a wide range of international and regional human rights treaties that guarantee the right to the highest attainable standard of physical and mental health, including SRHR, and the many other rights related to SRHR, including the right to life, the right to privacy, and to information, non-discrimination, and to be free from torture and other ill-treatment. These include the International Covenant on Economic, Social and Cultural Rights (ICESCR); the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); the Convention on the Rights of the Child (CRC); and the African Charter on Human and Peoples’ Rights (Banjul Charter). Uganda has also ratified the Protocol to the African Charter on Human and People’s Rights (Maputo Protocol).[9] Thus, the country has an obligation to respect, protect, uphold, and promote women’s right to have accessible, available, acceptable, and quality sexual and reproductive healthcare, in a non-discriminatory manner.

The Uganda Refugees Act of 2006 affirms refugees' rights under international and regional human rights instruments, including CEDAW, the African Charter on Human and Peoples' Rights, and the Refugee Convention and its Protocol. In March 2017, Uganda launched a national Comprehensive Refugee Response Framework which includes the Education Response Plan (ERP) for Refugees and Host Communities. The ERP addresses the challenges menstruation poses to girls' ability to attend school; and the Health Sector Integrated Refugee Response Plan for 2019–2024, also seeks to improve sexual, reproductive, maternal, neonatal, child, and adolescent health.

Articulating the extent of Uganda's obligations to respect and fulfil the right to health, the High Court of Uganda has held that Uganda must adopt legislation, policies, and programs to ensure the realization of the right to the best attainable standard of physical and mental health, including SRHR, and take all the necessary steps, including financial and human-resource-related, to implement these laws, policies, and programs. The State must also take measures to improve maternal health services, which include access to family planning, pre-delivery and post-natal care, emergency obstetric services and access to information and the resources necessary to act on the information.[10]

IV. KEY RECOMMENDATIONS

To advance accountability for SRHR in humanitarian settings, States and other humanitarian stakeholders are recommended to:

1. Respect, protect, and fulfill the human rights, including SRHR of women and girls in humanitarian settings.
2. Recognize accountability as a human rights obligation, core human rights principle, and essential element of ensuring access to available, accessible, acceptable, quality, and non-discriminatory SRH services and information in humanitarian settings.
3. Eliminate barriers and increase the full, effective, and meaningful participation of women and girls at all levels of decision-making within humanitarian response, including throughout the development, implementation, monitoring, and evaluation of SRHR programs and policies in humanitarian and nexus contexts.
4. Institutionalize and strengthen participatory, community-led, and rights-based accountability mechanisms within humanitarian and host health systems delivering SRH services; and leverage existing complaint mechanisms and independent review to promote integration and coordination across humanitarian systems and actors.
5. Advance the evidence for implementing participatory, community-led, and rights-based accountability mechanisms at the level of humanitarian response to inform best practice on which strategies, policies, and action must be based.
6. Invest dedicated and sustained resources through official development assistance and cooperation for establishing and maintaining accountability mechanisms as part of meeting the demand for essential SRH services through humanitarian and SRHR programming.

ENDNOTES

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2. U.N. Human Rights Council (U.N. HRC), Resolution adopted by the Human Rights Council on 7 October 2020, (45th Sess., 2020), U.N. Doc. A/HRC/RES/45/29 (2020).

3. U.N. HRC, Follow-up on the application of the technical guidance on the application of a human rights-based approach to the implementation of pol-icies and programmes to reduce preventable maternal mortality and mor-bidity (39th Sess., 2018), para. 38, 62(j), U.N. Doc. A/HRC/39/26 (2018) [hereinafter U.N. HRC, Follow-up on the application of the technical guid-ance]; Center for Reproductive Rights, Ensuring Sexual and Reproductive Health and Rights of Women and Girls Affected by Conflict (2017), available at https://reproductiverights.org/breaking-through-a-guide-to-sexual-and-reproductive-health-and-rights/; CENTER FOR REPRODUCTIVE RIGHTS, BREAKING GROUND 2020 (2021), available at https://reproductiverights.org/sites/default/files/documents/Breaking-Ground-2020.pdf.

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5. CEDAW Committee, Gen. Recommendation No. 30, para. 77.

6. U.N. HRC, Follow-up on the application of the technical guidance; see al-so U.N. Office of the High Commissioner for Human Rights (OHCHR), Comprehensive approach to promoting, protecting and respecting women's and girls' full enjoyment of human rights in humanitarian situations, (49th Sess., 2022), U.N. Doc. A/HRC/49/37 (2022).

7. Constitution, 1995, art. 2(1) (Uganda).

8. Centre for Human Rights and Development (CEHURD) in the Regional Network for Equity in Health in East and Southern Africa (EQUINET), Review of Constitutional Provisions on the Right to Health in Uganda, page 14 (2018), available at https://www.equinetafrica.org/sites/default/files/uploads/documents/CEHURD%20Constitutional%20Review%20Sep2018.pdf.

9. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, adopted July 11, 2003, CAB/LEG/66.6 (entered into force Nov. 25, 2005).

10. Center for Health, Human Rights and Development (CEHURD) & 3 Ors v Attorney General (Constitutional Petition-2011/16) [2020] UGCC 12.

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