# People and Their Health Systems: The Right to Universal Health Coverage and the SDGs in Africa

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## Contents

**Abstract**  The right to health is recognized as a basic human right in various United Nations official documents and in the founding principles of the World Health Organization whose constitution envisaged a right to the highest attainable standard of health for everyone. The health implications of the SDGs is linked to fundamental Human rights that the 2030 Agenda is anticipated to contribute extensively to (see footnotes 9, 10, 11).

We discuss the ability of Sub-Saharan African countries to protect the health rights of its populations given the challenges of poor economic development and significant poverty levels though some countries (Rwanda, Ethiopia, Ghana, etc.) have improved health services coverage by removing financial barriers. The right to health can be expensive and African countries did increase their health budgets, as decided in the "Abuja Declaration" target of allocating 15% of overall government budgets to health. Between 1990 and 2013 this allocation did increase from an average of 3.7% to 11.4%.

Attaining health rights in Africa requires certain policy emphases including protections from catastrophic expenditures for health, ensuring access to quality health services, and building effective "voice" for populations to exercise their rights. Enablers of health rights should include good policy and governance, with expanded social movements; and SSA countries should seize upon crises such as the

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Ebola outbreak to expand health rights. Scarce resources may mean rationing of health services, and it will be important to identify and utilize innovations and ICT technology that can help to make access to health care rights a reality for all.

# 1   Introduction

The right to health has been recognized as a basic human right in various United Nations official documents and is part of the founding principles of the World Health Organization whose constitution envisaged a right to "a state of complete physical, mental and social well-being, not merely the absence of disease" and recognizes a "right to the highest attainable standard of health" as a fundamental human right for all persons. This right to health entails the access to timely, adequate and reasonably priced health care which is still a problem for billions of poor and vulnerable peoples globally. The right to health is closely interrelated with other human rights such as the right to education, food, work, housing, non-discrimination and access to information.[1]

In September 2015, UN member states adopted unanimously the 2030 Agenda for Sustainable Development and its set of 17 Sustainable Development Goals (SDGs) with 169 targets aimed at achieving holistic economic and social sustainable development.[2,3] The 2030 Agenda and its Sustainable Development Goals are integrally linked to the human rights obligations of all UN Member States' as indicated in international human rights agreements and various international and regional instruments (see footnote 3).[4] The SDGs recognize and promote all human rights, along with gender equality and the empowerment of women and girls[5,6] and there is clearly progressive recognition that human rights are crucial to the achievement of sustainable development (see footnotes 7, 8).

The 2030 Agenda identifies human rights as being fundamental to the SDGs, and highlights the Agenda's basis in the Universal Declaration of Human Rights and international human rights treaties and therefore emphasizes the obligation of member states to respect, defend and support human rights and fundamental freedoms for all, without discrimination with respect to race, colour, sex, language, religion, political or other opinions, national and social origin, property, birth, disability or other status. It emphasizes the right to the various freedoms from non-consensual actions, and entitlement to a broad set of cares and services without discrimination. It

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[1]WHO (2017a).

[2]Dattler et al. (2016).

[3]United Nations, Office of the High Commissioner for Human Rights (2015a, b).

[4]Plan International (2016).

[5]United Nations, Office of the High Commissioner for Human Rights (2015a, b).

[6]United Nations (2015b).

also emphasized the interdependency and inter-relatedness of all rights (see footnote 6).[7] Health rights will benefit from the institution of fundamental human rights everywhere.

The SDGs focus on availability, accessibility, affordability and quality of education, health, water and other services which gives practical reality to human rights.[8] Its goals and targets include access to safe, healthy and adequate food for all, universal health coverage, free equitable and quality primary and secondary education, access to safe and affordable water, sanitation, hygiene and housing, and access to "safe, effective, quality and affordable essential medicines and vaccines for all" (see footnote 7), a strong emphasis on health. The SDGs health implications and its links to fundamental human rights is therefore quite clearly stated and it is anticipated that the goals shall contribute extensively to the realization of human rights[9,10] as practical tools for development and not just as abstract ideologies.[11] Commitments to the SDGs are political, however prior human rights treaties are legally binding on the states that have ratified them and this should encourage effective advocacy action on realizing their human rights obligations.[12]

Good governance and stewardship at all levels is critical to attaining human rights, through the rule of law, democracy, access to justice and to information, transparency and accountability, and the peace and security that is essential for sustainable development. The UN's crucial role in facilitating global governance means an operational United Nations system would have an important role to play towards attainment of the sustainable development goals and its implications of assuring human rights.[13,14] The WHO as a UN Specialized agency has an important role to play in the realization of health rights as part of other human rights.

## 2   Health Rights Are a Challenge for Low Income Countries

The ability of Sub-Saharan Africa to protect all the rights of its populations is hampered by poor economic performance, significant poverty levels and relatively low literacy rates in many communities. In some settings, political systems may appear to undermine fundamental access to rights including health rights and with good governance considered a prerequisite for rights based social and economic systems, governance specific to the health sector in Africa, has been seen as a

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[7]Fukuda-Parr (2001).

[8]The Danish Institute for Human Rights (n.d.-a).

[9]The Danish Institute for Human Rights (n.d.-b).

[10]Hunt (2015).

[11]Mclnerney-Lankford (2017).

[12]Tascioni (2016).

[13]The Center for Economic and Social Rights (n.d.).

[14]Evans (2012).

fundamental challenge to improving and delivering effective health services and sustaining health rights.[15] Coverage and access to health services has been variable across the Africa region especially among its lowest income countries though some countries (Rwanda, Ethiopia, Ghana, etc.) have significantly increased coverage and made progress towards removing financial barriers to health. Sustaining the right to health can therefore be an expensive affair and the countries of the WHO Africa region made a commitment in 1990 through the Abuja Declaration[16] that expected countries to increase average health spending as a proportion of government budgets to 15%. Between 1990 when the declaration was made and 2013, we have seen an increase from an average of 3.7% to 11.4% of government budgets being devoted to health which is significant if still below the declared target.[17] On average, Total Health Expenditure (THE) had also increased from an average of US$95 per capita in 1995 to $222 per capita in 2013[18] with the significant investments from disease specific global health initiative funds (GAVI, GFATM, PEPFAR, etc.). Average Governments' expenditure on health also rose from $40 to $110 per capita and these combined investments have led to improved life expectancy (50 to 58 years between 1990 and 2013).[19] However, these investments have significant external funding components and still need to reflect sustainability over time in order to sustain expanded access to improved health care and maintain the gains made so far.

The value of health as a basic human right is also important to the economic growth that is essential for LICs development and recent estimates by WHO-AFRO indicate an overall economic burden of ill health in the region at over US$2 trillion per annum with an economic gain of approximately $1 trillion per year in 2030 if certain SDG 3 targets are met.[20] The SDG era therefore provides an additional impetus to expand the right to health as a crucial development channel, founded on rights based principles and an overarching goal of poverty eradication, with "*no one left behind*". This approach requires cross-sectoral, interdependent and interdisciplinary actions in order to achieve important equity targets in general and for health in particular, with "*each country having primary responsibility for its own economic and social development*".[21]

Exercising the right to health in the low income and fragile economies in Africa faces a number of challenges. Health encompasses a number of rights and entitlements that shall need to be well defined and prioritized in order to be properly assessed and monitored in terms of where countries are in assuring these rights.[22] Due to limited financial resources and other knowledge management and

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[15]Yates et al. (2017).

[16]OAU (2011).

[17]WHO Regional Office for Africa (2011).

[18]WHO Regional Office for Africa (2011).

[19]WHO Regional Office for Africa (2011).

[20]WHO (2018).

[21]United Nations (2015a).

[22]Mann (2006).

institutional capacities needed to establish a sustained rights based approach to health, decision makers should first acknowledge and establish what rights are primarily at risk and what delivering these rights to populations lacking them would mean in practical terms, and then determine a sequence of steps to be taken to turn these rights into concrete services. Prioritizing what rights take precedence in a situation of limited resources may in itself become discriminatory if this leads to providing services to a majority rather than the relative few who may be more vulnerable or are part of marginalized sections of the population.

Universal Health Coverage, the critical target 8 of SDG3 and an essential measure of the right to health, requires 3 core components—namely, (i) protection from financial hazards when health care is accessed, (ii) availability and access to services of adequate quality, and (iii) a scope of services covered that deal with the main causes of illness and obstacles to wellbeing in a comprehensive way through the life-course. We discuss below how attaining universal health coverage provides a path to the realization of health rights as part of the SDGs.

• *Right to financial protection and avoiding catastrophic expenditure for health needs*

As indicated earlier, providing access to health care services in ways that enables health rights to be exercised fully is expensive. A major obstacle to the right to health for many citizens is the ability to pay to access and use services and that even when able to pay, it does not result in impoverishment that pushes families deeper into poverty. Financial barriers to receiving health care remain some of the most persistent obstacles to realizing the right to health in low income countries. Overcoming this obstacle is a major underpinning of attaining SDG 3 and its target 8 (Universal Health Coverage), in terms of providing access to services without individuals and families incurring catastrophic expenditures that push them further into poverty. Health services cost money and do need to be paid for, however, one may argue that it is incumbent on governments and society to find ways to finance health services without requiring citizens to bear full and direct costs, especially for life-saving care and care that allows a client to pursue his or her economic activities fully and contribute to society.

• *Right of access to life saving services and to responsive health services of good quality*

The WHO, through its constitutional mandate[23] assists countries to operationalize the right to health by providing technical assistance and support as needed to design and deliver an essential package of health services, and to make these services accessible to all of its population. The size, scope and distribution of these services and the ability of even the most vulnerable or marginalized populations to access services should be a measure of a country's ability to allow the effective exercise of health rights. As indicated earlier, the ability of African and other low-income

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[23]WHO (2016).

countries to mobilize resources for defined essential services is dependent on how broad a spectrum of services can be made available to the entire population. Countries therefore need to define what goes into the agreed package of essential health services that each citizen should have a right to. In some cases it may mean defining which citizens (often using income levels) is entitled to receive services that are cost free or subsidized. This may translate into a "rationing of rights" that may be counterfactual to the need to provide access for all citizens. However, the practical reality in many resources constrained environments is that exercising rights gets limited by the rationing of health care services.

It is important to note however, that even when an essential package is designated, available and accessible, it may not always result in improved health and health rights if the quality of services rendered is poor and does not result in the right outcomes to the patients or populations served. Health services should also be designed and the content of care packages inclusive of interventions that can be responsive to different contexts and population needs that is usually varied even within each country's borders. Context and geographical approaches that recognize and respond to cultural and social differences are essential to making the right to health a reality across various population and ethnic groups within each country. Governments and health service providers should therefore be responsible for designing and providing services that are culturally appropriate, and can respond positively to issues of gender, cultures and stigma that create or exacerbate vulnerabilities.

- *Individuals and communities' voice and expectations of health rights and capacity to exercise rights*

Outside of the strict boundaries of the technical constituents of Universal Health Coverage are a number of other elements that facilitate the correct demand and utilization of UHC. Expressing health rights in low income and traditional indigene settings shall need understand not only how individuals' rights are exercised but also on how expression of those rights impact on other individuals and society at large. For example individuals' right to confidentiality and non-disclosure of disease conditions are a well-recognized right. However these personal rights may translate into risk of deadly communicable disease outbreak or other major risks of harm to other individuals and communities. Under these circumstances, an individual's rights may come under pressure from its competition with broader community needs. This is especially important when resources are inadequate to police and assure protection to both the individual and his/her community. In these constraining situations and during certain crises, some health rights may have to be suspended, if it can be established as this is in the public and community's interest.

Health sector decision makers need to recognize in more depth that communities are like complex organisms whereas health systems and structures tended to be inflexible and ordered in ways that can be non-responsive to the nuances of complicated societal relationships with officialdom. This in the African context implies recognizing and dealing with the ethnically diverse urban and rural groups with complicated religious and cultural belief systems that can defy modern approaches to

exercising health rights. In the Sahelian countries of sub-Saharan Africa for example, enabling health rights for nomadic pastoralist groups that do not always respect borders and the usual norms of land use may generate non-compliance with health regulations, while impinging on the health rights of other ethnic groups.

In countries and communities without adequate democratization of power and influence and the capacity and space to exercise health rights, an ill-informed populace is not empowered and often lacks the civil society organizations that can represent and articulate their interests and needs effectively and generate a response. Civil society engagement experiences elsewhere have had enormous impact on expanding health rights in Brazil and other parts of South America with the emergence of social movements that allowed for a positive interaction with government to engender influence for neglected and vulnerable populations and to organize political power for the realization of rights.[24]

There is of course a reality that CSOs and other "spokespersons" for populations (e.g. parliamentarians, unionists) may not be true representatives of communities or be suborned into becoming a part of the government and other powerful influencers.

Health professionals, themselves often a backbone of the upper middle class, may well be a source of power and influence that may knowingly or unknowingly act against the best interests of the majority and the vulnerable sections of society. Where resources are scarce, the less vulnerable may tend to be left out—and what may well be a well-meaning issue of making efficient use for resources, turn otherwise into simply a giving satisfaction of the majority and the influential components of society.

It is therefore critical that the right to health is also articulated in terms of the "*public good*" it offers to all classes and sections of society as well as the entire population. Communicable diseases that may have been initially incubated in a marginalized sub-group can quickly affect the whole country through outbreaks that put people and economies at risk (e.g. the Ebola crisis in West Africa). Other diseases of poverty (both communicable and non-communicable) can reduce productivity and place unacceptable costs on the health expenditures and budgets.

Analyzing and understanding the positive influences that the right to health brings to individuals, communities and countries as a whole is essential to driving policy that results in turning these rights into practical reality and into clear health results.

## 3 Facilitators and Enablers for Mainstreaming Health Rights in Africa

Our observation in sub-Saharan Africa is that for health rights to become embedded in governance and policy, decision makers must identify and enhance the effect of certain critical enablers and facilitators of health and human rights. This involves

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[24]Fleury (2011).

engaging with critical stakeholders to understand and acknowledge health human rights and its public good benefits and provide the leverage to apply this awareness and knowledge to policy making.

Facilitating rights is dependent on a number of factors experienced in the Africa Region of WHO. Managing rights requires engagement with complex and interrelated factors in order to build a sustained process towards applying human rights.

- *Public policy and governance capacity and environment as an enabler*

LICs, especially the most fragile, often lack the research, analytical and institutional capacity to inform and influence policy development and decision making in ways that lead to the best possible rights results. The presence of significant donor resources in health in low income country settings means that analysis that is available often comes from donor and external sources which may at times lack the insights into the influences that affect governance effectiveness—(e.g. ethnicity considerations, and corrupt practices) that may hide real sources of power and influence that undermines health rights. In many of the region's countries, the needs and actions to address rights may vary in different parts of the same country and between countries, with varying social or religious norms that drive how these different contexts accept or adopt health policies and rights. The clarity of a right as a positive in one community may not be as lucid as an advantage in others and in situations of centralized governance, this may result in non-compliance with public health laws and other actions that are aimed at facilitating the rights to health.

- *Building Population and communities awareness and influence as an enabler of rights*

Linked in complex ways to the governance issue is the influence that traditions and culture can have on delivery of public goods. In simple terms, communities and population groups may perceive attempts to expand rights to health as impositions that may be detrimental to a way of life. In some parts of Africa, this may occur with groups that have practices like female genital cutting, various traditional religious societies, and in male dominant cultures that may undervalue girl children and their education, as well as various religious and cultural norms. The practices by certain cults in Sierra Leone significantly influenced and resisted Ebola prevention interventions during the West Africa outbreak and may have facilitated aspects of the worst EVD outbreak in history.

Therefore a question that can be posed to all health sectors is, "how should health public goods and rights be respected while also respecting cultures and traditions of individuals & communities?" secondly, "How can we avoid engendering gender discrimination, ethnic marginalization and stigma within vulnerable groups by being responsive to local cultural factors?"

- *Encouraging social movements and leadership*

Exercising health and other social rights is usually achieved through major social action against various entrenched interests and influences. Most indigenous and poor

communities are unable to generate the advocacy, power and partnerships needed to achieve these aims. Communities are often made to see rights as a privilege to be granted by governments and their leadership rather than as entitlements of citizenship. Establishing the right to health can only be sustained if linked to the other social rights of the most marginalized communities. It must be part of building political will and be essential for gaining political power (in democratic contexts) and for influencing other government outcomes (e.g. mining or land use rights) in order to achieve health rights.

The community leadership capacity required in achieving these rights and objectives are often missing or lack appropriate authority to exercise influence in positive directions in modern world systems. The interest of leadership in many low resources settings may also be geared towards protecting ethnic interests and political reality rather than through alliances built around class and economic interests. These leadership capacities may need to be carefully nurtured and matured as necessary facilitators of health and other human rights.

• *Use critical events and crises to foster health rights*

A crisis, especially a health one, can provide an opportunity for change and can be used to influence progress on the right to access health services. It is said that the 2nd world war created the opportunity for the UK to establish the NHS to provide health rights to the returning soldiers and their families and as part of a prize for the common sacrifice made by all classes of society for victory in that war.[25]

The existential challenge that Ebola posed to the three West African countries that were most severely affected may have concentrated minds of politicians and decision makers on the importance of ensuring that citizens had access to robust health services that provide protection not only to local communities, but is also an important hedge for continued to economic development and societal gain. In the case of Ebola, the international community also clearly found a need to enable health (and other) rights as a mutually beneficial public good for even in the poorest countries.

The HIV/AIDS pandemic was another example of how a health and social crisis had significantly transformed health care and rights, for example in certain situations, removing what seems to be a stranglehold by health professions over certain treatments and care roles and which allowed for a delegation of tasks to less expensive cadres of health workers in order to meet the health needs of the populations at risk. The HIV crisis also provided a platform to debate and arrives at the understanding that preventive action was not enough to mitigate the epidemic but the need to provide treatment was also as important to fighting the scourge and assuring the extension of health rights to all kinds of population groups that were previously unrecognized or marginalized through stigma.

Similar lessons came up again during the Ebola crises, ensuring that establishing treatment centres and offering relief to affected individuals and communities

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[25]Gorsky (2008).

including those in quarantines was as important as all other public health control measures. Public Health and social actions on their own would not have led to the end of the outbreak without innovations in engaging with communities and designing the outbreak response in ways that respected local culture and gained confidence of various population groups with the efforts to stop the outbreak. It is important that the international community as well as governments and CSOs be prepared to confront health crises and utilize the advocacy and innovation that such incidents bring to create better services for their populations' needs and to provide access to the expected health rights.

- *Education and fostering gender parity as a facilitator health rights*

Certain Sub-Saharan Africa cultural contexts did not give women full status to their health rights and this often created detrimental social, cultural and sexual right effects. These effects can clearly be moderated by education and economic empowerment of women which can also enhance women's connection to the health rights of their children and families. Given the right conditions, women in most communities are well placed to exercise and utilize health services effectively and engaging women as a centerpiece in exercising health rights and utilization of health services can improve how communities demand and express the right to health. The health of women and families, perhaps best measured through maternal mortality ratios, is one of the major indicators of how the right to life and to health is manifested in a country. The disparity in maternal mortality ratios between countries rich and poor, demonstrates an unacceptable level of avoidable death that clearly indicates the multiple obstacles and challenges undermining access to services that allows for a full expression of the right to safe child birth and care. The WHO Global Observatory[26] indicates for example maternal mortality ratio estimates for Equatorial Guinea at 342 deaths per 100,000 births, and for Botswana 129/100,000 even though Gross National Income (GNI) per capita is relatively close at PPP$7180 and $6750 respectively. In Sierra Leone, WHO maternal mortality estimates indicate that annual death rates may be even higher than the total deaths that occurred during the Ebola outbreak in that country comparing to figures seen in the year 2000.[27] Moreover, the outpouring of support and resources observed in the response to Ebola, has not been translated at anywhere near the same level, with the country's maternal mortality problem.

Operationalizing the right to health in fragile and low income countries will require effective tackling of several challenges, some of which are discussed in the previous sections. The economic and social situation in the WHO's Africa region present obstacles to the full exercising of health rights by individuals and societies and even governments willing to provide access to these rights can be stymied by these factors. The right to health in low income countries is linked to the right to universal health coverage as set of defined services and interventions that are within

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[26]WHO, Global Observatory Database (n.d.-b).

[27]Figueroa et al. (2017).

the resources and need of a country to provide. This right is linked to a number of other important rights (education, water and sanitation, etc.) that are important for human dignity.

- *Should one right be prioritized over another?*

This brings up the issue often confronted in health and raised by the HIV pandemic for example—can one health right be prioritized over another? How can this prioritization be made in a rational way? Are there priority rights exercised within the health sector and how do these match with other social rights that are also priorities in resources constrained contexts?

The challenge governments may face is having a hierarchy if rights which may mean suppression of other rights and elevation of others which may mean different benefits for different populations. For example, a government may prioritize Malaria services affecting 50% of the population over lymphatic filariasis affecting less than 1% but scattered and inaccessible. Each has debilitating social and economic effects on the individuals and communities affected but which should be tackled first? It is further exacerbated as a rights challenge when the prevalence of one condition or the other affects marginalized or vulnerable groups and populations who may also be denied other rights but lack the political influence to get remedies.

The idea of prioritizing rights in health requires agreeing on a hierarchy of needs and determining as part of a country's social contract, what rights can be demanded? What will be the criteria for deciding what is fundamental to each population group in a country and how can resources be designated to meet these needs in ways that achieve practical health outcomes? What should be available, even if not demanded as a right by the population?

In our work in Africa, a critical need is simply the protection from impoverishment or catastrophic expenditure when accessing health care. The data from the WHO-AFRO health financing shows that quite a significant number of the 47 countries in the Africa WHO region have out-of-pocket expenditures on health constituting above 40% of total health expenditure[28] a limit consider likely to spur catastrophic expenditure for poor families or likely to result in impoverishment. One may argue that it is a primary right of citizens not to have to choose between impoverishment and health care, and it is incumbent on governments and communities to find ways to ensure that money does not obstruct the right to health.

- *Right of access to responsive services of good quality*

Countries that offer access to health services should also guarantee that these services are the right services that will provide the right results, and that these are delivered in ways that are convenient and impactful for individuals and communities. This is again a factor in the ability to fully exercise and benefit from the right to good health. A number of factors undermine this aspect of facilitating rights. In most LICs, trained and qualified health workers are few in number and unevenly

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[28]WHO Regional Office for Africa (2011).

distributed across a country.[29] The internationally mobile cadres are often the subject of attraction and migration to richer countries, despite the investments made by their own countries to train them. Receiving countries consider it the right of the well-trained individual (but not the unskilled) to be able to migrate freely and work where they chose to. International unregulated migration of health professionals from poor to rich countries therefore undermines the right to health for populations in the source countries. Countries may have to make the choice between the individual rights of health professionals they've heavily invested in, and their ability to enable rights to health of the wider population.

## 4  How Can Africa Realize the Right to Health as Part of the SDGs?

SDG 3 is the health SDG that expresses a "healthy lives and wellbeing" goal as part of a sustainable development ideal, contributed to, but also contributing to many other SDGs. To much of the health sectors global operators, target 8 in Goal 3 (achieving Universal Health Coverage) best expresses an effort to realize the right to health for all populations. Practical steps are needed as many of the issues identified above as affecting or influencing health rights outcomes, require significant resources and capacity to fulfill needs. The WHO's and other health stakeholders efforts to achieve the SDGs are ways of actualizing the right to health and gradually expending its coverage and effectiveness to entire populations often under circumstances of scarce or misapplied resources and ineffective health strategies.

However, Africa has been a major beneficiary of the Global Health Initiatives such as GAVI, GFATM, PEPFAR, etc. that have mobilized significant resources to fight certain major diseases often in ways that do not build sustained health systems and informed decision making. In the absence of good drinking water and sanitation, and the absence of food, are the beneficiaries of excellent vaccination programs and treatment schedules likely to die from conditions that are even less expensive to resolve? The availability of funding for global priority programs generated some very good results but also some health systems challenges especially where absorptive capacity for resources was low and not strengthened prior to receiving these sizeable resources.

- *Governance, leadership and accountability weaknesses* at national and local levels

Many LICs and indeed MICs in the Africa region are constrained by overall leadership and governance weaknesses that undermine achievement of results and

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[29]Buchan et al. (2013).

being held accountable to the population for resources and availability and effectiveness of health services. There is an often high component of external donor resources in the Total Health Expenditures (THE) of most countries in Africa, linked to various "conditionalities" aimed at ensuring certain governmental actions. Sometimes, these conditionalities mean that government officials tended to owe more accountability to the sources of external funding than to their tax paying populations. Conditionalities may not always be a bad thing as they may include requirements for governments to for example provide services for marginalized groups or to implement gender sensitive actions.

However domestic resources, even in many low income countries, do constitute the higher proportion of the THE.[30] Reviews of total health expenditure by sub-Saharan African countries from WHO's database from National Health Accounts, indicates that some 60–66% of THE is from internal resources with about 30% from external resources and donors.[31] The lack of accountability for mobilizing and effectively utilizing these resources may undermine Universal Health Coverage (UHC) and the right to health. Improving governance and accountability in its broadest sense at all levels, including in districts and at community levels should be essential ingredients to the exercise of health rights and to manage the gradual fulfillment of UHC, the right to health and other human rights.

It is quite clear that healthy lives and wellbeing, as ordained in the SDGs, can only be achieved with extensive action that is outside of the health sectors. Which is why a broad multi-sectoral engagement on human rights will be critical to broadening and deepening health rights and wellbeing, which is defined by WHO as not only the absence of disease, but presence of physical, social and mental wellbeing.

The effort to bring about rights, especially to marginalized populations can only be effective if it involves a holistic approach that encourages access to all human rights and not only to health rights. The fragmentation in approach between various sectors that sometimes affects government agencies effectiveness can only undermine the ability of individuals and communities to exercise their rights.

An EU WHO Program on UHC that currently also involves bilaterally Luxembourg and Ireland, targets a number of low income countries in the region and elsewhere with a focus on facilitating policy dialogue and stakeholder consultations that encourage policy decisions and planning for universal health coverage.[32] Health systems experts are placed in the target countries as catalysts for discussion and debates on how policy can drive UHC and facilitates a rights-based approach to UHC. The results so far have been positive, moving countries on a sustained path towards effective policies that work towards attaining UHC and reaching the most vulnerable in society.

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[30]Elovainio and Evans (2013).

[31]WHO (n.d.-a).

[32]Reinicke (2016).

Moreover, recent estimates of the economic impact of ill-health in the WHO Africa region indicate that non-communicable diseases (NCDs), injuries and accidents constituted about 50% of the costs to countries but these receive only minimal donor support.[33] The package of essential services that countries develop as the basic access to health rights often has limited content for NCDs, and unlike communicable diseases, there are no agreements to moderate the costs of medicines and laboratory testing, etc. in order to effectively manage these diseases that have such a high impact on economic development.

This is why mobilizing and utilizing domestic resources effectively should become an important part of ensuring that priorities reflecting the actual health needs and rights of local populations are tackled and not suppressed and replaced completely by the global push to prevent spread of communicable and outbreak prone diseases.

An important aspect of WHO's work on improving health in the region is the Africa Health Observatory, established to coordinate a network of national health observatories that seek and publish improved data and information, and expands analysis and evidence capacity to encourage its use in policy dialogue and policy making. Information and evidence is essential to guide countries towards utilizing effective interventions and basing their actions on proven methods.

Data and evidence should play a major role in mobilizing communities and decision makers for health rights. An important aspect is to scale up new electronic and mobile communication technologies with quite high uptake rates for mobile phone technology in the region. The WHO entered into an agreement with the International Telecommunication Union in October 2017, to collaborate on expanding access to these technologies in the health sector.[34] The use of these technologies for enhancing data and evidence availability is important for understanding trends and impact but they also offer possibilities for expanding access to services in remote and hard to reach areas through telemedicine and other forms of virtual consultations and treatment.

- "*Thinking inside the box*" and sustained implementation of initiatives and ideas

The Africa region over the past 2–3 decades have been flooded with numerous initiatives and innovations, often originating from donor or partner countries and backed by funding, which make it very difficult to resist. These initiatives are often not informed by in-country expertise and tend to be experimental and short term. This does not allow for a sufficiently graduated learning curve for countries to internalize the approaches used and thus build sustainability.

The terms "low hanging fruit", "innovation" and "think outside the box" are often applied to a plethora of health innovations and initiatives though they are often

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[33]Nugent and Feigl (2010).

[34]WHO (2017b).

difficult to implement fully and ascertain benefits. . There is constant pressure to try something new, especially when backed with resources, but without enough efforts to build on prior experiences and existing interventions and to gradually scale these up. Universal access to health rights will require sustained effort to solve problems and learn lessons from implementation processes.

Investments from the global funds and other donor arrangements should also focus on building strong institutional research and analytical capacity, that is stable and not fleeting and allow for serious efforts to exhaust "inside the box" opportunities, before jumping to the next "innovative" idea. Incremental changes should be the required model with due regard to country contexts with gradual building of capacity and knowledge for sustained effect.

• Local and context specific responses and ownership of solutions

There is a need for health rights implementation solutions to be locally based. Globally determined strategies and approaches need to be significantly contextualized to reflect how local cultures and norms absorb and utilize health rights. A plethora of initiatives and one-off research and pilots don't get grounded into full reality and while there may be useful contributions to international academic knowledge and research, they often do not meet the sustainability test of the SDGs in establishing and sustaining health rights. This can be a difficult undertaking as communities in each country can be complex and multifaceted organisms, often with significant shifts and changes over time that require an evolving response to needs and demands. Therefore rights development efforts in health need to be sustained over time to build the capacity and confidence of communities' stakeholders and individuals and in order to achieve a well-grounded understanding of health and the rights to it.

• Closing "*knowledge & awareness gap*" between services and their communities

Accessing the right to health requires more effort at narrowing the gap in knowledge between communities and their governments and providers; both on how services should be organized and delivered but also on what their rights are and what is legally required of elected officials. It is essential to mobilize capacity for rights empowerment by creating "facilitators" for operationalizing health rights and moderating the interactions between communities and health systems managers as a way of building communities and individuals' capacities to exercise their human rights in health. Without populations and communities' internalization and ownership of their rights to health and their investment of effort to realize rights, universal health coverage remains a mirage.

# 5   Conclusion

The strong focus of the SDGs on equity with the slogan of "*no one left behind*" provides a good platform for LICs to give practical reality to the right to health and to improving the lives of most disadvantaged in countries and communities. In order to achieve these, each country must be held accountable on their primary responsibility for the population's own economic and social development and the overarching goal of poverty eradication.

The effort towards universal health rights will require significant cross-sectoral action and partnerships to achieve measurable results.

In order for everyone including the most vulnerable to exercise their right to health, services must be designed based on the resources available, to be culturally appropriate and to mitigate any negative impact due to gender, stigma and other vulnerabilities.

Improved governance and accountability with strong institutions that function well will be crucial to sustaining all human rights including the right to health.

As countries build effort towards realizing the SDGs and Goal 3, a clear vision needs to be articulated on how these efforts can lead to realization of the right to health. This, it is proposed will require the following strengths to be boosted.

1. Countries should build strong sub-national and local governance systems with efficient primary health care systems that bring accountability, resilience and security closer to each population group.
2. Improved governance processes including evidence based policy dialogue, that should lead to strategic prioritization of critical services that expand rights to health and remove financial, geographical & social barriers.
3. Build and/or strengthen institutions and processes that oversee and monitor the obligation of countries under the Universal Declaration of Human Rights and various related rights treaties and covenants of the UN, to respect, defend and support human rights and fundamental freedoms without discrimination and also the entitlement to certain sets of cares and services including for health.
4. The increasing role of ICT in democratization and communication of basic and other rights provides an opportunity that should be expanded in Africa to improve access to health care and facilitate the monitoring of health care trends and coverage.

The above, along with other factors should constitute the facilitators and enablers of health rights that allow for the demand for rights to develop as well as the accountability for providing access to health care and rights.

Analyzing and understanding the positive influences that the right to health brings to individuals, communities and countries as a whole is essential to driving policy that results in turning these rights into practical reality and into clear health results.

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