CIVIL SOCIETY PARTICIPATION IN HEALTH SECTOR PLANNING, BUDGETING, AND MONITORING IN SELECTED DISTRICTS IN UGANDA

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ABSTRACT

This article highlights some of the findings of a survey carried out by Action Group for Health, Human Rights and HIV/AIDS (AGHA) Uganda on health sector transparency, accountability and civil society participation in health sector budgeting and planning in selected districts of Uganda. It examines some components of participation including the right of access to information and the obligation of the state to seek the active and informed participation of the public in decision making. Uganda has embraced a participatory approach to developing plans and budgets for the health sector. However, some components of the right to participation in health-related decision making have not been fully embraced. The Ministry of Health has not taken adequate steps to ensure the active and informed participation of individuals and communities in health-related decisions. Health budgeting and planning is largely seen as a province for health planners and a few selected stakeholders. Moreover, limited information sharing and lack of capacity also undermine the ability of CSOs to meaningfully participate. This is magnified by the uncoordinated representation in planning even where there is an opportunity. These factors have been a major obstacle to meaningful participation.

I. INTRODUCTION

Public participation in decision making is an essential component of a rights-based approach to decision making and may result in a more accountable and transparent public sector. In the context of the right to health, the Committee on Economic, Social and Cultural Rights has reiterated that an important aspect of the right to health is, "the participation of the population in all health-related decision making at the community,

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national and international level."[1] Individuals and communities affected by health policy decisions are entitled to participate in the identification of priorities and targets that guide policy formulation.[2] This requires the active and informed participation of individuals and communities in health decisions that affect them with Government taking steps to facilitate effective participation of communities, by ensuring the right to seek and receive health-related information, the right to express views which are respected and the right to basic health education.[3] Meaningful participation also requires that special attention be given to the views and needs of the more vulnerable members of society including women, children, the elderly, persons with HIV/AIDS and other groups.[4]

Transparency within the health sector is a prerequisite for public participation. In the context of health sector planning and budgeting, transparency is defined as the full disclosure of all relevant policy and fiscal planning information in a timely and systematic manner.[5] The availability of information means decisions made will be backed by evidence. Civil society organizations (CSOs) in Uganda have a key role to play in monitoring the right to health by participating in health sector planning and budgeting at both the national and district levels. CSOs are important for public participation because in most cases they serve communities and various interest groups such as women, children, and people living with HIV/AIDS, among others. Their role and mandates put them in a unique position as they are often directly in touch with the communities they serve and therefore in position to effectively represent community interests.

The 1995 Constitution of Uganda underscores the importance of the active participation of all citizens at all levels.[6] Civil society organizations were involved in the development of the Poverty Eradication Action Plan (PEAP).[7] The Ministry of

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1. Committee on Economic, Social and Cultural Rights, General Comment 14, The Right to the Highest Attainable Standard of Health: E/C.12/2000/4, CESCR 11/08/2000 (hereinafter General Comment 14), para. 11.

2. PAUL HUNT, MISSION TO UGANDA: REPORT OF THE SPECIAL RAPPORTEUR ON THE RIGHT OF EVERYONE TO THE ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF PHYSICAL AND MENTAL HEALTH, E/CN.4/2006/48/Add.2 at 12.

3. HELEN POTTS, ACCOUNTABILITY AND THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH 10 (2008).

4. *Id.*

5. Daisy Owomugasho, *Uganda, in* BUDGET TRANSPARENCY AND PARTICIPATION: NINE AFRICAN CASE STUDIES (2007), at 282.

6. UGANDA CONST.(1995), art. 176(2)(b), and National Objectives and Directive Principles of State Policy.

7. GOVERNMENT OF UGANDA, POVERTY ERADICATION ACTION PLAN 6 (2000).

Health recently took steps to allow civil society organizations to participate in health sector planning, budgeting and monitoring at the national level. In 2005, owing partly to limited public participation in health planning, budgeting and monitoring, some Uganda Government officials mismanaged grant money from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFTAM).[8] Funds for AIDS, TB and malaria programs were misappropriated, creating skeptism from both donors and the international community on Uganda's ability to manage its grants.[9] As a result, the GFTAM required countries to have civil society representation in the Country Coordination Mechanisms (CCM) to participate in planning, but also to act as a watch dog on the use of resources.[10]

In 2007, the Action Group for Health, Human Rights and HIV/AIDS (AGHA) Uganda, launched a targeted campaign to build the capacity of selected Ugandan CSOs to advocate for government accountability and transparency in the health sector. AGHA and its partners developed a tool with a set of indicators and questions addressed to health planners and CSOs to monitor both the use of health resources and the level of civil society participation in health planning, budgeting, and monitoring at the national and district level. The questions were geared towards exploring the level and effectiveness of participation, as well as the barriers to CSO participation in the health sector in Uganda. The questions explored procedures taken in developing the national plan and district annual work plans, the parties involved in the planning process, the number and type of meetings attended by CSOs, whether CSOs were adequately prepared for meetings and if views were listened to, as well as the availability of health policy documents in lower level facilities, among others.

This article discusses the findings of this data collection process and explains some of the limitations which affect the level of civil society participation in health sector planning, budgeting and monitoring. First, this article gives a background to the survey and lays out the methodology used. Second, it provides a brief overview of the legal and policy framework for CSO participation in health decision making. Third, it explains the findings of the survey. Fourth, it briefly discusses the implications of the findings and finally draws conclusions. The findings reveal that health sector planning process at the national level is a collaborative process including various stakeholders

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8. Charles Wendo, *Why Global Fund Whip is Cracking Now*, THE NEW VISION, November 1, 2008, at 10; C. Natukunda, *Who is Responsible for What?* THE NEW VISION, November 1, 2008, at 11.

9. Wendo, *id.*

10. INTERNATIONAL TREATMENT PREPAREDNESS COALITION, MAKING GLOBAL FUND COUNTRY COORDINATING MECHANISMS WORK THROUGH FULL ENGAGEMENT OF CIVIL SOCIETY (Uganda Country Report, 2008), at 53.

which gives opportunity for CSO participation and allows health priorities and budgets to be influenced. However, the structures for CSO representation at the national level do not allow for democratic representation as there is no democratic process in place for selecting representatives.[11]

At the district level, although there are structures and policies in place to encourage CSO participation in health sector planning, budgeting and monitoring, the implementation of these policies and structures remains weak. The results suggest a variety of reasons for weak participation including a lack of open and transparent access to information regarding health budgets, resources, and policies, limited capacity of civil society in Uganda, a lack of coordination within civil society, and a lack of trust between CSOs and the political leadership. The Ministry of health and district planners have not taken adequate steps to facilitate effective participation of CSOs by ensuring the right to seek and receive health-related information, and the right to express views which are respected. Unless there is investment in a rights based approach to effective participation, CSO participation in health sector planning, budgeting and monitoring will remain minimal.

II. BACKGROUND

A. About AGHA

The Action Group for Health, Human Rights and HIV/AIDS (AGHA) is a non-governmental organization (NGO) founded in July 2003 to mobilize health professionals and health consumers to address issues of human rights as they relate to health, with a specific focus on HIV/AIDS.[12] AGHA brings together doctors, nurses, other health professionals, and NGOs and other institutions interested in promoting the right to health, to create local and national networks dedicated to global health advocacy.

Uganda is one of the poorest countries in the world and has a heavy burden of preventable infectious diseases.[13] Malaria constituents 15.4 percent of the total disease

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11. The Health Policy Advisory Committee has 2 elected civil society representatives. However, the procedure by which they were voted remains unclear to CSOs that do not belong to their coalitions.

12. For more information, see Action Group for Health, Human Rights and HIV/AIDS (AGHA) Uganda at <www.aghauganda.org>.

13. The Government of Uganda has reaffirmed its commitment to achieving the Millennium Development Goals (MDGs), which show extensive overlap with National Poverty Eradication Action Plan (PEAP). Through the Health Sector Strategic Plan (HSSP) I and II, Uganda has prioritized its

burden in the country.[14] About 100,000 children are HIV infected and 50,000 in need of Anti Retroviral Therapy (ART), but only 26 percent of those in need receive ART.[15] As of February 2009, about 160,000 patients had been initiated on ART which represents only 50 percent of those that are eligible for treatment.[16] Uganda has a fertility rate of 7.1, one of the highest in the world.[17] Neonatal and maternal conditions constitute the highest percentage of the burden of disease in the country at 20.8 percent.[18] Greater resources than available are needed to deal with the ever increasing population and high disease burden.

Corruption continues to be a problem in Uganda's health sector. The scandal over the mismanagement of GFTAM grants combined with less globally publicized but no less critical mismanagement of HIV, TB, and malaria medicines, threaten the health rights of the population. Weak monitoring systems in the government structures and laxity by the civil society and the public to aggressively monitor health sector spending have facilitated mismanagement of health sector funds. As a result, AGHA launched a targeted campaign to promote transparency and accountability in the health sector.

B. The Monitoring Tool

In order to better understand the engagement of civil society in health budgeting and monitoring in Uganda, AGHA developed a set of indicators for monitoring the use of health sector resources and civil society participation in Uganda. These indicators and the resulting data collection instruments were developed through participatory approaches involving other CSOs under the umbrella of Voice for Health Rights (VHR), a coalition of civil society organizations in the health sector. The purpose of the indicators was to assess the current status of accountability, transparency, and participation of civil society in the health sector in Uganda, in order to generate

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allocation of the limited resources for health as a commitment to progressively achieving the milestone of 15% of national budget for health by 2010, and the amount per capita that needs to be spent to meet the Uganda National Minimum Health Care Package. *See*, HSSP II, 2005/6-2009/10 (July 2005), at 1.

14. *Id.*, at 2.

15. Save the Children/Ministry of Gender, Labour and Social Development, *Calling for the Realization of the Rights of Orphans and Other Vulnerable Children*, THE NEW VISION, Friday November 21, 2008, at 38-39.

16. Ministry of Health, Press Statement on the Cut-off of CD4 Cell Count for Initiating New AIDS Patients on Anti-retroviral Treatment, February 10, 2009.

17. MINISTRY OF HEALTH, ANNUAL HEALTH SECTOR PERFORMANCE REPORT, 2006/2007; GOVERNMENT OF UGANDA, UGANDA DEMOGRAPHIC HEALTH SURVEY (2006).

18. *Id.*

information and data that could be used to inform and promote dialogue between health sector leadership and civil society, as well as the advocacy efforts by CSOs. The indicators and the resulting data collection tool focused on five areas of inquiry (i) Planning and financial accountability; (ii) Timeliness in release of funds; (iii) CSO meaningful participation; (iv) Access to information and (v) General management. The focus of discussion for this paper however is limited to health sector planning, CSO engagement and access to information which are directly linked to participation.

C. Methodology

1. The District Health System.— AGHA and its partners collected data in eight districts and at the national level. There are over 80 districts in Uganda each of which is individually responsible for management of its health services. The district is the key administrative unit in Uganda, with lower administrative units known as County, Sub-counties, parishes and villages.[19] The District Health System consists of various tiers under the overall direction of the District Health Officer (DHO).[20] Each district usually has a District Hospital and the district is sub divided into health sub-districts (HSDs). Each HSD has a Health Centre level IV (HC IV) and the head of the HSD is usually the officer in-charge of the HC IV. At a lower level, there are HC IIIs and HC IIs.[21] The DHO sends resources to the head of each HSD for use of all HCs in that HSD.

2. The Pilot-Test and Data Collection.—After the indicators and the data collection tool were developed by AGHA in consultation with its CSO Partners, it was piloted in Mukono district in March 2008. After the pilot phase, data was collected from seven other districts that were selected to represent each region of the country. The districts that participated were Bushenyi, Kitgum, Lyantonde, Mukono, Pallisa, Rakai, Soroti and Tororo. Whenever possible, AGHA and its partners worked with health sector civil society groups which were already active in these districts to help set appointments and collect the necessary data. Two methods were used to collect the data. First, at each district, one-on-one interviews were conducted with the District Health Officer (DHO) and the Accounts Officer at the District Health Office. The purpose of the personal interviews was to elicit responses from the district planners on

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19. Other departments include the District Educational Office and the District Forest Office.

20. The District Health System comprises a well-defined population living within a clearly delineated administrative and geographic boundary and includes all actors in the recognized spheres of health within the district. *See*, HSSP II, *supra* note 13, at 15.

21. *Id.*

the procedures for district planning and budgeting, and to get financial figures on the planned and actual funds available for implementing programs in the financial year 2006/2007. These interviews also helped to assess the availability and accuracy of information. Interviews were also conducted with two CSO representatives to the national Health Policy Advisory Committee, as well as the Assistant Commissioner Planning/Health Services at the Ministry of Health.

Second, Focus Group Discussions (FGDs) were conducted in seven districts with about 10 to 12 members of CSOs including one or two lower level health center managers. The intention of the focus groups was to develop a broad and deep understanding of the opinions of the CSO staff, healthcare managers at the health sub-district about the district planning process, particularly in relation to CSO participation in planning, and access to health information. The notes from the interviews and FGDs were then transcribed and compiled according to districts in a database designed in line with the various thematic areas. The research theme then identified the emerging ideas or patterns. The emergent patterns and connections within and between the categories were identified, and the relative importance of the different themes and interconnections highlighted.[22] The research team also collected and reviewed supplementary materials, from Government publications including the National Health Policy, Health Sector Strategic Plan II, and the 2007 Ministry of Health Transfers to the districts.

3. Challenges and Limitations of the Data.—Like any other research process, the data collection and data itself faced a number of challenges. First of all, the research team focused its efforts and interviews on the District Health Officer (DHO) and the Accounts staff in the DHOs office, as well as with CSOs in the district. The research team did not visit the office of the Chief Administrative Officer (CAO) who is the district accounting officer and the custodian of the district development plan and budget. Secondly, the research did not focus on the Health Unit Management Teams and the Village Health Teams which are supposed to be the structures at the health sub-districts that facilitate the involvement of communities in managing their health. This is largely because these structures are not yet functional and therefore could not be consulted in many districts. Collecting information about and from these teams would have provided another insight into the structures at the district level available to provide oversight and enhance public participation in health sector management.

22. ELLEN TAYLOR-POWELL & MARCUS RENNER, ANALYZING QUALITATIVE RESEARCH (2003).

III. LEGAL AND POLICY FRAMEWORK GOVERNING PUBLIC PARTICIPATION IN DECISION MAKING

Although Uganda's legal and policy framework that governs the health system has put in place measures to allow the public to participate in fiscal and policy planning and have access to public information, in practice there is greater public participation at the national than at the district level.

A. Legal Framework for Civil Society Participation at the National Level

1. Public Participation.—Under the 1995 Constitution and the 1997 Local Governments Act, responsibilities and power has been given to the people at the lower levels so that they can participate in governance by managing their own affairs.[23]

2. Access to Information.—Access to information in government possession is one of the ways of strengthening the culture of transparency and accountability in the public sector, and is a pre-requisite for public participation in decision making. In furtherance of public participation, the 1995 Constitution also guarantees the right of access to information. Article 41 (1) guarantees the right of access to public information.[24]

3. The Right to Health.—Uganda's legal framework does not expressly provide for either the right to health, or public participation in health related decision making, but some provisions in the law make reference to the right to health. The 1995 Constitution obliges the state to take practical measures to ensure the provision of basic

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23. Article 176 (1) of the Constitution states that decentralization shall be based on the district as a unit under which there shall be such lower local and administrative units as Parliament may by law provide. The lower administrative units on which the health sub districts are based—the county, sub county, parish and village are created by the Local Government Act, 1997.

24. Article 41 provides: "Every citizen has a right of access to information in the possession of the State or any other organ or agency of the State except where the release of the information is likely to prejudice the security or sovereignty of the State or interfere with the right to the privacy of any other person." The Access to Information Act, 2005 was enacted to promote an efficient, effective, transparent and accountable Government. The Act also seeks to promote transparency and accountability in all organs of the state by providing the public with timely, accessible and accurate information. This will empower the public to effectively scrutinize and participate in government decisions that affect them. However, the rules of procedure to regulate the procedures of this Act have however never been made hence delaying the effective operationalization of the law.

medical services to the population.[25] Article 39 recognizes the right of every Ugandan to a healthy and clean environment. Article 45 recognizes that all those rights, including the right to health, which are not mentioned explicitly shall not be disregarded. Uganda is a party to the International Covenant on Economic, Social and Cultural Rights which recognizes the right of individuals and communities to participation in health-related decision-making.

B. The Policy Framework

The Ministry of Health (MoH) has created structures and policies which allow civil society to participate in health planning. The National Health Policy (NHP) calls for a sector wide approach (SWAp) to health policy formulation.[26] The Health Sector Strategic Plan (HSSP) II (2005/06–2009/10), which provides the strategy for implementing the National Health Policy was developed through an intensive and interactive process that involved all key stakeholders in health development in Uganda. There are key structures and processes that facilitate the participation of various stakeholders including civil society representatives in health sector planning. The major one is the Health Policy Advisory Committee (HPAC). HPAC provides policy guidance to the sector and allows for civil society representation through two civil society organizational representatives. The heads of department at MoH have been proactive in involving CSOs in HPAC, but civil society organizations also advocated for representation on this committee. The Civil Society representatives were formally selected to sit on HPAC by the MoH, and HPAC currently doubles as the Country Coordination Mechanism (CCM) for the GFTAM.[27]

There is a growing recognition and appreciation of the role of CSOs in health sector planning at HPAC. As a result, CSOs are increasingly influencing policy at the national level. One CSO representative on HPAC felt that representation was effective because her views are taken into consideration, and the views of the CSO representatives are increasingly considered in decision-making.[28] At the moment, a CSO representative is the Vice Chairperson of HPAC lending credibility to CSO representation at this forum.[29] However, civil society is starting to question the mode

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25. Objective XX of the 1995 Constitution of Uganda.

26. MINISTRY OF HEALTH, NATIONAL HEALTH POLICY 7 (1999).

27. Interview with Enid Wamani, Vice Chairperson, HPAC September 22, 2008. See also, INTERNATIONAL TREATMENT PREPAREDNESS COALITION, *supra* note 10.

28. Interview with Enid Wamani, *id.*

29. Interview with Robinah Katiritimba, Uganda National Health Consumers Organization, October 2008.

by which the current representatives were selected.[30] The two persons on HPAC represent over 1000 CSOs carrying out health related activities. The MoH required CSOs at the national level to select their representatives and then forward the names to the MOH with evidence in form of minutes of the meeting. The names forwarded came from only two constituencies—CSOs working in malaria related activities and a coalition known as Voice for Health Rights.[31] Other organizations outside these networks did not get a chance to participate in this decision making process.

The Annual Government of Uganda (GoU)/Development Partner (DP) Joint Review Mission (JRM) is another mechanism for civil society participation in health sector planning. Through the JRM, the MOH invites CSOs and other stakeholders to review the Annual Health Sector Performance Report and determine whether overall performance has been satisfactory. The JRM also sets the priorities for the following year at the strategic level, through the identification of priority technical programmes, agreeing to undertakings and determining broad allocations for the budget cycle. AGHA participated in the JRMs in 2007 and 2008, and also contributed to a report on health sector performance in Kitgum district in 2008. Lastly, there is the National Health Assembly (NHA) which was created to provide an annual forum for the central and local governments, civil society, and development partners to review sector policy, plans and performance.

Although there is an increasing recognition of the role of CSOs in policy formulation at the national level, CSOs still face a number of challenges. Firstly, CSOs generally do not have a single voice. Each CSO, even while representing civil society in HPAC, has a mandate it adheres to, and a constituency it represents which is generally narrow. CSOs therefore do not speak as one voice. As one of the HPAC CSO representative stated, "I remain accountable to my constituency … the few issues I have raised have been listened to…."[32] This is largely because there is no set criteria for selecting CSO representatives at these structures. Selection is based on prominence or visibility of a particular CSO within the Ministry of Health and a few selected coalitions.[33] Secondly, although the CSOs that participate in these fora are required to

30. Minutes of AGHA meeting with CSO representatives, November 6, 2008.

31. Malaria and Early Childhood Illness NGO Secretariat (MACIS), UNHCO. By virtue of their nationwide scope of work, other representation comes from The AIDS Support Organization (TASO), African Medical Research Foundation (AMREF), and the Private Not for Profit Institutions like the Uganda Catholic Medical Bureau, the Uganda Protestant Medical Bureau, Uganda Muslim Medical Bureau and the Private sector including Uganda Manufacturers Association.

32. *Id.*

33. Interview with Dr. George Bagambisa, Assistant Commissioner Health Services/Planning, Ministry of Health, September 28, 2008.

provide feedback to the people they represent, this does not always happen. The feedback that is provided is usually only given to the smaller constituency that the CSO represents, and not to civil society as a whole. Thirdly, CSOs are very many in number, diverse in mandate, most of them uncoordinated, and struggling even to keep their projects running due to limited resources. Compared to the Development Partners (DP) who are said to be well coordinated, the majority of the CSOs lack the human resource and financial capacity to engage in public policy formulation.

During a consultative meeting AGHA held with CSO representatives from Kitgum District, they raised the concern that development partners have a stronger voice in decision making because they provide technical and financial support both at the district and national level.[34] One CSO representative at HPAC reiterated the need for her constituency to build their technical capacity by familiarizing themselves with working documents like the National Health Policy, the HSSP, the Millennium Development Goals, and other guiding documents.[35] There is a growing recognition and visibility of CSOs at the national level, which provides a good opportunity to make involvement effective. The window is open for CSO participation at the national level. The challenge is therefore for CSOs to effectively coordinate themselves to ensure transparent and democratic representation.

C. Framework for Public/CSO Participation at District Level

Whereas the mechanism for CSO participation at the national level has been somewhat streamlined through structures and processes, there is still need for greater operationalization and restructuring of the mechanisms for collaboration between districts, health sub-districts and CSOs. The National Health Policy broadly provides for a collaborative mechanism between communities and local health authorities, but does not explicitly lay down procedures for consultation and collaboration.

At the district level, the District Health Teams (DHTs) were established as a technical group charged with the responsibility of planning, budgeting, coordinating resource mobilization, and monitoring of overall district performance.[36] The DHTs, alongside the diverse partners including CSOs and DPs develop the District Health Sector Strategic Plan, which in turn is an integral part of the rolling District Development Plan. The Chief Administrative Officer (CAO) holds an annual conference to review the district budget which is passed by the District Council. In

34. AGHA-CSO Meeting, *supra* note 30.
35. Interview with Robinah Kaitiritimba, CSO Representative on HPAC, October 2008.
36. HSSP II, *supra* note 13, at 19.

some districts, CSOs are allowed to passively participate in the annual budget conference. The NHP established the Health Sub-District (HSD) as a functional sub-division or service zone of the district health system to bring quality essential care closer to the people, allow for identification of local priorities, and more importantly involve communities in the planning and management of health services and increase responsiveness to local needs.[37] Each HSD management team is expected to provide overall day to day management oversight of the health units and community level health activities under its jurisdiction.[38] Community participation at village level is supposed to be coordinated by a network of functional Village Health Teams (VHTs) who facilitate the process of community mobilization and empowerment for health action.[39] Each village is supposed to have a VHT comprised of 9-10 people selected by the village (LCI).[40] The VHT is responsible for: mobilization of additional resources and monitoring of utilization of all resources for their health programs including the performance of health centres.[41] In reality, these teams are not yet in place in most districts due to lack of resources for training and supporting these teams.

IV. FINDINGS

A. District Health Planning

1. Procedures for District Development Plans.—According to the data collected through the survey, there were no clearly set standard procedures for developing the district development plans and therefore involving stakeholders like CSOs. The procedures varied from district to district. On the whole, district priorities are developed through meetings organized by planners from the District Technical Planning Committee (DTPC). The DTPC calls budget planning meetings to develop a work plan. Generally the districts have a bottom-up approach. Views are collected from lower level committees at the sub district and parish levels. Four DHOs reported that views are also obtained from staff of various departments who meet under different sectors. While in four of the districts it was reported that the budget meetings are attended by sub county leaders, in the other four, only the heads of the various district departments attend. The criteria used in identifying stakeholders for the planning

37. NHP, § 5.3.
38. *Id.*, HSSP II, *supra* note 13, at 19.
39. *Id.*, at 20-21.
40. *Id.*
41. *Id.*

process varied from district to district. One DHO said the CAO identifies a team and the Chief Finance Officer (CFO) chairs the meeting. Another DHO said it was the DTPC. Yet another DHO said identification of stakeholders is based on the guidelines set by the Ministry of Local Government. There was a general feeling that little or no representation of CSOs exists at the lower levels because most CSOs do not have branches at the lower levels. Furthermore, there may be no funds to support such meetings at the lower levels: "*At the sub-county, they [CSOs] are not there because they [the sub-county leaders] may not have funds to facilitate these meetings.*"[42] Respondents did note that at the lower levels, there are supposed to be village health teams (VHTs) which comprise of community members who participate in the management of health facilities, but these VHTs are not functional which limits civil society participation. The variation in the procedure highlights the need to develop standard guidelines for development of district plans, particularly priorities for health. There is also need to develop clear standards or criteria to identify stakeholders who should be involved in the development of the district plan and to hold district leadership accountable to following these standards. These stakeholders should include CSOs that carry out health-related activities in the districts concerned.

2. Staff Involvement in Planning.—Health Unit management staff have considerable expertise about community needs because of their experience within the health centers. These key stakeholders must be involved in the planning cycle early enough to ensure that the budgets and work plans address the needs they identify in their work. In all the districts surveyed, health facility staff were involved in planning and budgeting, but lower-level health unit staff who are closest to the community were only involved in the planning process at a later stage. A FGD Participant from Kitgum said, "*I think the district should conduct studies so that the planning process is informed by current information.*"[43] Health unit staff from all levels could help bring this current information to the planning process.

B. CSO Meaningful Participation

According to one CSO representative, meaningful participation is defined as, "Participating to understand and to contribute, as well as to monitor implementation."[44] By definition, meaningful participation should also include the ability to participate in

42. FGD, Soroti.
43. FGD, Kitgum.
44. Interview with Robinah Kaitititimba, *supra* note 35.

a way that actually influences policy. The data collected at the district level provided little evidence that civil society is able to influence policy, contribute to or even monitor implementation of policies.

1. The Number of Interest Groups.—In terms of the number of interest groups represented, there was a general feeling that the numbers (1-2 people) of CSOs represented on district health planning meetings and lower council level was small. There is a secretary for health who sits on the District Council and is supposed to act as a community representative. However, CSO representatives felt that many other interest and vulnerable groups such as people living with HIV/AIDS, youth, the elderly were not adequately represented on the district health committee.[45] Yet meaningful participation requires that special attention be given to the views of vulnerable groups and information should be shared with the more vulnerable members of society to enhance participatory methods.

2. Number of Planning Meetings—Concerning the number of meetings, FGD participants indicated that the number of District Council and Sub County council health related meetings were high (average of eight per year). Although the number seemed high, some FGD participants felt that measuring the proportion of the meetings they attended was a challenge, given that there were some meetings to which they were not invited: "*When we are not invited, we can't even know that meetings take place.*"[46] However some respondents reported that they successfully attended all the scheduled meetings. *"I think for HIV Committee, I was able to attend all the meetings planned in that financial year."*[47] There are no clear benchmarks or guidelines on the number and even the type of meetings that CSOs should attend in a year. The District AIDS Committee (DAC) was often cited by respondents as a committee where there is good CSO representation and participation.[48] Yet recently the DACs have been crippled by lack of resources for coordination of meetings: "*These District AIDS Committees were active when they were funded by Uganda AIDS Commission but since it closed we have not had any meetings because of funds.*"[49]

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45. FGD.
46. FGD Participant, Lyantonde.
47. FGD Participant, Lyantonde.
48. However, there was some concern about insufficient provision for participation of PLHA on the DACs.
49. FGD Participant, Tororo.

3. Notice for Meetings.—While CSOs are sometimes invited to the annual budget conference, this is the last stage of the district planning process and does not give ample opportunity for influencing priorities. In some districts, CSOs are given very short notice of the meetings limiting their ability to prepare adequately. Even the District Councillors may receive the district budget the day before the Budget Conference, limiting their time to adequately prepare for deliberations.[50] In some cases, even when notice is sufficient, members of the community and CSOs do not want to attend the meeting because they do not recognize or understand their role in budgeting or in monitoring the spending of funds: *"I think the public is involved but it's not maximum as some of them are not aware, they don't know what is being planned and budgeted. Those who know may participate at parish level but when it comes to implementation, they don't see where the money goes. So when it comes to calling people to come and plan, they* [the community*] say, 'Why should I go? After all I don't see where the money goes."*[51]

The audit also found that meaningful participation and engagement of CSOs is limited by mutual mistrust between some of the organizations and district planners. Some district officials were implicated in the misuse of monies from the Global Fund, and in some cases district officials have been found to divert public drugs to private clinics. CSOs in Kitgum were frustrated by the fact that a number of government staff arrested for stealing drugs have been released without trial.[52] CSOs also complained that they are not involved in the management of funds received after they have been disbursed. Their limited involvement ends at the planning process. On the other hand, it was mentioned that CSOs too had elements of corruption. District officials pointed out that some CSOs are reluctant to share their work plans and budgets with district officials. CSOs also do not engage Government in the planning and management of their resources

Generally, there is limited CSO engagement in implementation. For progress to be achieved in the government obligation to enhance public participation in decision making, there is certainly strong need to engage CSOs in implementation, given their networks of resource persons at the grassroot level. If CSO participation is to be meaningful, those involved must be adequately informed and facilitated to participate. CSOs and indeed all public officials involved in health planning must be aware of the number and type of planning meetings they are to attend in a year, the agenda for these meetings, the relevant documents that facilitate these meetings, and must be given all

50. AGHA-CSO Meeting, *supra* note 30.
51. FGD Participant, Kitgum.
52. *Id.*

the relevant information in adequate time to prepare for these meetings. This is what active and informed participation entails otherwise participation will amount to mere representation that does not influence decision making.

4. Challenges Faced.—Challenges to effective CSO participation cited included lack of information, lack of coordination amongst CSOs, inadequate skills to advocate and lobby, and mistrust between CSOs and public/civil servants. In order to achieve meaningful participation, there must be transparency and accountability to build trust, proper and timely communication, training in lobbying and advocacy skills, and an emphasis on the principal of participatory methods where civil society is represented and consulted at all levels. The existing mechanism of public engagement must be strengthened and based on participatory approaches, which includes routine meetings, joint planning right from the onset of the planning cycle, and joint implementation.

C. Access to Information

Access to health related information is a crucial aspect of meaningful participation. The majority of respondents reported that there was some access to information either on request or voluntarily, but capacity constraints such as inadequate or lack of human resources, infrastructure, equipment and logistics were also identified to be hampering the flow of information. Respondents also stated that some stakeholders guard the information in a jealous manner, instead of sharing it broadly with others. There is certainly a strong need for the districts to develop clear information dissemination strategies, ideally leveraging the existing mechanisms. FGD respondents from Bushenyi said, "*The government should always give information, and we shouldn't struggle for the information. For example, the district has not bothered to tell us that at such a health centre there are ARVs so that people can go there for treatment*."[53] Staff in the health facilities did not have adequate access to relevant policies such as Human Resource and Financial Policies, National Health Policy and the Health Sector Strategic Plan. Inaccessibility to relevant policies and documents can contribute to poor conceptualization and misinterpretation of issues, which will greatly impact on the quality of service delivery. Health sector staff and stakeholders must be oriented on the existing policies that affect their work.

53. FGD, Bushenyi.

V. DISCUSSION OF FINDINGS

Uganda has embraced a participatory approach to developing plans and budgets for the health sector. Considerable progress has been made in implementing the decentralization strategy envisioned in the Constitution and National Health Policy. However, some components of the right to participation in health-related decision making have not been fully embraced. The human rights approach to participation requires the active and informed participation of individuals and communities in health decisions that affect them. Government is obliged to take steps to facilitate the effective participation of communities, by ensuring the right to seek and receive health-related information, the right to express views which are respected, and the right to basic health education.

The findings of this survey however suggest that the Ministry of Health has not taken adequate steps to ensure the active and informed participation of individuals and communities in health decisions. Not much has been done to educate the public, District Council Members, and CSOs about the right to participation in planning, the right to seek and receive health planning information, and the right to express views that are respected. This is manifested by the fact that many health facility staff do not have access to basic planning documents such as the HSSP, NHP, as well as by the mistrust between CSOs and District Health Planners. Health planning is largely seen as the role of health planners and a few selected stakeholders. Moreover, limited information sharing and lack of capacity also undermines the ability of CSOs to meaningfully participate, magnified by the uncoordinated representation in planning even where there is an opportunity. These factors have been major obstacles to meaningful participation.

A. Lack of Active and Informed Involvement

Although the structures for CSO representation at the national level have been set out through processes such as HPAC and its working groups, these structures have not yet been developed at the district level. Some CSOs have participated in meetings at the Districts but have not been officially elected by other CSOs as their representatives. The number and type of meetings to be attended by CSOs has also not been defined. In some districts, CSO involvement in budgeting comes too late because by the time they get involved, decisions about the budgets have already been made.

B. Limited Information Sharing

Participation requires that information should be available and not withheld if tangible health-related decisions are to be taken. Yet, not much has been done to educate the planners at the district and CSOs about the importance of information sharing in health-related decision making. Joint planning at the districts is limited by the lack of trust between CSOs and District Health Officials and the exchange of allegations of corruption. As a result, there is limited information sharing between CSOs and District Health Officials. CSOs and DHOs should share information that will facilitate the plans for the communities that they serve.

C. Lack of Technical Capacity

Another limitation affecting participation is the lack of technical capacity on the part of some CSOs. At both the district and national level, some CSO representatives lack the capacity to understand technical issues of health policy planning including health priorities and strategies in the MDGs, PEAP, the NHP and the HSSP. Moreover, CSOs are diverse, understaffed, and poorly facilitated. This limits their ability to fully participate in health sector planning. Yet where information is guarded jealously, CSOs will remain under capacitated, and unable to engage in meaningful discussions with health planners.

D. Uncoordinated Representation

There are no set criteria or guidelines for CSO representation in health sector planning both at the national and district level. Therefore, there is a general problem of uncoordinated representation. At the national level, CSOs are selected on the basis of prominence and visibility of their leadership.

Additionally, inadequate feedback mechanisms hinder civil society representatives from truly representing broader civil society in health sector planning and decision making. CSO representatives are supposed to bring information back to their constituents—some are better at this than others. However, because CSOs at health planning processes are not representative of all the CSOs, there is a problem of giving feedback to those they are supposed to represent. This limits not only the ability of the represented to understand their role in health sector planning, but also raises the question as to who is being represented. The process for choosing these representatives is not clear or transparent, which also contributes to concerns within the sector about how they are being represented at the policy level. All this is magnified by the fact that

coordination of civil society is still weak in Uganda, and CSOs still do not have a unified voice while representing others. This is largely because CSOs have varied mandates and are diverse except for the UAC Partnership committee. Without a common forum for consultation and providing feedback, there is a risk that the few CSOs involved in health sector planning represent only very limited constituencies or interests.

VI. CONCLUSION

A policy and legal framework for public participation in planning and governance exists in Uganda. But this framework does not comprehensively embrace a human rights perspective. This is because Government officials in the health sector, particularly at the district level, have not taken steps to facilitate effective participation of communities. Not much has been done to ensure the right to seek and receive health-related information, and the right to express views which are respected. As a result, health planners and CSOs have not understood the need for CSO engagement and therefore information sharing. This is magnified by the fact that CSOs remain uncoordinated, diverse and with varying interests. The district level planners need to take steps to actively engage CSOs in planning by providing them with information on time, and engaging them at the onset of the planning process. CSOs on their part must devise means of coordinating their activities so as to ensure that representation is democratic, feedback to others is provided, and that they have a unified voice. CSO representatives must also enhance their capacity to understand technical issues in health planning to enable them to meaningfully influence health decision making.