

HUMAN RIGHTS CENTRE

ACCOUNTABILITY

AND THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

DR. HELEN POTTS



FOREWORD

One of the central features of human rights is accountability. Without accountability, human rights can become no more than window-dressing.

Whether human rights are applied to development, poverty reduction, trade, neglected diseases, maternal mortality, HIV/AIDS or anything else, they require that accessible, transparent and effective mechanisms of accountability be established.

Curiously, however, the human rights literature devotes relatively little attention to accountability. And there is even less written about accountability and the right to the highest attainable standard of health.

Because of this, accountability is cloaked in misunderstandings. While it is often associated with judicial accountability, in practice there are many effective non-judicial forms of accountability. Accountability is similar to, but different from, responsiveness, responsibility, answerability and evaluation. To complicate matters, accountability does not readily translate into some of the world's most commonly spoken languages. The idea is understood – and esteemed – but not always easily translated.

As Dr. Helen Potts explains in this accessible, practical and timely study, accountability in the context of the right to the highest attainable standard of health is the process that provides individuals and communities with the opportunity to understand how governments and others have discharged their right to health obligations. In other words, accountability provides governments and others with the chance to explain what they have done and why. Where mistakes have occurred, accountability requires redress. It is a process that helps to identify what works, so it can be repeated, and what does not, so it can be revised.

While it is possible – and necessary – to cast the net of human rights accountability over numerous actors, here Dr. Potts focuses on the right to health accountability of governments.

In recent years, there has been much discussion in many health sectors about performance targets and financial accountability. As Dr. Potts explains, however, these are not the same as the accountability arising from the right to the highest attainable standard of health. Her study explores different forms of accountability; the relationship between monitoring, redress and accountability; and the pre-conditions for effective accountability. The publication provides numerous practical examples and case studies.

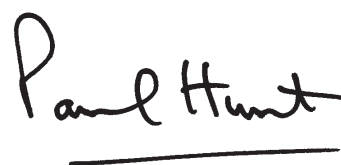
This introductory study benefited from a consultation hosted by the British Medical Association in London during October 2007, as well as discussions at the annual conference of the International Federation of Health and Human Rights Organisations, held in Zimbabwe a couple of weeks later. The research was also discussed at a conference, held at the University of Warwick during November 2007, organised by the Centre for the Study of Globalisation and Regionalisation and the UNDP HIV/AIDS Group. These meetings ensured that drafts of the study were reviewed by a large number of people with expertise and interest in the area. Many other researchers, policy-makers and civil society representatives also commented on various drafts. Colleagues in the Human Rights Centre, University of Essex, advised throughout. I am very grateful to all those who gave their time and shared their insights.

Most of all, however, I am extremely grateful to Dr. Potts for the learning and hard work that she has invested in this pioneering publication, and the Open Society Institute (Public Health Program) for their indispensable financial support.

I have no doubt that this study will be of great assistance to all those working in the fields of health and human rights. I hope it will generate more publications and research, as well as a deeper appreciation of the crucial role of accountability and the right to the highest attainable standard of health.

Front cover photographs – clockwise from top left:
 Photograph © Council of Europe. Parliamentary Assembly of the Council of Europe in session. | Photograph © 2005 Khalid Mahmood Raja, courtesy of Photoshare. An elderly woman casts her vote during local government elections in 2005 in Rawalpindi City District, Pakistan. | Photograph courtesy of Care-Perú. Gloria Corimayhua, Community Leader, Huancané, Puno, Perú presenting the health priorities of her community to the Ministry of Health officers and the general audience at the Third National Health Conference, Lima, July 2006. | Photograph 2004, courtesy of Care-Perú. Opening Ceremony of the Second National Health Conference 2004. Pilar Mazzetti, Peruvian Minister of Health, launches a national mobilisation on health rights and responsibilities. Second National Health Conference, Lima, August 2004.

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Abbreviations

AAAQ	Availability, Accessibility, Acceptability, Quality
AAY	Antyodaya Anna Yojana
AHRC	Asian Human Rights Commission
AIDS	Acquired Immune Deficiency Syndrome
CAPAH	Coalition of African Parliamentarians Against HIV and AIDS
CAT	Committee Against Torture
CCLSP	Cambodia-Canada Legislative Support Project
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CERD	Committee on the Elimination of Racial Discrimination
CESCR	Committee on Economic, Social and Cultural Rights
CHC	Community Health Centres
CRC	Convention on the Rights of the Child
CSGR	Centre for the Study of Globalisation and Regionalisation
ECHR	European Convention for the Protection of Human Rights and Fundamental Freedoms
EFHIA	Equity Focused Health Impact Assessment
GTT	Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors
HIA	Health Impact Assessment
HIV	Human Immunodeficiency Virus
HOM	Humanist Committee on Human Rights

continued overleaf

HRC	Human Rights Committee
HREOC	Human Rights and Equality Opportunity Commission
HRIA	Human Rights Impact Assessment
IACHR	Inter-American Commission on Human Rights
ICC	International Criminal Court
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICCPR	International Covenant on Civil and Political Rights
ICJ	International Court of Justice
ICoJ	International Commission of Jurists
IFHHRO	International Federation of Health and Human Rights Organisations
JSA	Jan Swasthya Abhiyan
MKSS	Mazdoor Kisan Shakti Sangathan
MCT	Mother to Child Transmission
MSF	Médecins Sans Frontières
NGO	Non-Government Organisation
NHRC	National Human Rights Commission
NHRI	National Human Rights Institution
NHRM	National Rural Health Mission
NORAD	Norwegian Agency for Development Cooperation
OHCHR	Office of the High Commissioner for Human Rights
PACE	Parliamentary Assembly of the Council of Europe
PCT	Primary Care Trust
PHC	Primary Health Care Centre
PHM	People's Health Movement
PHR	Physicians for Human Rights
PMTCT	Prevention of Mother to Child Transmission
PRHW	People's Rural Health Watch
PUCL	People's Union for Civil Liberties
RFC	Right to Food Campaign
SADC-PF	Southern African Development Community Parliamentary Forum
TAC	Treatment Action Campaign
UNDP	United Nations Development Programme
UPA	United Progressive Alliance
WHO	World Health Organisation

EXECUTIVE SUMMARY

Accountability is a distinctive, complex and central feature of human rights. Despite the critical role of accountability, little work has been done to explore its meaning and content in the context of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health ('the right to the highest attainable standard of health' or 'the right to health'). As a result, the notion of accountability is often seriously misunderstood. The purpose of this project is to address this misunderstanding through the development of an accessible, practical publication on accountability and the right to health.

While it is clear that there are now numerous and diverse organisations and arrangements involved in right to health activities, as a matter of international human rights law, the State remains ultimately accountable for guaranteeing the realization of the right to health. Accordingly, the relationship focused upon is that of the State (the government and its agents, for example, health policy makers) and rights-holders. The monograph is an introduction to accountability rather than a detailed toolkit, and is designed to be used as a starting point for health policy makers seeking to develop greater understanding of the area.

Section I briefly reviews the sources and content of the right to the highest attainable standard of health, to provide the context in which 'accountability' is explored. Included in treaties at the regional and international levels, the right to health is considered to contain the freedom to make decisions about one's own health; the entitlement to a system of health protection; available, accessible, acceptable health facilities, goods and services that are appropriate and of good quality; non-discrimination; government obligations to respect, protect and fulfil the right to health; participation; monitoring; accountability mechanisms and remedies.

Section II explores the concept of accountability, noting along the way that a requirement for accountability is not new to the health sector. In particular, financial, performance, and political/democratic accountability are well known. Although right to health accountability is also concerned with these categories, its focus is the degree to which governments are complying with their obligations arising from the right to the highest attainable standard of health.

Accountability in the context of the right to the highest attainable standard of health is the process which provides individuals and communities with an opportunity to understand how government has discharged its right to health obligations. Equally, it provides government with the opportunity to explain what they have done and why. Where mistakes have been made, accountability requires redress. It is a

process that helps to identify what works, so it can be repeated, and what does not, so it can be revised. Accountability is not the same as responsiveness, responsibility, answerability or evaluation, as none of these concepts include a legal compulsion to explain and to provide remedies.

Accountability begins with government ensuring the incorporation and implementation of accountability processes into all health policy. This involves continuous monitoring by government *and* civil society to find out what is working, what is not, what has been omitted and what needs to change. Just as rights-holders have the right to receive information on whether government is fulfilling their right to health obligations, government has an obligation to make public, in an understandable form (that is, transparently), all available information about the implementation of the right to health.

In addition, mechanisms are required to assess the data; allow explanation and justification of deficiencies; encourage better performance; and provide remedies if required. A sector as complex as the health sector requires a wide variety of accountability mechanisms to review the important and difficult decisions made within it. There are five broad types of accountability mechanisms: *judicial*, for example, judicial review of executive acts and omissions; constitutional redress, statutory interpretation, public interest litigation; *quasi-judicial*, for example, national human rights institutions, regional and international human rights treaty bodies; *administrative*, for example, human rights impact assessment; *political*, for example, parliamentary committee review of budgetary allocations and the use of public funds, democratically elected health councils, healthcare commissions; *social*, for example, the involvement of civil society (independently or in collaboration with government) in budget monitoring, health centre monitoring, public hearings and social audits.

Remedies to redress violations of the right to health are key to ensuring that human rights have meaning. Remedies may take any one or more of the following forms: restitution, rehabilitation, compensation, satisfaction and guarantees of non-repetition. The first three remedies focus on the rights-holder and are concerned with redressing the impact of the violation on the individual or

group rights-holder. The last two remedies, satisfaction and guarantees of non-repetition, are particularly important in ensuring the introduction of systematic accountability processes in the long term. For example, satisfaction and guarantees of non-repetition remedies include organisational improvements in the ministry concerning health planning, budgeting and policy formulation, and right to health training for government and health workers.

The final section of the monograph notes that for a variety of reasons, it is not possible to provide a simple checklist of what needs to be in place to ensure accountability. However, there are some pre-conditions for effective accountability, such as a strong commitment and long-term vision on the part of government to the incorporation of the right to health into the day-to-day work of health policy makers; the presence of a national health plan that incorporates the right to health; the establishment of effective institutional arrangements for civil society and the government to work together; the establishment of effective monitoring systems; access to, and implementation of, the decisions of accountability mechanisms that are relevant to health policy; and the development of ongoing right to health training for health policy makers at all levels.

To conclude, this is a preliminary work. Much more needs to be done by the human rights community and the health community, working in collaboration, to investigate, understand and further refine accountability. For example, the application of the accountability process to specific issues would be one way of further refining accountability in the context of the right to the highest attainable standard of health.



Photograph © 2007 Carl Whetham, courtesy of Photoshare. Crowds gather to demonstrate for democracy in Sukbaatar Square, in Ulan Bator. The Mongolian Democratic Association called on civil society to demand a free and just society from the Mongolian government.

PREFACE

This monograph is an introduction to accountability in the context of the right to the highest attainable standard of health. The principal aim is to assist government health policy makers to understand the content and role of accountability in the context of this right. This understanding will support the incorporation of the right to health into the development and implementation of health plans.

There has been a trend in all regions of the world towards a reduction in the role of the State in delivery of health services, and there are now numerous and diverse organisations and arrangements that are involved in right to health activities. These include bilateral and multilateral agreements, non-government organisations, private national and international corporations, international and regional financial institutions and individuals, families and communities. The presence of these diverse arrangements complicates the identification of who is accountable for implementation of the right to health. However, as a matter of international human rights law, the State remains ultimately accountable for guaranteeing the realization of the right to health. It is therefore more urgent than ever to address the complex issue of accountability of government for implementation of the right to health.

A requirement for accountability is not new to the health sector.¹ In particular, financial, performance, and political/democratic accountability are well known. Financial accountability, concerns the tracking and reporting on allocation, disbursement and utilisation of funds. It involves auditing, budgeting and accounting. Performance accountability is concerned with demonstrating and accounting for performance in the light of agreed upon indicators. The focus is on service, output

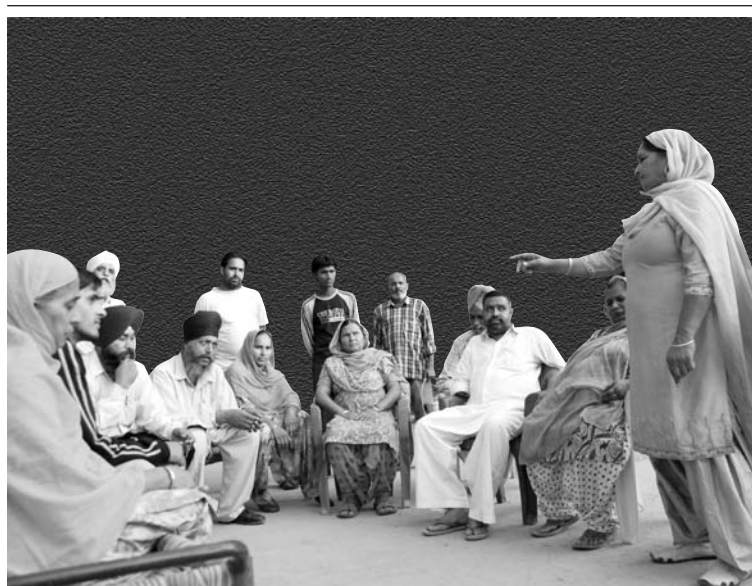
and results. Political or democratic accountability involves policy making, the political process and elections.

Although right to health accountability is also concerned with these three categories, its focus is the degree to which governments are complying with their obligations arising from the right to the highest attainable standard of health.

As an introduction to accountability in the context of the right to health, this monograph covers the following issues:

- n **It provides a brief review of the right to the highest attainable standard of health.** An understanding of the content of the right to health is a necessary prerequisite. The monograph provides a brief review of the content of the right to health to assist those who may be unfamiliar with the right.
- n **It describes the process of accountability and provides examples of various accountability mechanisms that are available at the national, regional and international levels.** Accountability provides rights-holders with an opportunity to understand how government has discharged its obligations, and also provides an opportunity for government to explain its conduct. The document illustrates, through examples, the various mechanisms that provide these opportunities.
- n **It describes the types of remedies that should be available to rights-holders.** Rights-holders are entitled to effective remedies when there has been a failure on the part of government to fulfil their right to the highest attainable standard of health obligations. The document describes the types of remedies which should be available to individuals and groups.
- n **It provides examples of accountability in action.** Case studies from different regions of the world are drawn upon to give examples of the tangible benefits of effective, transparent and accessible accountability.
- n **It provides a list of key factors required for accountability in the context of the right to health.** Finally, the document provides a list in summary form of the key factors that need to be in place.

Photograph © 2007
Pradeep Tewari,
courtesy of Photoshare.
The elected president
(sarpanch) of village
Khuda Jasu, near
Chandigarh, India,
addresses community
issues at a monthly
meeting of the village
welfare committee.



The monograph can be a practical information resource and advocacy tool for both health policy makers and health advocates. It can assist health policy makers in fulfilling the obligations of the government regarding the right to health. At the same time, it can operate as an information resource to support those advocating for accountability on the part of government for the implementation of the right to health.

SECTION I: INTRODUCTION

Ensuring accountability on the road towards universal access involves a number of things. It means monitoring Governments' steps aimed at progressive realization of these rights and highlighting any failure to do so. It means holding Governments accountable for obligations of immediate effect, for example where scaling up access discriminates against a certain group such as children, those involved in the sale of sexual services, or injection drug users. Above all, it involves providing the framework, mechanisms and environment for holding officials accountable, including ensuring freedom of speech, accessible justice, transparent government (including transparent budget processes), the ability of civil society to organise and the safety of activists to hold their Governments to account.

Louise Arbour, United Nations High Commissioner for Human Rights, statement on the occasion of World AIDS Day, 1 December 2006.

Accountability is a distinctive, complex and central feature of human rights. In the context of human rights, accountability is concerned with the requirement of the State to fully comply with its obligations under the international and regional human rights treaties to which it is a party. Concrete cases of individuals and groups seeking government accountability show that the real challenge is to convert this legal commitment into specific measures of implementation. Despite the critical importance of the role of accountability, little work has been done to explore its meaning and content in the context of the right to health. As a result, accountability is often seriously misunderstood. Sometimes, for example, accountability is misunderstood to mean only 'naming and shaming', or blame and punishment.²

As a concept it is not new to the health sector.³ Sometimes it is understood simply in terms of financial accountability: a device to check that health funds are being spent as they should be. At other times it relates to the performance of the health sector: demonstrating and accounting for performance in light of agreed upon indicators. It is also understood in a political sense: the presence of institutions, procedures, and mechanisms to ensure that the government delivers on its electoral promises, represents citizens' interests, and responds to societal needs and concerns.⁴ It has also been described in terms of a 'short route to accountability', where it is understood as increasing the power of civil society to demand better services from private provision.⁵

Right to health accountability is also concerned with these categories. However, right to health accountability is much broader. Accountability in the context of the right to health is the process which provides individuals and communities with an opportunity to understand how government has discharged its right to health obligations. Equally, it provides government with the opportunity to explain what it has done and why. Where mistakes have been made, accountability requires redress. It is a process that helps to identify what works, so it can be repeated, and what does not, so it can be revised.⁶

Practical examples which are 'snap-shots' have been incorporated throughout this monograph to show how right to health accountability is relevant to the daily work of health policy makers. In addition, case studies have been provided in Appendix I to illustrate how different types of mechanisms work together to achieve accountability on the part of government. In the context of the right to health, there are many different types of accountability mechanisms, including judicial procedures, national human rights institutions, health commissioners, democratically elected local health councils, public hearings, patients' committees, impact assessments, and so on. A sector as complex and important as the health sector requires a range of effective, transparent, accessible, independent accountability mechanisms. The media and civil society organisations also have a crucial role to play.⁷

Monitoring and evaluation have been features of health planning for some time. What benefits will be gained by the incorporation of right to health accountability into the day-to-day work of health policy makers? Put simply, the incorporation of the accountability process into the day-to-day work of health policy makers will directly support the development and implementation of better quality health policy, improve health outcomes and also assist government to progressively realise the right to health. The monograph is an introduction to accountability rather than a detailed toolkit. It is designed to be used as a starting point for health policy makers to develop greater understanding of the area. This understanding can be gained, in part, by understanding the content of and obligations contained in the right to health. A good place to begin therefore is through a brief review of the right to the highest attainable standard of health.

Photograph © 2007 Leah McElrath, courtesy of Renna Communications. ACT UP Protest March, New York City, commemorating ACT UP's 20th anniversary of AIDS activism and direct action.



A. THE RIGHT TO HEALTH AND ITS SOURCES

The right to the highest attainable standard of health is a fundamental human right. The right to health is not a right to be healthy; the government cannot fully ensure good health, as it is influenced by some factors which are in whole or in part outside the government's control, such as individual susceptibility to ill health. As with all human

rights, the right to health is interlinked and related to both civil and political rights (e.g., life, expression, association) and other economic, social and cultural rights (e.g., education, housing, social security, work, culture).⁸

The right to health can be found in laws at three different levels: international, regional and national.

1. INTERNATIONAL

There are many international human rights treaties (also known as covenants or conventions) that recognise the right to the highest attainable standard of health. Though first formulated in the World Health Organisation (WHO) Constitution (1946), the central formulation of the right to health is contained in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR or the Covenant) (see Box 1 below).

The right is also contained in international treaties that have been created to protect the human rights of particular groups, such as children, women, people with disabilities and those who are subject to discrimination on the basis of race.⁹ These treaties highlight the preoccupation that human rights have with people who are vulnerable to discrimination and marginalisation and who may require special attention.

2. REGIONAL

In addition to international standards, the right to health is recognised in regional human rights treaties, including:

- n *The African [Banjul] Charter on Human and Peoples' Rights*, Article 16;
- n *The African Charter on the Rights and Welfare of the Child*, Article 14;
- n *The European Social Charter (Revised)*, Articles 11 and 13;
- n *The Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights* (Protocol of San Salvador), Article 10.

Other regional instruments, which do not explicitly recognise the right to health but which offer indirect protections through other health-related rights, include:

- n *The American Declaration on the Rights and Duties of Man*;
- n *The American Convention on Human Rights*;
- n *The Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women*;
- n *The European Convention for the Protection of Human Rights and Fundamental Freedoms and its protocols*.

3. NATIONAL

The right to health is recognised in numerous national constitutions.¹⁰ When the right to health is enshrined in

the Constitution or in domestic laws, it creates an opportunity for an individual or group to pursue a complaint

Box 1: ICESCR, Article 12

- | | |
|---|---|
| <ol style="list-style-type: none"> 1. The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of health. 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: <ol style="list-style-type: none"> a. The provision for the reduction of the still-birth-rate and of infant mortality and for the | <ol style="list-style-type: none"> healthy development of the child; b. The improvement of all aspects of environmental and industrial hygiene; c. The prevention, treatment and control of epidemic, endemic, occupational and other diseases; d. The creation of conditions which would assure to all medical service and medical attention in the event of sickness. |
|---|---|

and seek a legally binding decision in the national courts if the right to health or another relevant right (e.g., the right to freedom from discrimination) has been violated.

The right to health has also been indirectly protected in national courts through the incorporation of the right

into another human right. For example, the Supreme Court of India has, in several cases, found that economic and social rights such as the right to health, are an integral part of the fundamental rights guaranteed by the Constitution.

B. WHAT DOES THE RIGHT TO HEALTH CONTAIN?

Summary

The right to health contains:

- The freedom to make decisions about one's own health;
- The entitlement to a system of health protection;
- Available, accessible, acceptable health facilities, goods and services that are appropriate and of good quality;
- Non-discrimination;
- Government obligations to respect, protect and fulfil the right to health;
- Participation;
- Monitoring;
- Accountability mechanisms; and
- Remedies.



Photograph 2004, courtesy of Care-Perú. Opening Ceremony of the Second National Health Conference 2004. Pilar Mazzetti, Peruvian Minister of Health, launches a national mobilisation on health rights and responsibilities. Second National Health Conference, Lima, August 2004.

The right to the highest attainable standard of health contains the following overlapping and interrelated elements:¹¹

1. FREEDOMS AND ENTITLEMENTS

The right to health encompasses both freedoms and entitlements. The freedoms include, for example, the right to make decisions about one's health, including sexual and reproductive freedom, and the right to be free from interference, such as non-consensual medical

treatment. The entitlements include, for example, the right to emergency medical services, and to the underlying determinants of health, such as adequate sanitation, safe water, adequate food and shelter, safe and healthy working conditions, and a healthy environment.

2. AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY, QUALITY

The right to the highest attainable standard of health also contains four inter-related and essential elements: Availability, Accessibility, Acceptability, and Quality (AAAQ).¹² While these essential elements are often described in connection with health care services, they also apply to the underlying determinants of health.

The AAAQ framework is summarised here:

Availability

Health facilities, goods and services must be available in sufficient quantity within the country.¹³ This includes, for example, hospitals, clinics, trained health workers,

essential medicines, preventive public health strategies and health promotion as well as underlying determinants, such as safe drinking water and adequate sanitation facilities. Availability is concerned with the physical presence of health facilities. For example, whether there are a sufficient number of health workers and health facilities in rural areas; whether there is a national public health plan; whether there is a health complaints commissioner or similar; whether sexual and reproductive health services are provided.

Accessibility

Health facilities must be accessible to everyone without discrimination, especially the most vulnerable or marginalised people. They must be physically and economically accessible. For example, while a health centre may be available at the local level, people in wheel chairs may not be able to access the centre because of the lack of wheel chair ramps, or the health workers may not speak the same language as the people attending the health centre. If the centre provides no physical access for people with a disability or no one at the centre speaks the local language, the health centre is not accessible, though it may be available. If the health centre charges user fees and those in need cannot pay the fee, the centre is not economically accessible.

Accessibility also includes the right to seek, receive and impart information on health. This latter component of accessibility is particularly important for accountability.

Protection and enforcement of the right to seek, receive and impart information on health is a pre-requisite for accountability. Without publicly available health information, monitoring — an essential element of the accountability process — will be difficult to undertake.

Acceptability

Health facilities must be respectful of medical ethics, culturally appropriate and gender sensitive. For example, medical treatment must be explained in a manner that is understandable to the person who is to receive the treatment. Health workers will need to be aware of cultural sensitivities in the provision of health care; for example, modes of delivery differ with culture. A gender perspective may need to be incorporated into local health facility budgets to identify gender-based gaps in the budget allocation to programmes of the health facility.

Quality

Health facilities must also be scientifically and medically appropriate and of good quality. For example, the provision of a mammography machine to a health centre may not be scientifically and medically appropriate in a situation where resources (human and technical) are scarce and the main health issue for women is cervical cancer. Further, the underlying determinants of health must be appropriate and of good quality. Thus, for example, health education, in addition to hospitals and medicines, must be of good quality.

3. NON-DISCRIMINATION AND EQUALITY

Central to the right to the highest attainable standard of health is *non-discrimination and equality*. The right to health belongs to everyone. A person's chances of enjoying good health must not be disadvantaged because of their sex, race, age, language, disability, health status (e.g., HIV/AIDS), sexual orientation, or socio-economic or other status. In addition, health policy must be developed

in a manner that respects cultural diversity. Special attention must also be paid to promoting the equality of women, men and disadvantaged groups. Indeed, careful consideration of health resource allocations is required to ensure that health policy and spending promote equality rather than perpetuating inequalities. Hence the importance of gender budget analysis.¹⁴

4. PARTICIPATION

A further important aspect of the right to health 'is the *participation* of the population in all health-related decision-making at the community, national and international levels.'¹⁵ People are entitled to participate in decision-making and policy formulation relating to their health at local, national and international

levels. Steps must be taken to develop mechanisms to enable participation to take place. Importantly, effective participation relies in part upon other rights, such as the right to seek, receive and impart health-related information; the right to express views freely; and the right to basic health education. Full participation on a non-discriminatory basis also requires special attention to sharing information with, and seeking the views of, women and men, as well as the views of disadvantaged people. Participation is essential to the establishment of effective, accessible and easily understood accountability in the context of the right to the highest attainable standard of health.

Photograph courtesy of the Participation and Practice of Rights Project. Leticia Osorio, Odindo Opiata, Inez McCormack and Bruce Porter, Panel Members at the Evidence Hearing on the Right to Housing, Belfast, 13 June 2007.



5. PROGRESSIVE REALIZATION AND RESOURCE AVAILABILITY

The right to the highest attainable standard of health is subject to progressive realization and resource availability. Put simply, all countries are expected to be doing better in two years time than they are doing today (progressive realization), while resource availability means that what is required of a developed country is of a higher standard than what is required of a developing country. Many countries do not currently have the capacity or the resources necessary to implement fully the right to health for all people. Nonetheless, governments must take deliberate and concrete steps toward the full realization of the right to the highest attainable standard of health for all. The corollary to the obligation to progressively realise the right to health is that 'there is a strong presumption that retrogressive

measures taken in relation to the right to health are not permissible'.¹⁶

Governments, in order to demonstrate that they are complying with the obligation to continuously improve the enjoyment of the right to health, must identify clear indicators and benchmarks in their national health strategy and action plan and ensure the collection of relevant data for measuring progress over time. This data must be broken down on the basis of major social classifications (e.g., sex, ethnicity, urban/rural, age, socio-economic status) to identify whether any particular group is disadvantaged. While it is government that has the obligation to develop indicators and benchmarks, indicators which measure progressive realization can also be developed by civil society (see Box 2).

6. MINIMUM CORE

In addition to the obligation to progressively realise the right to health, there are some core obligations of immediate effect. These core obligations require, at the very least, minimum essential levels of primary health care, food, housing, sanitation, essential drugs and the adoption

and implementation of a national health plan. Even in the presence of limited resources, the government is required to give first priority to the most basic health needs of the population and to pay particular attention to protecting the most vulnerable sections of the population.

Box 2: The participation and practice of rights project – community identified indicators to measure progressive realization

The Participation and Practice of Rights Project (PPR Project) commenced in 2001 and supports communities in using a human rights-based approach to address social and economic inequalities. In North Belfast, the PPR Project works with a group of residents who live in a high rise complex of flats known locally as the Seven Towers. The flats are overcrowded and in poor condition, and many individuals with children and people with health problems are inappropriately housed there. The problems in the Seven Towers have been repeatedly raised with the Northern Ireland Housing Executive (NIHE), which has responsibility for social housing in Northern Ireland, and has received high profile media coverage. Despite this, little has changed in the thirty years since the Seven Towers were constructed.

The residents of the Seven Towers, following human rights training and with the assistance of the PPR Project, developed in 2007 a set of outcome indicators to measure whether the government is meeting its commitment to progressively realise the right to adequate housing and the right to health in their community over a defined time period – one year. The PPR Project identified that much of the work done to date on setting indicators, is aimed at States who wish to set human rights indicators to evaluate their own progress in realising human rights. Accordingly, the PPR

Project adopted a 'bottom-up' approach with the aim to assist communities to set their own indicators and to do so in relation to very specific issues selected by that community. The group chose the following issues: pigeon waste in the partitions on the landings; maintenance and repair; and the issue of families being inappropriately housed in the Towers. The group aimed not only to resolve these issues but to influence the way the NIHE went about addressing them, in order that the benefits of their work could be felt among other communities with similar problems. Each indicator was linked to a human rights standard, and a benchmark was set. The Seven Towers indicators, which are to be measured by the resident's group themselves, are primarily 'outcome' indicators, measuring how government policies and practices have impacted at community level. The Seven Towers group meet with the NIHE quarterly to review progress and submit reports to the Minister responsible for housing, who has committed to working with the residents to meet the indicators. The reports were also submitted to an International Panel of housing rights experts, who validated the unique approach at a residents' hearing in June 2007.

Source: Prepared in collaboration with Nicola Browne of the Participation and Practice of Rights Project, Belfast.

7. INTERNATIONAL ASSISTANCE AND COOPERATION

In accordance with the obligations envisaged in the United Nations Charter and some human rights treaties, (for example, the ICESCR, Article 2, and the Convention on the Rights of the Child, Article 2), developing

countries have a responsibility to seek international assistance and cooperation, while developed countries have some responsibilities towards the realization of the right to health in developing countries.

C. HOW IS THE RIGHT TO HEALTH MADE REAL?

The right to health is made real, principally, through first, the government's compliance with specific right to health obligations; secondly, rights-holders claiming their rights.

1. GOVERNMENT COMPLIANCE WITH RIGHT TO HEALTH OBLIGATIONS

The State has specific obligations under international law to respect, protect and fulfil the right to health. For example, the obligation to respect places an obligation on States to refrain from denying or limiting equal access for all persons (e.g., prisoners, asylum seekers) to health facilities. The obligation to protect means that States should take steps to prevent third parties from jeopardising the health of others; the

private delivery of health facilities does not nullify government obligation to regulate those services. The obligation to fulfil requires governments to adopt necessary measures, including legislative, administrative and budgetary measures, to ensure the full realization of human rights, including the right to the highest attainable standard of health (e.g., access to primary health care facilities).

2. PEOPLE CLAIMING THEIR RIGHTS

As well as the elements set out above, the right to the highest attainable standard of health empowers rights-holders to demand accountability (see next section). Rights-holders are entitled to have access to effective accountability mechanisms at the national, regional (if

available) and international levels. Rights-holders are also entitled to effective remedies when government has failed to discharge its right to health obligations. These remedies may take the form of restitution, rehabilitation, compensation, satisfaction or guarantees of non-repetition.



Photograph, courtesy of the Colombian Network of Women for Sexual and Reproductive Rights, 2006. Colombian Network of Women for Sexual and Reproductive Rights Campaign September 28th Social Protest (Red Colombiana de Mujeres por los Derechos Sexuales y Reproductivos. Campaña 28 de Septiembre). Adán, (sculpture by Fernando Botero) 'If men could get pregnant, abortion would be a commandment', Medellín – Colombia.

SECTION II: ACCOUNTABILITY



Photograph courtesy of Care-Perú. Gloria Corimayhua, Community Leader, Huancané, Puno, Perú presenting the health priorities of her community to the Ministry of Health officers and the general audience at the Third National Health Conference, Lima, July 2006.

A. WHAT IS ACCOUNTABILITY?

Accountability is the process which requires government to show, explain and justify how it has discharged its obligations regarding the right to the highest attainable standard of health. This process also provides rights-holders with an opportunity to understand how government has discharged its right to health obligations. As part of the process, if it is revealed that there has been a failure on the part of government or its agents to fulfil the obligations contained in the right to the highest attainable standard of health, rights-holders are entitled to effective remedies to redress this failure.

Accountability is both prospective and retrospective. Viewing it as a prospective process it draws attention to its potential to improve performance: to identify what works, so it can be repeated, and what does not, so it can be revised. Viewing it as a retrospective process it draws attention to the remedies that should be available when there has been failure on the part of government to fulfil its obligations. As both a prospective and retrospective process, it necessarily includes the monitoring of conduct, performance and outcomes. It is also continuous (see *Figure 1 overleaf*) and commences with the government ensuring the incorporation and implementation of accountability processes into all health policy.

The accountability process requires the incorporation of monitoring into all aspects of policy development and implementation. This monitoring is conducted on a continuous basis by government. It can also be

conducted by civil society, either collaboratively with government or independently. The accountability process also requires the presence of accessible accountability mechanisms to provide a forum for explanation and justification. This explanation and justification can take place in a variety of settings and need not be confined to formal settings such as the courts or national human rights institutions. Other settings include democratically elected health councils, public hearings, and national or local public meetings. The media also has a crucial role to play.

In addition, remedies for the non-fulfilment of right to health obligations are to be available. Remedies (see *pages 28-29*) in the context of the right to health are broad, as they include the modification of monitoring processes, human rights training, and organisational improvements concerning planning, budgeting and policy formulation, in addition to judicial remedies such as compensation.

Present in each of these elements — monitoring, accountability mechanisms and remedies — is participation. While the form of participation will vary between the elements and also within them, (e.g. judicial accountability mechanisms versus social accountability mechanisms), it is an essential element of the accountability process.

Hence, an effective accountability process is comprised of the following essential elements: monitoring, mechanisms, remedies, and participation.

Figure 1: The Accountability Process

B. WHAT ACCOUNTABILITY IS NOT

Right to health accountability is not the same as:

- n responsiveness,
- n responsibility,

- n answerability; or
- n evaluation;

as none of these concepts include a legal compulsion to explain and to provide remedies.

C. MONITORING IN ACCOUNTABILITY

Summary

Monitoring in accountability:

- n Rights-holders have the right to receive information on whether government is fulfilling its right to health obligations;
- n Government has an obligation to make public all available information about the implementation

of the right to health;

- n Monitoring information must be made accessible to rights-holders in an understandable, (transparent) form;
- n Monitoring can be undertaken by government, civil society, or a combination of both.

Meaningful accountability is not possible without monitoring. Progressively realising the right to health requires that policies and practice be brought into line with right to health standards.

Monitoring plays a dual role in relation to accountability.

- i. It provides, on an ongoing basis, the information that government needs to determine what areas should

be focused on in order to reach its targets for the realization of the right to health.

- ii. It provides rights-holders with the information they need to claim their rights and to hold the government to account when obligations have not been fulfilled.

Health policymakers use a very large number of

health indicators relevant to health policy effectiveness and national and international reporting. However, these health indicators do not usually capture all that right to health monitoring demands. For example, right to health monitoring would also require indicators on the participation of individuals and groups in the development, implementation and review of health policy, as well as indicators on the protection of the right to seek, receive and impart information on the right to health. Ways to address this important deficiency in health indicators can be found elsewhere, for example, in the 2006 report of the Special Rapporteur on the right to health, to the Human Rights Council.¹⁷

As rights-holders are entitled to obtain information and as government has an obligation to release all relevant material, the results of monitoring must be made public. When the findings are released they are an important tool for accountability. There are multiple avenues available to government for the release of this information. For example, in many countries there is an institution at the national level which prepares, on a periodic basis, reports on the health status of a population. Right to health monitoring information could be included in these reports. In addition, many countries have a national human rights plan. The information gained from monitoring could also be released in the annual report to parliament on the implementation of the national human rights plan. This monitoring information could also be made available at the regional and international levels.

Government has an obligation to monitor its activity. In addition, government activity must also be monitored by civil society. Too much dependency on government monitoring could result in unquestioningly accepting the data that is offered. Accordingly, as part



Photograph courtesy of Care-Perú. Citizen Surveillance Initiative, 'How are our rights respected within public health services?'. Community leaders from Azángaro, Huancané and Melgar provinces of Puno Region attend a local workshop on health rights and legal enforceability mechanisms.

of the right to seek, receive and impart information, civil society organisations should perform a monitoring role. This monitoring role can be undertaken independently or in cooperation with the government and its agents.

There are many places where this external monitoring is taking place (either cooperatively or independently). For example, in the Puno region of Perú, health care centres are monitored by women in the community who report back to the regional representative of the National Human Rights Institution (see *Case Study No. 5 on page 35*).

In India for example, monitoring of health care facilities is supported by the government through the National Rural Health Mission Framework (see *Box 3*).

Box 3: Community monitoring under the National Rural Health Mission — India

The United Progressive Alliance (UPA) Government, elected in 2004, launched the National Rural Health Mission (NRHM; 2005) with a view to bringing about dramatic improvement in the public health system and the health status of the people of India. A key component of the accountability process incorporated into the NRHM framework has been the inclusion of community monitoring of health services at the community, district and state level. The intention is to allow the community and its representatives to give direct feedback about the functioning of public health services, which will include input into the planning of public health services.

The community and community-based organisations will monitor demand/need; coverage; access; quality; effectiveness; behaviour and presence of health care personnel at service points; possible denial of care; and negligence. This monitoring is commencing on a pilot basis in 35 districts across nine states. Though actual data collection for monitoring is yet to begin, once fully operational it will be an integral part of the public health system. Further information can be obtained at http://mohfw.nic.in/NRHM/Community_monitoring/community_monitoring.htm

Source: This case has been prepared in collaboration with Abhay Shukla, National Joint Convenor, Jan Swasthya Abhiyan.

In addition, the Jan Swasthya Abhiyan (JSA or People's Health Movement-India) conducts independent monitoring in seven northern states (see Box 4 below).

Box 4: Social audit and community monitoring of health services in India

JSA has had an ongoing process of critical engagement with the NRHM framework in the form of the People's Rural Health Watch (PRHW), which is an independent initiative by JSA to audit the state of rural public health services periodically, particularly in the light of the official NRHM initiative. This auditing is independent of the official framework and has been conceptualised and implemented entirely by JSA. This programme has been implemented in seven northern states and involves JSA member organisations independently collecting information about the activities conducted under the NRHM, both at the state and national levels. Two rounds of these periodic surveys have been completed so far.

Interviews are conducted with health care providers in community health centres (CHCs) and primary health care centres (PHCs); patients in the CHC or PHC; village-based health workers; and people in the village community. The information collected from the CHCs and PHCs covers the following broad areas: the availability of health centres in the selected area; the availability of staff

and personnel in these health centres; the availability of infrastructure, services and medicines in these centres; women and children's health services and their management; problems faced by the doctors and other personnel in performing their duties; and the changes being introduced by the NRHM.

The questionnaire for the village health workers covers the broad areas of socio-economic background, selection process, quality of training, actual activities and tasks, and interaction with other health personnel. The questionnaires for patients and village community members deal with accessibility, availability and quality of health services in their respective areas. The survey information is then included in reports which are made publicly available and which serve a dual purpose. First, the reports assist with ensuring public awareness regarding implementation of the NRHM. Secondly, the reports assist with maintaining pressure on the government to be accountable for the promises of the NRHM.

Source: This case has been prepared in collaboration with Abhay Shukla, National Joint Convenor, Jan Swasthya Abhiyan.

See also the Resources Page in Appendix II for a link to Dignity Counts: A Guide to Using Budget Analysis to Advance Human Rights. This publication draws upon a case study of the Mexican national government budget to provide guidance to civil society organisations and others on how to use budget analysis as a tool to assess government compliance regarding economic, social and cultural rights

obligations.

The above examples, as relevant to the North as they are to the South, highlight that health policy makers need to be aware of how civil society monitoring can assist them in their work and how they can work cooperatively with civil society to progressively implement the right to health and to ensure government accountability for its implementation.

Box 5: Participatory budgeting in Brazil

The 1988 Brazilian Constitution initiated devolution of power from the federal to state and local governments and the creation of a new participatory culture. This culture is embodied in such institutions as participatory budgeting, which has significantly improved accountability in some jurisdictions. The process is used in a number of Brazilian cities, but the original and most rigorous example is in the city of Porto Alegre. The city's sixteen administrative units have Regional Plenary Assemblies that meet twice yearly to discuss and settle budgetary issues. Any inhabitant of the city may attend the assemblies, but only residents of the region may vote. At the first meeting of each year, held in March, delegates are elected to participate in more or less weekly meetings over the next three months to work out the region's spending priorities for the coming year. The meetings are

held in neighbourhoods throughout the region. At the end of this phase, the delegates report back to the second meeting, where proposals are debated and voted upon and two delegates are elected to represent the region in the Participatory Budgeting Council. The Council meets over the following five months to formulate a city budget out of the regional agendas. The mayor can accept the budget or remand it for revisions, but the Council can override the mayor's veto with a two-third majority vote endorsing the pre-remanded version.

Since the introduction of participatory budgeting in Porto Alegre in 1989, the process has spread to hundreds of cities in North and South America, Europe, Asia and Africa.

Source: Pan American Health Organization. (2000) Healthy Municipalities and Communities – Country Profiles – Brazil: www.paho.org/English/AD/SDE/HS/hmc_Brazil.htm (accessed 25 February 2008).

D. ACCOUNTABILITY MECHANISMS

Summary

Accountability mechanisms:

- n The right to health requires that rights-holders have knowledge of and access to effective and easily understood accountability mechanisms at the national, regional and international levels;
- n Under the right to health, those with obligations

should be held to account so that misjudgements can be identified and corrected, problems exposed and reforms identified;

- n A sector as complex as the health sector requires a wide variety of accountability mechanisms to review the important and difficult decisions made within it.

An accountability mechanism is the procedure through which government is answerable for its acts or omissions in relation to right to health obligations. The procedure provides rights-holders with an opportunity to obtain information on government action, and to ask for explanations. It also provides government with an opportunity to explain its actions. In the absence of accessible and effective accountability mechanisms, the right to health will be largely meaningless to rights-holders.

There are five broad types of accountability mechanisms:

- 1. Judicial** e.g., judicial review of executive acts and omissions, constitutional redress, statutory interpretation and public interest litigation;
- 2. Quasi-judicial** e.g., national human rights institutions, regional and international human rights treaty bodies;
- 3. Administrative** e.g., human rights impact assessment;
- 4. Political** e.g., parliamentary committee review of budgetary allocations and the use of public funds, democratically elected health councils and healthcare commissions;
- 5. Social** e.g., the involvement of civil society (independent or collaborative with government) in budget monitoring, health centre monitoring, public hearings and social audits.

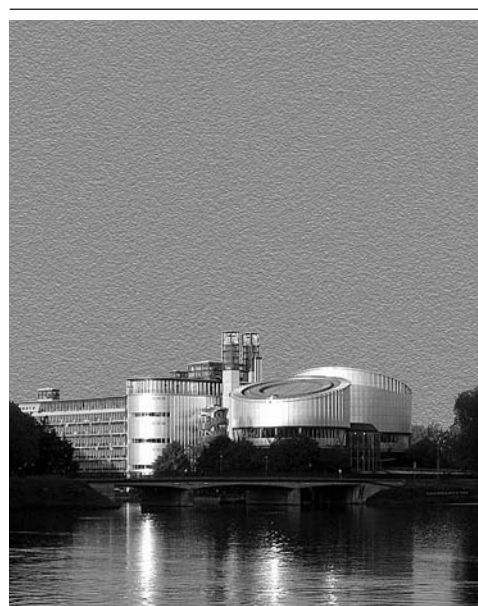
These different types of accountability mechanisms can be found at the national, regional and international levels. Some mechanisms can be described as 'specific' and others as 'general' accountability mechanisms. Specific accountability mechanisms, such as national human rights institutions, have been developed specifically to address human rights accountability.

General accountability mechanisms, while not developed for the purposes of human rights accountability, do have the capacity to address accountability in the context of the right to health e.g., democratically elected health councils.

This document is not definitive of all accountability mechanisms for the right to health. Accountability is a dynamic, flexible and context dependent process and subject to constant change. The examples provided in each mechanism are illustrative rather than exhaustive and are intended to highlight, through the variety of topics addressed, how accountability is relevant to the daily work of health policy makers. Purely for the purposes of organisation, the examples are divided into three types (national, regional and international) and then categorised under the types of mechanisms listed above. Within each of these sub-categories, reference is made to both specific and general accountability mechanisms where appropriate.

The focus is predominantly at the national level. While it is important for health policy makers to be aware of the accountability mechanisms available at the regional and international levels, it is the mechanisms that are available at the national level that will be most relevant to the day-to-day work of health policy makers. Web links are provided where appropriate and Appendix III contains a resource and web link page for those who wish to read further.

Photograph © Kpalion 2004.
European Court of Human Rights in Strasbourg.



ACCOUNTABILITY MECHANISMS > 1. NATIONAL

JUDICIAL (SPECIFIC)

The entrenchment of the right to health, either directly or indirectly, in the national constitution (or other legislation) may grant a specific right to health accountability mechanism which can provide access to the courts to enable rights-holders to challenge government legislation and policy. In addition to constitutional entrenchment, judicial mechanisms can hold the government to account through expansive interpretation of constitutionally entrenched rights such as the right to life. Judicial mechanisms can also hold government to account through the identification of legislation which is inconsistent with international human rights obligations, judicial review of executive decision-making, statutory interpretation, and the review of administrative tribunal decision-making.

Examples

South Africa

See *Case Study No. 1: Access to Drugs*, on pages 31–32. The Constitution of South Africa includes a Bill of Rights that recognises the right to health in Section 27. The case of the *Minister of Health v Treatment Action Campaign* provides an example of a judicial accountability mechanism in action. The Constitutional Court drew upon the general comments developed by the Committee on Economic, Social and Cultural Rights (in addition to other documentation) to develop an interpretation of Sections 27 and 28 of the South African Constitution. The Court determined that health policy was to be 'reasonable' in development and implementation. For policy to be 'reasonable', it was to be comprehensive, coordinated between levels of government, and focused on those in greatest need.

India

In *Paschim Banga Khet Mazdoor Samity & Ors v State of West Bengal & Anor* (1996) AIR SC 2426 / (1996) 4 SCC 37, the Supreme Court of India held that the government could not, on account of financial constraints,

escape its obligation to provide emergency treatment.

The case concerned a man who suffered serious head injuries following a fall from a train. He was taken to a number of State hospitals but none was able to provide him with emergency treatment; they lacked bed space, as well as trauma and neurological services. The issue before the Court was whether inadequate medical facilities for emergency medical treatment constituted a denial of the right to life. The Court found that there was a constitutional duty of government-owned hospitals to provide timely emergency treatment to someone seriously ill. This obligation was imposed by Article 21 of the Constitution of India – the right to life. The Court asked the government of West Bengal to pay the petitioner compensation for the loss suffered. It also directed the government to formulate a blue print for primary health care with particular reference to treatment of patients during an emergency.

Columbia

See *Case Study No. 2: High Impact Litigation as an Accountability Mechanism*, on pages 32–33. The Colombian Constitutional Court identified an inconsistency in domestic criminal law with international and regional human rights obligations and the impact of this inconsistency on the health of women. The decision had a direct and immediate effect on health policy makers: pertaining to the provision and regulation of abortion services within the public health care sector, and the issuing of technical guidelines which follow the recommendations of the World Health Organisation. The case also highlights that simply putting regulations in place is insufficient. In addition to regulation, dissemination of the decision and education of health workers is necessary to ensure that women are not denied access to these services. To assist with these processes, the relevant authorities in Colombia have collaborated with Women's Link and *La Mesa* to monitor the provision of services and address denial of services where necessary.

QUASI-JUDICIAL (SPECIFIC)

National Human Rights Institutions can be described in broad terms as independent bodies established by government for the specific purpose of advancing and defending human rights.¹⁸ These bodies can take many forms and range from human rights commissions to human rights ombudsmen and public defenders. National Human Rights Institutions frequently work with Social Accountability mechanisms to ensure the implementation of the right to health and government accountability.

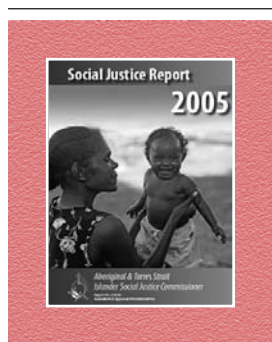
Photograph © 2004 Jan Swasthya Abhiyan. Public Hearing on the Right to Health Care, organised by the National Human Rights Commission and JSA. Programme Organiser Madhya Pradesh JSA.



Examples

Australia

The Human Rights and Equal Opportunity Commission (HREOC) has a well developed practice of public inquiry into systemic violations of human rights, especially economic, social and cultural rights. These inquiries began soon after HREOC was established in 1986. Public inquiries have been conducted into homelessness and children, children in immigration detention, human rights and mental health, the forcible removal of Aboriginal and Torres Strait Islander children from their families, rural and remote school education, and racist violence. All of these issues have an impact on health and are relevant to health policy development. The reports are tabled in parliament, result in changes in policy and increased public expenditure in inquiry areas, raise community awareness of human rights issues, and raise public expectations of more effective government action to address the human rights of vulnerable and marginalised groups. These inquiries are good examples of the usefulness of this quasi-judicial mechanism to investigate systemic violations of the right to health and



to call government to account. See, for example, the *Social Justice Report 2005*, which makes key recommendations relevant to the development of Indigenous health policy and sets out a human rights framework for achieving health equality within a generation.

Colombia

Case Study No. 2: High Impact Litigation as an Accountability Mechanism, on pages 32–33, records how the *Superintendencia Nacional de Salud* and the *Oficina del Procurador General de la Nación* are working collaboratively with Women's Link Worldwide to monitor the provision of sexual and reproductive health services to women in Colombia.

India

Case Study No. 3: The Right to Health Care Campaign, on pages 33–34, records a collaboration between the JSA and the National Human Rights Commission that has culminated in the holding of regional and national public hearings on the right to health care and the joint development of a National Action Plan on the Right to Health Care.

India

See *Case Study No. 4: Hunger amidst Plenty*, on pages 34–35, for an example of Supreme Court appointed commissioners with an extensive accountability mandate which includes the power to enquire about any violation of the orders of the Supreme Court and to demand redress by the State.

Perú

See *Case Study No. 5: Accountability through Monitoring*, on pages 35–36, regarding a collaboration between social accountability mechanisms and the Regional Defensoría del Pueblo (Perú Ombudsman's Office), which has resulted in the identification of bad practices in local health centres, addressing these bad practices and the subsequent improvement of health service provision.

QUASI-JUDICIAL (GENERAL)

In addition, general quasi-judicial bodies such as Patients' Rights Commissions or Tribunals, Healthcare Commissions, and Health Complaints Tribunals are present in many countries. They are usually autonomous bodies created pursuant to legislation. The mandate and powers of these quasi-judicial bodies vary, and can include determining complaints about the public health service, the independent health service, and health workers. These bodies can also carry out reviews of public and independent health sector performance, and investigations and research into the public health sector. Their focus tends to be on the curative health sector rather than the underlying determinants of health and/or prevention. Nevertheless, their work provides important assistance regarding the right to health for health policy makers through the issues they identify, the decisions of the tribunals, and the findings and recommendations of research and investigations.

Examples

New Zealand

The Health and Disability Commissioner is an independent agency set up to promote and protect the rights of consumers who use health and disability services; assist with the resolution of problems between consumers and providers of health and disability services; and improve the quality of health care and disability services. A complaint mechanisms was established under the *Health and Disability Commissioner Act 1994* and has become the primary vehicle for dealing with complaints about the quality of health care and disability services in New Zealand. In addition, a *Code of Health and Disability Services Consumers' Rights* (the Code) became law on 1 July 1996 as a regulation under the Health and Disability Commissioner Act. It confers a number of rights on all consumers of health and disability services in New Zealand and places corresponding obligations on providers of those services. Application of the Code is very wide, as it extends to any person or organisation providing, or holding themselves out as providing, a health service to the public or a section of the public, whether that service is paid for or not. Access to decisions and case notes of the Commissioner are available on the website. The cases include professional conduct, medical, dental and nursing care, the physical condition of health services and the quality of health care provision.

Source: *Health and Disability Commissioner* at www.hdc.org.nz

Photograph courtesy of HREOC, Australia. Cover of the Social Justice Report 2005 (original cover photograph Heidi Smith, 2004).

United Kingdom

See, for example, the *Healthcare Commission Review of Maternity Services*. The Healthcare Commission conducted the first national review of National Health Service (NHS) maternity services in England in response to concerns about maternity units. The review published on 25 January 2008, found significant variation in the quality of care across the country. Only one in four of NHS maternity services could be described as 'best performing'. In the absence of formal standards in maternity units, the review of 148 Primary Care Trusts (PCTs) providing maternity services set performance benchmarks for maternity for the first time, taking into account guidance from the National Institute for Health and Clinical Excellence and the National Service Framework for Maternity Services, and a range of issues that women and clinicians said were important. PCTs will now be able to use these to measure improvement, and the Commission will conduct a follow-up review to check on progress.

Source: Healthcare Commission at <http://2007ratings.healthcarecommission.org.uk/homepage.cfm>

ADMINISTRATIVE (SPECIFIC)

Human rights impact assessment (HRIA) is a relatively recent concept that seeks to predict the potential consequences of a proposed policy on the enjoyment of human rights.¹⁹ The objective of HRIA is to introduce an explicit process into the existing repertoire of actions undertaken by decision-makers or groups of people likely to be affected by decision making so that they can take action to improve the policy before it is finalised. The process seeks to reduce potential negative impacts on the population, and to enhance the potential positive impacts of a proposed action.

Examples

See the United Nations Educational, Scientific and Cultural Organization (UNESCO) report, *Impact Assessments, Poverty and Human Rights: A Case Study Using The Right to the Highest Attainable Standard of Health*, which draws key criteria from three human rights impact assessment initiatives:

1. the Norwegian Agency for Development (NORAD) Handbook in Human Rights Assessment,
2. the Rights & Democracy Initiative on Human Rights Impact Assessment, and
3. the Humanist Committee on Human Rights (HOM) Health Rights of Women Assessment Instrument,

to develop a HRIA methodology which specifically focuses upon the obligation of governments to undertake impact assessments in order to comply with their obligation to progressively realise the right to health. The methodology is developed through the integration of human rights into existing impact assessments. It operates as an accountability mechanism for decision makers and is based on the internationally recognised tried and tested impact assessment methodology and

the principles of health impact assessment (HIA). The ultimate goal of the HRIA methodology is to ensure that governments, from the outset of the policy making process, seek to ensure that any new proposal or modification includes consideration of, amongst others: access to health related facilities, participation, monitoring, accountability mechanisms and remedies. Although a new area, policy makers could, with relative ease, incorporate HRIA into other forms of impact assessment that they are using, such as Equality Impact Assessment, Social Impact Assessment or HIA.

ADMINISTRATIVE (GENERAL)

The development of HIA provides some useful guiding points which could be used to underpin HRIA, particularly the work completed on the production of the *Equity-Focused Health Impact Assessment Framework* (EFHIA).²⁰ Both forms of impact assessment are preoccupied with ensuring that the concerns of the most disadvantaged people in the population are included in the policy making process, prior to implementation, in more explicit ways. Just as HRIA is concerned with ensuring, amongst other concerns, non-discrimination and the meaningful participation of people in decisions that affect their lives,²¹ EFHIA emphasises the right of people to participate in decisions that affect them and the identification by policy makers of the distribution of the impact of a policy within the population.²² Additional tools for the incorporation of human rights into impact assessment are located in Appendix III Resources and Weblinks.

Example

An example of an HIA which has an equity focused framework embedded within it, is the Atlanta BeltLine Health Impact Assessment, Centre for Quality Growth and Regional Development, Georgia Institute of Technology (www.cqgrd.gatech.edu/HIA). The Atlanta BeltLine is one of the largest and most comprehensive planning and urban design projects in Atlanta. It consists of a 22 mile loop of rail that will be converted to a transit system and park system that encircles the core of Atlanta. The Atlanta Beltline Health Impact Assessment, commenced in 2005 and completed in 2007, was an unprecedented assessment of the Atlanta Beltline's health impacts and is one of the first HIAs performed in the United States to evaluate a major transport and land use project that has the potential for long-term, widespread health and development impacts.

This HIA adopted a broad understanding of health and disaggregated the data collected on the basis of age, employment, ethnicity, income, and residential area. As a result, equity was embedded into the research and its findings. To ensure equitable outcomes of this 25 year development plan, the HIA recommended that the development plan would need to ensure that there would be sufficient affordable and healthy housing. 'Healthy housing' was defined as being of good condition; safe; free from pollutants and excess noise,

temperature and humidity; situated in a safe neighbourhood; and providing access to goods and services. In addition, programmes and partnerships to address displacement would need to be developed. The HIA was also able to identify that the planning area with the largest minority population and the largest numbers of children under the age of 18 and adults 65 years and over, was also relatively underserved by parks, compared with other planning areas within the BeltLine. Importantly, the HIA also recommended the development of a 25 year citizen engagement framework. This was subsequently incorporated into the design of the project and is achieved through a 5 part engagement framework that is designed to keep Atlanta residents informed and actively engaged in the BeltLine's creation. For more information on the Atlanta BeltLine, see www.beltline.org.

POLITICAL

Political accountability depends on the nature of the political system in a country. As a result, the power of a political accountability mechanism will vary from one country to another. Despite this variation, political accountability is central. Through linkages to social accountability mechanisms, especially the media, political accountability can ensure remedies, particularly 'satisfaction' (see page 29), ranging from political embarrassment to removal from office. Included within political accountability mechanisms are parliamentary committees, democratically elected health councils and free and fair elections.

PARLIAMENTARY COMMITTEES

Parliamentary committees exist in many countries and come in almost endless varieties.²³ They can be specific or general accountability mechanisms. Their function and composition varies from country to country. They conduct inquiries into specified matters such as investigation of policy issues, proposed legislation or government activities such as international assistance and cooperation. During this process they may take submissions and hear witnesses. Accordingly, this accountability mechanism can also provide a forum for a form of participation by civil society. Although the parliamentary committee process provides an important accountability

mechanism, it is a mechanism that is weak in many countries and requires substantial capacity building.

Examples

United Kingdom

The United Kingdom has a highly developed committee system. Three committees relevant to accountability and the right to health are the Joint Committee on Human Rights; the International Development Committee; and the Foreign Affairs Committee. For example, the Joint Committee on Human Rights completed an inquiry in August 2007, into the victimisation and neglect of older people within the United Kingdom healthcare system. Research conducted by the British Institute for Human Rights, and described in its report *Something for Everyone*, raised possible human rights violations, including the right to respect for private life and the right to physical integrity (Article 8, ECHR), the right to freedom from inhuman and degrading treatment (Article 3, ECHR), and the right to life (Article 2, ECHR). In its report, the Committee examined how human rights could be applied to ensure that older people in hospitals and care homes could be treated with greater dignity and respect. The Committee made several recommendations including, the adoption of a strategy to make the Human Rights Act (1998) integral to policy-making and social care across the UK Department of Health, better staff training in human rights principles and their inclusion in health professionals' qualifications, and the development of more robust complaints procedures.

Source: Joint Committee on Human Rights, www.parliament.uk/parliamentary_committees/joint_committee_on_human_rights/olderpersonsinhealthcare.cfm

Canada

The Parliamentary Centre (www.parlcent.ca), a not-for-profit, non-partisan organisation, provides support to parliaments and legislatures to improve the effectiveness of representative assemblies. The Centre provides support to parliaments in Asia, Africa, Latin America, Eastern Europe and the Middle East. For example:

- n The Centre acts as the Secretariat for the Coalition of African Parliamentarians Against HIV and AIDS (CAPAH) (www.parlcent.ca/africa/CAPAH/index_e.php.) CAPAH was formed in February 2006, with the



Photograph © Deryc Sands. Debate in the House of Commons, UK.

aim to collaborate with existing institutions and regional bodies such as SADC-PF in order to ensure that the response to HIV/AIDS is prioritised and monitored at the national and regional levels.

- n The Centre is the Canadian Executing Agency for the Cambodia-Canada Legislative Support Project (CCLSP) (www.parlcent.ca/asia/cclsp_e.php?template=print). It implements and manages the project to promote democracy in Cambodia by building the capacity of both the National Assembly and the Senate. Included within the outcomes is the capacity development of the Commissions of Parliament to incorporate gender analysis in legislation and to improve public policy consultation.

HEALTH COUNCILS

Democratically elected health councils represent a form of political accountability which have gained considerable popularity in recent decades. Usually statutory bodies, they are present in many countries and have a variety of powers. Their powers vary from the approval of health plans and budgets, to the provision of a complaints mechanism (in which case they overlap with quasi-judicial mechanisms) to simply attempting to increase the voice of civil society in the development of health policy.

Example

Brazil

The Brazilian Health Councils System acknowledges the contribution citizens can make to accountability through the presence of health councils at the municipal, state and national levels. Mandated by law, representatives of civil society (50 per cent), health workers (25 per cent) and government officials and contracted-out service providers (25 per cent), come together at the monthly meetings of the health councils to make binding decisions, approve budgets and health plans, and play a role in ensuring accountability. In December 2000, municipal health councils were operational in 5,451 municipalities, with approximately 88,000 council members. The health councils are linked institutionally to the executive agencies – the National Health Council, State Health Councils, and Municipal Health Councils. The health councils' actions are guided by the recommendations from the health conferences, which take place at the three levels of government, with the broad participation of several social sectors. These conferences are convened every four years by the executive branch to evaluate the health situation and propose guidelines for the formulation of health policy.

The monthly health councils also make it possible for the public to voice its demands, as they are open to the public. Whilst only elected council members are entitled to vote, all those present at the monthly meetings have a right to express an opinion. As the meetings are open to the public, the health councils permit greater adaptation of the programs offered by the system. Many public health units and public hospitals have also been setting

up councils or other advisory bodies with significant representation of users.

Source: PAHO Brazil Health System Profile, March 2005, www.paho.org

FREE AND FAIR ELECTIONS

Free and fair elections can provide a retrospective general accountability mechanism through the removal of office for failure to implement electoral promises. It is a generally agreed assumption that free and fair elections by themselves are no guarantee of good governance.²⁴ While they provide a means of government accountability to citizens, they occur only periodically, and their accountability can be in the presence of poorly defined issues and sudden policy reversals.²⁵

SOCIAL

Social accountability mechanisms involve citizen action to oversee government conduct. Through a process of social mobilisation and the use of the media, these mechanisms can provide a set of checks and balances on the proper conduct of government.²⁶ Social accountability mechanisms can also act as quasi-official agents, and can also create new formal accountability mechanisms.

There is a myriad of national, regional and international civil society movements working individually and collaboratively to develop mechanisms to call governments to account for implementation of the right to health. See for example, the national organisations mentioned in this document: the Treatment Action Campaign, JSA, the Right to Food Campaign, Care-Perú, Rosengrenska, La Mesa, MKSS, and the Participation and Practice of Rights Project. At the regional level, see for example, the Asian Human Rights Commission (AHRC) (www.ahrchk.net/index.php), and International Women's Rights Action Watch – Asia Pacific (IWRAP Asia Pacific) (www.iwraw-ap.org). At the international level, see for example, Global Health Watch, (www.ghwatch.org), The Peoples' Health Movement (PHM) (www.phmovement.org), the International Federation of Health and Human Rights Organisations (IFHHRO) (www.ifhhro.org), Physicians for Human Rights (PHR) (<http://physiciansforhumanrights.org>), the Open Society Institute (OSI) (www.soros.org), Amnesty International (www.amnesty.org), Human Rights Watch (HRW) (www.hrw.org), the International Centre for the Protection of Human Rights (Interights), the International Service for Human Rights (ISHR) (www.ishr.ch), and the International Commission of Jurists (ICJ) (www.icj.org). In addition many international NGOs have national and regional chapters.

Examples

Social accountability mechanisms as quasi-official agents

Social accountability mechanisms can act as quasi-official agents, either participating directly in accountability mechanisms or substituting for failing state

accountability institutions. They regularly work with other accountability mechanisms, for example, quasi-judicial mechanisms, to obtain a response from government and to monitor government accountability processes.

Colombia

See *Case Study No. 2: High Impact Litigation as an Accountability Mechanism*, on pages 32–33, which records how the Superintendencia Nacional de Salud and the Oficina del Procurador General de la Nación are working collaboratively with Women's Link Worldwide to monitor the provision of sexual and reproductive health services to women in Colombia.

India

See *Case Study No. 3: The Right to Health Care Campaign*, on pages 33–34, which describes a collaboration between JSA and the National Human Rights Commission (NHRC) that has culminated in the holding of regional and national public hearings on the right to health care and the joint development of a National Action Plan on the Right to Health Care, which has been sent to the central government and all state governments for action.

India

See *Case Study No. 4: Hunger amidst Plenty*, on pages 34–35, for an example of Supreme Court appointed Commissioners with an extensive accountability mandate that includes the power to enquire about any violation of the orders of the Supreme Court and to demand redress by the State for those violations.

Perú

See *Case Study No. 5: Accountability through Monitoring*, on pages 35–36, regarding a collaboration between social accountability mechanisms, the Regional *Defensoría del Pueblo* (Perú Ombudsman's Office), and community women to monitor and report on local health services that has resulted in the identification of bad practices, addressing these bad practices and the subsequent improvement of health service provision.

Social accountability mechanisms creating new formal accountability mechanisms

Social accountability mechanisms can also create new formal accountability mechanisms. Consider, for example, the development of the NGO Shadow Report to the UN treaty monitoring bodies, such as the Committee on Economic, Social and Cultural Rights (CESCR) and the

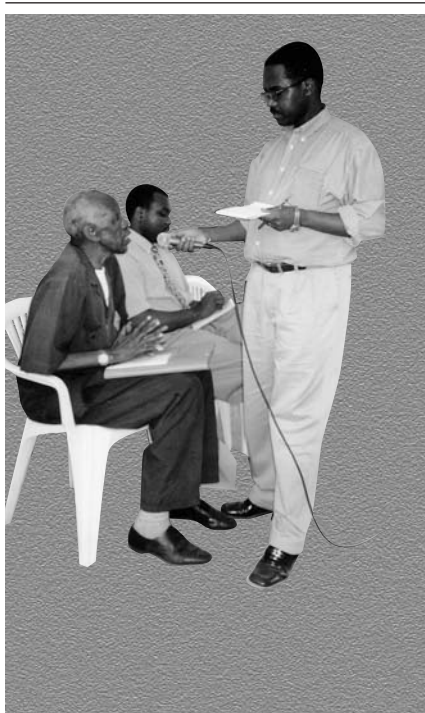
Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW Committee). These shadow reports provide information that supplements State reports and assists the committees to address concerns that may have been misreported, under reported or omitted in the State report.

NGOs can submit 'shadow reports' to the CESCR on any aspect of a government's compliance with the ICESCR. Shadow reports should be submitted through the CESCR Secretariat at the Office of the High Commissioner for Human Rights (OHCHR) in Geneva (www2.ohchr.org/english/bodies/cescr/NGOs.htm). See for example the supplementary information on the Philippines, provided by the Center for Reproductive Rights (1 November, 2007) to the Pre-Sessional Working Group of the CESCR (www2.ohchr.org/english/bodies/cescr/docs/info-ngos/CRR_letterPhilippines.pdf).

NGOs can submit 'shadow reports' to the CEDAW Committee on any aspect of a government's compliance with CEDAW. These shadow reports can be submitted to the CEDAW Committee, either prior to or at the committee session. NGOs can also send their shadow reports to IWRAP-Asia Pacific, a non-governmental organization, in advance of the session. IWRAP-Asia Pacific distributes NGO shadow reports electronically, and/or in hard copy, to CEDAW experts in advance of the session. In addition, NGOs play a pivotal role in the work of the Commission on the Status of Women. NGOs have been influential in shaping the current global policy framework on women's empowerment and gender equality. They continue to play an important role in holding international and national leaders accountable for the commitments they made in the Beijing Declaration and Platform for Action (www.un.org/womenwatch/daw/ngo/index.html).

MEDIA

The media plays a significant role in today's society by providing a very wide range of information in a variety of ways. The media strongly influences community attitudes, beliefs and behaviour; plays a vital role in politics, economics and social practice; and can influence political popularity. Civil society movements frequently engage the media and hence rely on the presence of a free media that is willing to engage in critical journalism. The effectiveness of social accountability mechanisms is weakened in the absence of the protection and enforcement of the human rights of expression, association and information.



Photograph © 2001 CCP, courtesy of Photoshare. Live broadcast of the KUBA road show at EXPO 2001, an annual trade fair in Kigali, Rwanda. In this photo, a journalist interviews a community opinion leader about HIV/AIDS prevention.

Examples

South Africa

Case Study No. 1: Access to Drugs, on pages 31–32, describes a case in which the Treatment Action Campaign (TAC) engaged in intensive public mobilisation in the form of rallies, vigils and marches around the country, all of which attracted enormous support and media interest. The media played a critical role in reporting rallies; mobilising public opinion against government policy; reporting court decisions and appeals by government against those court decisions; and providing ongoing reporting of the governments implementation (or not) of the court decisions.

Colombia

Case Study No. 2: High Impact Litigation as an Accountability Mechanism, on pages 32–33, shows how Women's Link Worldwide recognised the important role of the media in disseminating information on the campaign. Through media reporting of civil-society mobilisation, there was a reframing of the public debate on abortion. People had the opportunity to hear many different voices. As a result, popular perception of

the issue evolved and the level of debate matured. The debate became one based on public health and human rights and supported by scientific data and constitutional arguments, and moved away from a discussion about church doctrine. The debate matured to the point that it included discussion regarding the separation of church and State; this marked a notable milestone for Colombia.

Sweden

Case Study No. 6: Sweden and the Special Rapporteur on the Right to the Highest Attainable Standard of Health, on page 36, describes how the media has played a critical role in publicising the visit to Sweden of the Special Rapporteur on the Right to Health and his findings. Government policy in Sweden regarding undocumented migrants and access to health care services, results in Sweden being in breach of its human rights obligations. This has challenged the Swedish people's view of themselves as a humanitarian nation. Partly as a result of media reporting of the visit, there is a growing social movement within Sweden for a change in government policy.

ACCOUNTABILITY MECHANISMS > 2. REGIONAL

JUDICIAL

At a regional level there are three specific, judicial accountability mechanisms: the African Court of Human and Peoples' Rights; the European Court of Human Rights; and the Inter-American Court of Human Rights. Each court has considered cases that have had an impact on health policy. The example provided comes from the Inter-American Court of Human Rights.

Example

Brazil

Ximenes-Lopes v Brazil Judgment of July 4, 2006. Series C No. 149

This case concerned the death of a man with a mental illness four days after his admission to a privately run psychiatric facility. The State of Brazil acknowledged partial liability for violation of Mr. Damião Ximenes-Lopes' rights to life (American Convention, Article 4) and personal integrity (American Convention, Article 5). The Court held unanimously that the first recourse the State should have provided was an effective investigation and a legal proceeding conducted pursuant to the requirements of Article 8 of the Convention, providing for the discovery of the truth, punishment of the perpetrators and the award of adequate compensation. In addition to compensatory damages for the relatives of the deceased, the Court ordered that the government publish a copy of the judgment at least once in the Official Gazette and in another nationwide daily newspaper and continue to develop an education and training programme for health workers and any person involved in mental health services.

QUASI-JUDICIAL

At a regional level there are three specific, quasi-judicial accountability mechanisms: the African Commission on Human and Peoples' Rights; the European Committee of Social Rights; and the Inter-American Commission on Human Rights. Each of these quasi-judicial mechanisms has addressed specific right to health cases with relevance to health policy makers. The example provided comes from the African Commission on Human and Peoples' Rights.

Example

The Gambia

Purohit and Moore v The Gambia, Communication No.241/2001.

This is an example of an accountability mechanism with significant implications for health policy, as a new mental health policy emerged from the process. The applicants alleged, amongst others, that the legislative regime in The Gambia for mental health patients violated the right to enjoy the best attainable state of physical and mental health (Article 16 of the African Charter on Human and Peoples' Rights) and the right of the disabled to special measures of protection in keeping with their physical and moral needs (Article 18(4) of the African Charter on Human and Peoples' Rights). The principal legislation governing mental health in The Gambia at the time was the Lunatic Detention Act (1917).

The African Commission urged the government to repeal and replace the impugned legislative regime and provide adequate medical and material care for persons



Photograph © Council of Europe. Parliamentary Assembly of the Council of Europe in session.

suffering from mental health problems in The Gambia. In 2004 the Gambian Department of Health officials met with the WHO and commenced work on drafting a mental health policy and strategic action plan for The Gambia. The documents were drafted on the basis of a situational assessment of mental health in the country, several wide consultations with key national stakeholders, a series of training workshops on mental health policy and ongoing technical review and inputs on different drafts from WHO and other key actors. The Mental Health Policy and Strategic Plan, developed with the support of WHO, were finalised in December 2006. The policy and plan set out a clear vision and concrete strategies to provide high quality mental health care to those in need. Major objectives include the provision of equitable, accessible, cost-effective and quality mental health and substance abuse services in the community and the promotion and protection of the rights of people with mental and substance use disorders. In September, 2007, the Secretary of State for Health, Dr. Mbowe, officially approved The Gambia's mental health policy. In addition, Mr Bakary Sonko was appointed as the first Mental Health Coordinator in The Gambia. He will be coordinating the implementation of the newly developed policy and plan.

Source: ESCR-Net www.escr-net.org/caselaw, World Health Organisation at www.who.int/mental_health/policy/country/thegambia/en, and Interights at www.interights.org/showdoc/index.htm?keywords=purohit&dir=databases&refid=3086

POLITICAL

At a regional level, there are several parliamentary assemblies and inter-government organisations which operate to varying degrees as accountability mechanisms. The parliamentary assembly with the broadest mandate is the Parliamentary Assembly of the Council of Europe.

Example

Europe

The Parliamentary Assembly of the Council of Europe (PACE) (<http://assembly.coe.int>) is made up of 47 member states, and aims to achieve greater unity among its members through common action, agreements and debates. The conditions for membership are pluralistic democracy, the rule of law and respect for human

rights. The rules of procedure for the PACE provide for 10 committees, one of which is the Committee on Legal Affairs and Human Rights.

The Committee on Legal Affairs and Human Rights considers all legal and human rights matters which fall within the competence of the Council of Europe. It plays a key role in the scrutiny given by PACE to the newly democratic States of Europe, in order to ensure they apply the rule of law and respect human rights, parliamentary democracy and the rights of minorities. The Committee covers a very broad range of legal topics, on which it appoints parliamentary Rapporteurs mandated to prepare reports which culminate in resolutions and recommendations addressed to the Council of Europe. Examples of recent topics include the state of human rights in Europe, secret detentions and illegal transfers of detainees involving Council of Europe member states, member states' duty to cooperate with the European Court of Human Rights, and the implementation of judgments of the European Court of Human Rights.

Africa

The Coalition of African Parliamentarians Against HIV and AIDS (CAPAH) www.parlcent.ca/africa/CAPAH/index_e.php aims to collaborate with existing institutions and regional bodies such as SADC-PF in order to ensure that the response to HIV/AIDS is prioritised and monitored at the national and regional levels and capacity building to achieve this aim is undertaken. This is in response to research which has revealed that the level of parliamentary participation and oversight on HIV policy making and programmes is weak in many African countries. Most African executive branches of government have not developed an accountability relationship with their parliaments on matters relating to HIV/AIDS. Parliamentarians have in the past considered HIV to be a health problem and therefore primarily the responsibility of the executive. While SADC-PF has recommended that African parliaments form specific HIV/AIDS parliamentary committees, few have done so. In addition to the stigma associated with HIV and weak oversight capacity, parliamentarians lack training on the complexities of HIV/AIDS and the linkages with policy areas beyond health policy.

See also the following regional parliamentary assemblies and inter-governmental organisations:

- Andean Parliament at www.parlamentoandino.org;
- Central American Parliament at www.parlacen.org.gt;
- Parliament of the Economic Community of West African States at www.parl.ecowas.int;
- Southern African Development Community at www.sadc.int;
- East African Legislative Assembly at www.eac.int/eala/index.htm;
- European Parliament at www.europarl.europa.eu;
- Association of Southeast Asian Nations at www.aseansec.org

ACCOUNTABILITY MECHANISMS > 3. INTERNATIONAL

JUDICIAL

At an international level, there is no judicial accountability mechanism specific to the right to health. However, the decisions of two international courts have the potential to impact on health policy at a domestic level.

Example

The International Criminal Court (ICC)

(www.icc-cpi.int) established by the Rome Statute of the International Criminal Court, addresses accountability for gross human rights violations which by their very nature have an impact upon the health of individuals and groups. As of 17 October 2007, 105 countries are States Parties to the Rome Statute.

The International Court of Justice (ICJ)

(www.icj-cij.org) has addressed issues related to health. See, for example, Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory, Advisory Opinion, I.C.J. Reports 2004, p.136 at 191, where, in the opinion of the Court, the construction of the wall and its associated regime impedes the exercise by the people concerned of the rights to work, health, education and an adequate standard of living, as contained in the ICESCR. The decision was the first time the Court provided an advisory opinion which explicitly included human rights.

QUASI-JUDICIAL

United Nations Committee Treaty Bodies

At an international level, the United Nations Committee Treaty Bodies, such as the CESCR, the CEDAW Committee, and the Committee on the Rights of the Child (CRC), address right to health accountability. The CESCR monitors implementation of the ICESCR by its States parties. All States parties are obliged to submit regular reports to the Committee on how economic, social and cultural rights are being implemented. The Committee examines each report and addresses its concerns and recommendations to the State party in the form of 'concluding observations'. These reports and concluding observations are available at www2.ohchr.org/english/bodies/cescr/sessions.htm.

In addition, several other treaty monitoring committees have the competence to consider individual communications that concern issues related to the right to health of individuals and groups. These committees are: CEDAW Committee, Human Rights Committee (HRC), Committee on the Elimination of Racial Discrimination (CERD) and Committee Against Torture (CAT).

The CEDAW Committee is also mandated to initiate inquiries into situations of grave or systematic violations of women's rights. This procedure is optional and is only available where the State has become a party to the Optional Protocol to the CEDAW (www.un.org/womenwatch/daw/cedaw/protocol/whatis.htm).

Special Procedures

'Special Procedures' is the general name given to the mechanisms established by the Commission on Human Rights and assumed by the Human Rights Council to address either specific country situations or thematic issues in all parts of the world. Amongst their activities, most Special Procedures receive information on specific allegations of human rights violations and send communications to governments asking for clarification. They also undertake country and other missions. In 2002, the Human Rights Commission appointed a Special Rapporteur on the right to the highest attainable standard of health (the Special Rapporteur). The mandate of the Special Rapporteur is set out in Commission on Human Rights resolutions on the right to health, in particular resolution (2002/31) (http://ap.ohchr.org/documents/dpage_e.aspx?m=100).

Example — United Nations Treaty Bodies

CESCR Reports – Ukraine

The CESCR considered the fifth periodic report of Ukraine, in November 2007. The CESCR had expressed concern in the concluding comments to the fourth periodic report of the Ukraine at the increase in the spread of HIV/AIDS in the Ukraine. The governments fifth periodic report directly referred to these concerns of the CESCR and described current HIV/AIDS statistics, the establishment of a special interim commission on 'HIV/AIDS, tuberculosis and drug addiction', the establishment of a national coordinating council on HIV/AIDS prevention, and the adoption of the National AIDS Programme (2004–2008). At the same time, the content of an NGO shadow report provided the CESCR with information related to high levels of discrimination against people living with HIV/AIDS, in particular, injecting drug users and sex workers; the government report made no reference to HIV/AIDS related discrimination. As part of the recommendations in the concluding comments, the CESCR recommended that the Ukraine government take urgent measures to combat discrimination against persons living with HIV/AIDS and high risk groups. The fifth periodic report of the Ukraine, the CESCR concluding comments, and the NGO shadow report are available at www2.ohchr.org/english/bodies/cescr/cescrs39.htm. The CESCR's concluding comments to the fourth periodic report are available at [www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/E.C.12.1.ADD.65.En?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/E.C.12.1.ADD.65.En?Opendocument).

HRC Individual Complaints – Perú

KL v Peru (Communication no. 1153/2003). In this case, a seventeen year old woman, pregnant with an anencephalic fetus, was denied access to a therapeutic abortion which the laws of Perú allowed. The pregnancy severely compromised her physical and psychological health. The Center for Reproductive Rights, the

Counseling Center for the Defense of Women's Rights (DEMUS), and the Committee for the Defense of Women's Rights (CLADEM) filed a complaint under the Optional Protocol to the ICCPR seeking a remedy for the failure of State officials' to protect the petitioner's right to be free from inhumane and degrading treatment, among other rights. In 2005, the Human Rights Committee issued its ruling on the case, establishing that denying access to legal abortion violates women's human rights. This decision marked the first time that an international human rights body held a government accountable for failing to ensure access to legal abortion services.

Source: Center for Reproductive Rights, www.reproductiverights.org/crt_ab_access_legal.html#peru.

CEDAW Optional Protocol, Article 8 Inquiry Process

In October 2003, the CEDAW Committee decided to conduct an inquiry concerning Mexico, following the receipt of reliable information containing allegations of the abduction, rape and murder of women in the Ciudad Juárez area of Chihuahua, Mexico. Following the inquiry, the CEDAW Committee concluded that the situation was not one of sporadic instances of violence against women, but rather it was one of 'systematic violations of women's rights, founded in a culture of violence and discrimination that is based on women's alleged inferiority, a situation that has resulted in impunity.'²⁷ The CEDAW Committee made significant recommendations, many of which the Government of Mexico has commenced to implement. The recommendations included:



the strengthening of coordination and participation at the federal, state and municipal levels with a view to increasing the effectiveness of the 40-point action plan and other programmes to address violence against women, the incorporation of a gender perspective into all investigations, policies and programmes, the establishment of early warning search mechanisms for cases involving missing women and girls in Ciudad Juárez and Chihuahua state, and the total autonomy and independence of the forensic department. Despite these recommendations, the CEDAW Committee noted during consideration of the sixth periodic report of Mexico that crimes against and disappearances of women continued, and that government efforts were insufficient to successfully complete investigations of cases and to properly prosecute and punish the perpetrators, as well as to provide remedies to the victims and their families. The report of the inquiry and the reply from the Government of Mexico is available online (www.un.org/womenwatch/daw/cedaw/protocol/dec-views.htm). The CEDAW Committee's concluding comments on the Government of Mexico's 6th Periodic Report is also available online at www.un.org/womenwatch/daw/cedaw/36sess.htm.

Example — United Nations Special Procedures

Sweden

Case Study No. 6: *The Special Rapporteur on the Right to the Highest Attainable Standard of Health* on page 36 records that the mission to Sweden by the Special Rapporteur in 2006 and the subsequent report have augmented an existing movement to ensure access to health care by undocumented migrants (see *Annexure III Resources and Weblinks* for a link to this report and other country mission reports). The Special Rapporteur's report has been a valuable tool to advocate and lobby for a change in the law and in policy. It has been used by organisations such as *Rosengrenska*,²⁸ as well as members of the Swedish Parliament to claim that by denying undocumented migrants access to health care services, Sweden is in breach of its international human rights obligations.

Photograph courtesy of OHCHR, 2006. Committee on Economic, Social and Cultural Rights consideration of the Tadjikistan Periodic Report.

ACCOUNTABILITY MECHANISMS > CONCLUSION

The right to the highest attainable standard of health requires accessible and effective accountability mechanisms at the national, regional and international levels. Under the right to health, those with obligations should be held to account so that misjudgements can be identified and corrected, problems can be exposed and reforms identified.

The preceding illustrations show the wide range of right to health accountability mechanisms, such as healthcare commissions, NHRIs, democratically elected local health councils, public hearings, impact assessments, judicial proceedings, and so on. The case studies

show that while it is principally the judicial accountability mechanism that provides the final platform for government accountability, this is a mechanism that rarely operates in isolation from other mechanisms. Frequently, recourse to judicial mechanisms arises from and feeds back into other accountability mechanisms.²⁹ It is essential therefore that many different types of accountability mechanisms are available. Indeed, a sector as complex as the health sector requires a wide variety of accountability mechanisms to review the important and difficult decisions made within it.

E. EFFECTIVE REMEDIES

Summary

Governments have an obligation to ensure that:

- n There are adequate legal or other appropriate remedies available to any rights-holder claiming that his or her right to health has been violated.
- n These remedies take one or more of the following forms: restitution; rehabilitation; compensation; satisfaction; and guarantees of non-repetition.
- n The right to a remedy for a violation of the right to health includes the right to access national, regional (if applicable) and international procedures for protection.
- n The procedures to obtain a remedy for violation of the right to health are known by all rights-holders.

Remedies to redress violations of the right to health are key to ensuring that human rights have meaning. Remedies may take any one or more of the following forms:³⁰

Restitution

Restitution involves the re-establishment of a situation that existed prior to the violation of the right to health. For example, if legislation or policy has been introduced to limit access to health care services by particular groups, restitution would involve amendment of the legislation or reversal of the policy.

Compensation

Compensation should be provided for any economically assessable damage resulting from a violation of human rights. The State has an obligation to take all necessary measures to safeguard persons within its jurisdiction from infringements of the right to health by third parties. Such infringements include illness and injury caused through the non-regulation of privately

controlled health services, and illness and injury caused through the non-provision of health services which are allowed by law (see *Box 6*). Economically assessable damage includes the following:

- n physical or mental harm, including pain, suffering and emotional distress;
- n loss of opportunity, for example, education;
- n costs required for medicines and medical services;
- n material damages and loss of earnings, including future economic loss; and
- n costs required for legal or expert assistance.

Rehabilitation

Rehabilitation includes medical and psychological care as well as legal and social services. As rehabilitation includes provision of social services, this remedy could include the provision of services such as water and basic sanitation (see *Box 7*).

Box 6: Inter-American Commission on Human Rights, Report No 21/07, Petition 161-02 Friendly Settlement. Paulina del Carmen Ramírez Jacinto, Mexico, 9 March 2007

Paulina del Carmen Ramírez Jacinto, a 14 year old, became pregnant as a result of rape. Despite authorisation for an abortion given by the Attorney General's Office, public health officials deceived Paulina Ramirez into withdrawing her request. The case was settled through a friendly settlement agreement reached by all the parties in the case. The Government of Baja California agreed to substantial remedies which included:

- n compensation in the form of consequential damages covering legal expenses and educational expenses,
- n the provision of health services (including psychological),
- n the provision of school supplies and enrolment

fees for herself and her child,

- n the public acknowledgement of responsibility,
- n the amendment of legislation,
- n the provision of training courses to health workers, and
- n the conduct of a national survey to assess the enforcement of official standards regarding medical assistance in cases of domestic violence, and to measure progress with the implementation of the National Program for the Prevention and Attention of Domestic, Sexual, and Violence against Women.

Source: Inter-American Commission on Human Rights, www.cidh.org/annualrep/2007eng/Mexico16102eng.htm

Satisfaction, and guarantees of non-repetition

These two remedies include:

- n full and public disclosure of the truth;
- n an apology, including public acknowledgement of the facts and acceptance of responsibility;
- n an official declaration or a judicial decision;
- n judicial or administrative sanctions against the persons responsible for the violations;
- n inclusion of right to health training for government and health workers;
- n conducting and strengthening, on a priority and continued basis, right to health training to all sectors of society, in particular to government ministers and their department staff and members of other political parties;
- n legislation;
- n monitoring and enforcement mechanisms;
- n organisational improvements in the ministry concerning planning, budgeting, policy formulation;
- n renewed commitment to or reaffirmation of the original obligation, accompanied by an action plan including benchmarks and dates for achievement.

The first three remedies focus on the rights-holder and are concerned with redressing the impact of the violation of the individual or group rights-holder. The last two remedies, satisfaction, and guarantees of non-repetition, are particularly important in ensuring the introduction of systematic accountability processes

in the long term.

All of the remedies mentioned above should be available through the judicial accountability mechanism of every State that is a party to the ICESCR. Many of these remedies (for example, full and public disclosure of the truth, or renewed commitment to an original obligation, or inclusion of right to health training for government and health workers), could also be made available through other accountability mechanisms, in particular



Photograph courtesy of Treatment Action Campaign. MTCT demonstration in Guguletu, June 2001.

the quasi-judicial and political mechanisms. In addition, remedies such as apologies or the introduction of right to health training could be made available within social accountability mechanisms, such as public hearings and mass social audits.

Box 7: Grootboom and others v Government of the Republic of South Africa and others

This case, an example of an underlying determinant of health, concerned the enforceability of economic and social rights in the South African Constitution, in particular sections 26 (right to housing) and section 28(1)(c) (children's right to shelter). A group of adults and children had moved onto private land from an informal settlement. They were subsequently evicted from the private land, and camped on a sports field in the area. They could not erect adequate shelter, as most of their property had been destroyed during the eviction. The group was in a precarious position: no security of tenure and no adequate shelter. They applied to the Cape of Good Hope High Court for an urgent order, against all levels of government, to be provided with temporary housing. The Court found that the children and, through them, their parents were entitled to shelter under section 28(1)(c) and ordered each level of government to provide them with temporary housing in the form of tents, portable latrines

and a regular supply of water. This formed the basis of an appeal to the Constitutional Court by the government (see CCT 11/00).

During the High Court case, an offer was made by the three levels of government (national, provincial, municipal) to ameliorate the immediate crisis situation in which the children and adults were living. This offer was accepted. However some four months later, an urgent application was made to the Constitutional Court in which it was revealed that each level of government had failed to comply with the terms of the agreement. The application was heard on the 21 September 2000 (CCT 38/00). On that day the Court crafted an order which included the provision of a specified number of temporary toilets and taps pending the construction of permanent toilets and water taps on the sports ground.

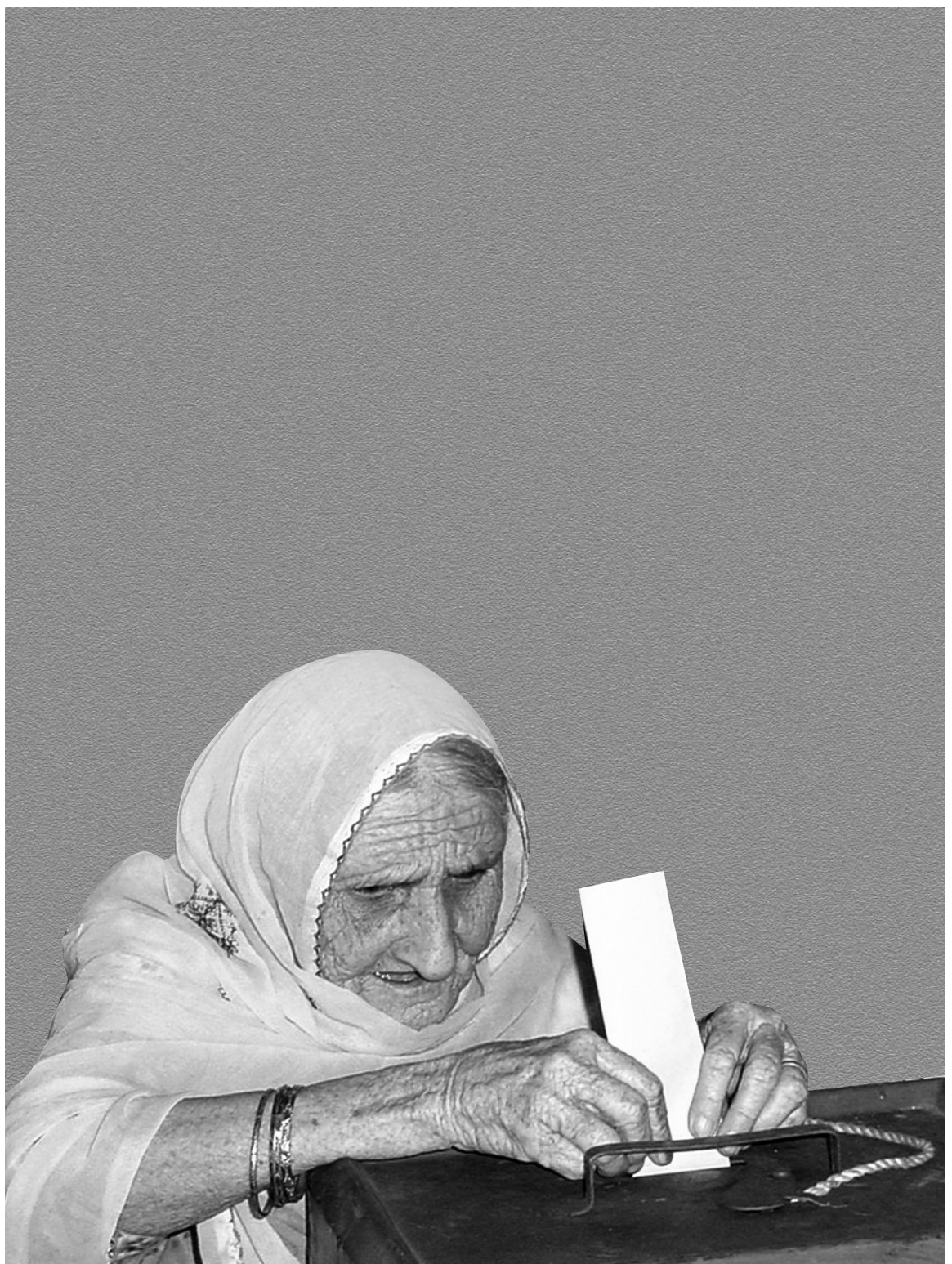
Source: South African Legal Information Institute, www.saflii.org/za/cases/ZACC/2000/14.html

F. PARTICIPATION IN ACCOUNTABILITY

Accountability establishes a dialogue between the government and rights-holders. It engages them in discussion.³¹ Hence, participation is present throughout the process of accountability. The methods of participation (for example, social audits, public hearings and legal representation in

judicial mechanisms) will vary with the context.

Because of the constraints of space, a companion monograph on participation and the right to health is currently being developed and will be released in the second half of 2008.



Photograph © 2005
Khalid Mahmood Raja,
courtesy of Photoshare.
An elderly woman casts
her vote during local
government elections in
2005 in Rawalpindi City
District, Pakistan.

SECTION III: CONCLUSION

The previous sections have aimed to provide to health policy makers, an introduction to accountability in the context of the right to health. It is by no means the end of the story. This is a preliminary work and much more needs to be done by the human rights community and the health community, working in collaboration, to investigate, understand and further refine accountability in the context of the right to health. For example, the application of the elements of accountability to specific issues would be one way of further refining accountability in the context of the right to health.

For a variety of reasons, it is not possible to provide a simple checklist of what needs to be in place to ensure accountability. However, there are some pre-conditions for effective accountability, such as:

- n A strong commitment and long-term vision on the part of government that the right to health should be incorporated into the day-to-day work of health policy makers;
- n The presence of a national health plan that incorporates the right to health;
- n Institutional mechanisms to ensure effective participation in the development, implementation and review of the national health plan;
- n The establishment of effective institutional arrangements for civil society and the government to work together;
- n The establishment of effective monitoring systems;
- n Access to, and implementation of, the decisions of accountability mechanisms that are relevant to health policy;
- n The development of ongoing right to health training for health policy makers at all levels.

These are some of the pre-conditions for ensuring a central feature of the right to the highest attainable standard of health: accessible, easily understood and effective accountability.

APPENDIX I: THE CASE STUDIES

APPENDIX I: THE CASE STUDIES

CASE STUDY 1

ACCESS TO DRUGS — SOUTH AFRICA *

The case of the *Minister of Health v Treatment Action Campaign (No 2)* (TAC Decision) challenged the South African government's prevention of mother to child transmission (PMTCT) of HIV policy, which limited the provision of the drug Nevirapine to a small number of 'pilot sites' (2 in each of the 9 provinces).

On the 21st August 2001, a constitutional claim was filed by the Treatment Action Campaign (TAC), Save Our Babies, and the Children's Rights Centre against the Government.³² The parties sought a declaration that the current policy was unconstitutional and asked that Nevirapine be made available to HIV pregnant women who gave birth in the public health sector, and to their babies, when medically indicated and that the government plan and implement in a reasonable manner an effective national PMTCT programme, including the provision of voluntary counselling and testing (VCT), and where appropriate, Nevirapine or other appropriate medicine, and formula milk for feeding. The TAC asked

that the government be ordered to meet these demands within clear time frames and subject to the further scrutiny of the court.

The hearing took place in the Pretoria High Court on the 27th and 28th November 2001. Judgement was handed down on the 14th December. On all key issues Mr. Justice Botha found in favour of the TAC. His Honour declared that a countrywide PMTCT programme was an obligation of the State and ordered that the government develop an effective comprehensive programme to prevent or reduce PMTCT. Between December and July 2002, there followed a series of appeals and counter appeals, during which time the government refused to comply with the ruling of the High Court. On the 5th July 2002, the Constitutional Court held unanimously that the government's policy had not met its constitutional obligations to provide people with access to health care services in a manner that was reasonable and took account of pressing social needs. The government

policy discriminated against poor people: those who could afford to pay could get access to the drug.

The TAC constitution empowers the organisation to lobby, advocate and undertake all forms of legitimate social mobilisation. Hence, the TAC did not only rely on litigation. Indeed, the TAC considers that litigation emerges from and feeds back into a social context. From August 2001, the TAC engaged in intensive public mobilisation in the form of rallies, vigils and marches around the country, all of which attracted enormous support and media interest. During court hearings, people wearing the TAC's trademark 'HIV-positive' T-shirt, health professionals and journalists would pack the court. 'Stand Up for Your Rights' marches and demonstrations were organised in Johannesburg, Cape Town and Durban to coincide with the final Constitutional Court hearing, which commenced on the 2nd May 2002. In Johannesburg over 5,000 people marched to the court, affirming the Constitution, the importance of social mobilisation to claim rights and the constitutionally assigned role of the judiciary in determining disputes over government policy. The Constitutional Court itself was filled with activists, health workers and the media.

The judgement of the Constitutional Court did not end the disputes over the provision of PMTCT services. The judgement was simply the conclusion of a legal battle that the TAC had already won outside the courts through the skillful use of litigation in the broader social struggle. Social pressure and litigation continued to be necessary to get the government and the provinces to

comply with the court's order. Despite reluctance on the part of the government to implement the Constitutional Court decision, it is clear that both the judicial and social accountability mechanisms have had an impact on policy making. The current South African HIV/AIDS Strategic Plan *HIV & AIDS and STI Strategic Plan for South Africa 2007-2011* (the Strategic Plan), developed in consultation with government departments, academic institutions, and non-government organisations (amongst others), indicates that drug regimes for PMTCT need to be updated according to WHO Guidelines.³³ The WHO Guidelines recommend combination therapy where possible.³⁴ In November 2007 the government of South Africa announced that it was switching to combination therapy across all provinces. A national PMTCT program has been implemented in over 80 per cent of government clinics. This decision also laid the groundwork for a national AIDS treatment program, which was announced in 2003. By October 2006, approximately 165,000 to 175,000 people were obtaining antiretrovirals through this program.³⁵

** This case study has been prepared in collaboration with Lisa Forman and draws upon her SJD dissertation, 'A Transformative Power? Assessing the Role of the Human Right to Medicines in Increasing Access to AIDS Medicines – International Human Rights Law, TRIPS and the South African Experience.' (SJD Thesis, University of Toronto, Faculty of Law, 2007) [unpublished]. The case study also draws upon the article by Heywood, M. (2003) 'Preventing Mother-To-Child HIV Transmission in South Africa: Background, Strategies and Outcomes of the Treatment Action Campaign Case against the Minister of Health', South African Journal of Human Rights, 19:278.*

CASE STUDY 2

HIGH IMPACT LITIGATION AS AN ACCOUNTABILITY MECHANISM: THE UNCONSTITUTIONALITY OF ANTI-ABORTION LEGISLATION — COLOMBIA *

The Women's Link Worldwide (Women's Link) initiative in Colombia demonstrates the use of high-impact litigation as a means of strategically advancing human rights issues. Abortion in Colombia was a criminal offence prior to 2006. Colombian official statistics at the time indicated that 350,000 clandestine abortions were carried out every year and were the third major cause of maternal deaths. At the same time as Colombian legislation criminalised abortion, the country was (and is) a party to several international human rights treaties including the following: ICESCR, CEDAW, ICCPR, and CRC. Colombia is also a party to the American Convention on Human Rights.

Mónica Roa, a Colombian attorney and Programmes Director for Women's Link, filed a complaint at the Constitutional Court in April 2005 arguing that Penal Code provisions on abortion were inconsistent with Colombia's obligations pursuant to the international human rights treaties to which Colombia was a party. When Women's Link came to Colombia and introduced the idea of utilizing high impact litigation to seek the

de-criminalisation of abortion, they found important allies to support this work. *La Mesa por la Vida y la Salud de las Mujeres* (La Mesa – Working Table for the Health and Life of Women) had been holding regular meetings to discuss the issue of abortion, the proposal of new laws for consideration by the Congress and advocacy for changes in public policy.

Women's Link recognised the important role of the media in disseminating information on the campaign. Through media reporting of civil-society mobilisation, there was a reframing of the public debate on abortion. People had the opportunity to hear many different voices. As a result, popular perception of the issue evolved and the level of debate matured. The debate involved doctors, public health experts, members of the women's movement, and pro-choice Catholic women. Importantly, the church became just another voice in a wider debate. The debate became one based on public health and human rights supported by scientific data and constitutional arguments, and moved away from a discussion about church doctrine. The debate matured

to the point that it included discussion regarding the separation of church and State, marking a notable milestone for Colombia.

On 10th May, 2006 the Colombian Constitutional Court handed down an historic decision when it determined that Colombian legislation criminalising abortion was unconstitutional and women were entitled to a termination of pregnancy in three specific circumstances: when the pregnancy threatens the life or health of the woman; when there is malformation of the fetus which is incompatible with life outside of the womb; and when the pregnancy is the result of rape, incest, or insemination or in-vitro fertilization without consent.

The language used by the Court was ground breaking in the acknowledgment of women's reproductive rights and the implementation of international human rights in a national context. The decision had immediate effect — women had a right to be provided with abortion services when requested. Women's Link worked in collaboration with *La Mesa* to lobby the government to develop a policy which included clear and unambiguous rules regarding the provision of abortion services. The government regulated abortion services and issued technical guidelines which follow the recommendations of the WHO. On December 22, 2006, the government

included abortion services as part of the services to be provided by the public health system. Despite the presence of these guidelines and the provision of services, there have been incidents of denial of services and abuse of women by medical practitioners. Women's Link continues to monitor the provision of abortion services and has publicly denounced health workers who have denied services to women. Both the *Superintendencia Nacional de Salud* (the State body in charge of monitoring the provision of health services and which can impose administrative sanctions) and the *Oficina del Procurador General de la Nación* (Inspector General's Office, a quasi-judicial body that works towards respect for human rights and the prevention of human rights violations) have said they will take appropriate measures to address the situation. In addition, these government bodies intend to formalise Women's Link's monitoring role through an institutional agreement to ensure that Women's Link can continue to monitor and identify cases of denial of services. More information and other useful tools for health policy makers and advocates can be found at www.womenslinkworldwide.org.

** This case study has been prepared in collaboration with Mónica Roa, Programmes Director for Women's Link Worldwide.*

CASE STUDY 3

ACCOUNTABILITY AND THE RIGHT TO HEALTH CARE CAMPAIGN — INDIA *

Health sector privatisation policies during the 1990s in India led to stagnation in funding for public health systems and consequent deterioration in public health services. This was accompanied by spiralling, unregulated growth of the private medical sector — making even basic health services increasingly inaccessible for common people. A social response to the lack of access to quality health care had developed in India during the 1980s and 1990s in reply to the unresponsiveness of the government to the situation. This social response gained significant momentum with the formation of *Jan Swasthya Abhiyan* (JSA) in 2000 — a nationwide coalition of over 20 networks and over one thousand organisations. JSA works collaboratively with the National Human Rights Commission (NHRC) and provides support to other campaigns that focus on the improvement of access to various determinants of health, such as food security, education and housing.

A growing concern with deteriorating access to health care culminated in JSA launching a 'Right to Health Care campaign' on 6th September 2003, the 25th anniversary of the Declaration of Alma Ata. A national public consultation was organised in Mumbai which was attended by over 250 delegates from 16 states of India. Over 60 cases of 'Denial of Health Care' from various parts of the country were presented. Selected testimonies of 'Denial of Health Care' were then presented

to the Chairperson of the NHRC. As part of the campaign, subsequently Jan Sunwais (people's health tribunals) on health rights were organised in some states, where cases of denial of health care were presented to government officials in the presence of the public. Public attendance at these hearings varied from hundreds to over a thousand people. In the state of Maharashtra alone, six such people's tribunals in various regions, focussing on a range of health violations, were organised in 2004.

From July 2004, JSA, in collaboration with the NHRC, organised regional public hearings on the right to health care in all the regions of the country. Each of these public hearings was attended by hundreds of delegates representing various districts and states, along with senior public health officials from the relevant states and representatives of the NHRC. Public hearings were organised in the Western region (Bhopal, July 04), Southern region (Chennai, August 04), Northern region (Lucknow, September 04), Eastern region (Ranchi, October 04) and North eastern region (Guwahati, November 04). These hearings were advertised and reported in regional newspapers, and initiated a process of enabling people to present their testimonies of denial of health care, while enhancing awareness of the fact that health care is a human right. Over 200 cases of denial of health care were documented in the course of the campaign.

These regional public hearings culminated in a national public hearing on the right to health care on 16–17 December 2004. The national hearing was attended by the Central Health Minister, health secretaries or senior health officials from 22 states across the country, the NHRC chairperson and officials, and over 100 JSA delegates selected from over 20 states across the country. A series of presentations on the scale, depth and range of health rights violations were made by JSA representatives. The hearing concluded with the presentation of a national action plan on the right to health care, which was jointly developed by NHRC and JSA and subsequently sent to the central and all state governments for action. This is a significant step forward in recognition of the right to health care at the national level.

JSA continues to collaborate with the NHRC to promote the implementation of the right to health care.

Ongoing activities include: representing civil society during national review meetings on health rights organised by NHRC in 2006 and 2007; conducting critical reviews of the implementation of the National Rural Health Mission and in the process, advocating for implementation of the right to health care; proposing the development of People's Health Plans as a necessary component of the process of making public health systems work effectively and in a responsive manner; and providing continued support to, and collaboration with, other organisations in the implementation of community monitoring of health services. For further information on the activities of JSA, see www.phm-india.org.

** This case study has been prepared in collaboration with Abhay Shukla, National Joint Convenor, Jan Swasthya Abhiyan and draws upon draft chapter on 'Right to Health' by Abhay Shukla, Claudio Schuftan and Laura Turiano prepared for the Global Health Watch Report 2007/08.*

CASE STUDY 4

A DETERMINANT OF HEALTH — 'HUNGER AMIDST PLENTY' AND THE RIGHT TO FOOD CAMPAIGN — INDIA *

The Indian Right to Food Campaign (RFC) is a highly decentralised, informal network of organisations and individuals committed to the realization of the right to food. The RFC began in the context of two related situations which existed in India in mid-2001: the lack of a government response to hunger and starvation amidst severe drought, particularly in the state of Rajasthan, and the presence of mounting food stock levels in India.

The campaign began with protests and public meetings to bring the issue to the attention of the media and public. In addition, public interest litigation on the right to food in the form of a writ petition submitted to the Supreme Court of India was commenced in April 2001 by the People's Union for Civil Liberties — Rajasthan (PUCL-Rajasthan).³⁶ The petitioner argued that the right to food is a fundamental right of all Indian citizens and demanded that the country's food stocks should be used to prevent hunger and starvation in the country without delay. The petitioner argued that the right to nutrition is implied in Article 21 of the Constitution of India — the right to life. Though judgement is still awaited, the Supreme Court has held hearings at regular intervals since April 2001 and has issued many significant directions in the form of 'interim orders'. The Court continues to monitor government action and to entertain new requests. These orders have directed the Indian government to undertake certain activities which have included:

- n the introduction of midday meals in all government and government assisted primary schools;
- n the provision of highly subsidised grains (Antyodaya

Anna Yojana) to certain categories of highly vulnerable households, for example, widows and aged people without family support; and

- n the provision of a childcare centre in each settlement.

In addition, the Supreme Court appointed two commissioners (Dr. N.C. Saxena and Mr. S.R. Sankaran) in 2005 for the purpose of monitoring the implementation of all orders relating to the right to food. The main functions of the commissioners include ensuring the functioning of an effective micro-level grievance redress system, ensuring dissemination of information by state governments, establishing a permanent monitoring mechanism for hunger-related issues, and ensuring accountability for failures of state agencies. The commissioners are also mandated to enquire about any violation of the orders of the Court and to demand redress with the full authority of the Court. In addition they are to provide reports to the Court from time to time. To date the commissioners have provided six reports. The commissioners have appointed advisors in several states to assist them in their work.

To ensure accountability on the part of the government with regard to the implementation of the right to food, the participants of RFC pursue a variety of activities. Jan Sunwai (public hearings) have been one of the most popular and widely used methods. The purpose of the public hearings is to ensure that the voices of the people can be heard and the progress of implementation of the various schemes related to the right to food can be monitored and evaluated. These hearings have been held in many localities in India and promote public

discussion on the issue of accountability. The hearings uncover cases of corruption, poor implementation of policies, evidence that little had been done to spread information about people's entitlements and as a result, lack of knowledge about various schemes and entitlements.

Some of the larger public hearings bring together people from across a state. They are attended by hundreds of people, local and senior government officials,

the commissioners and/or their advisers as well as the media. The panels for the hearing can include retired justices, academics, national and international non-government organisation representatives, ex parliamentarians, the commissioners and/or their advisers. Further information on the work of the RFC is available at: www.righttofoodindia.org.

** This case study has been prepared in collaboration with S. Vivek, Right to Food Campaign - India.*

CASE STUDY 5

ACCOUNTABILITY THROUGH MONITORING: CARE PERÚ'S IMPROVING THE HEALTH OF THE POOR: A RIGHTS BASED APPROACH — PERÚ*

Improving the health of the poor and marginalised in countries such as Perú, will not be achieved through technical interventions and the provision of funding alone. Significant, sustainable change can only happen if the poor have a much greater involvement in shaping policies, practices and programmes, and by ensuring what is agreed actually happens. To this end, CARE Perú's Improving the Health of the Poor: A Rights Based Approach programme (the Health Rights Programme), which commenced in January 2004, seeks to improve the health of the poor and marginalised in Perú through the improvement of the relationship between Peruvian society and the State and through the creation of greater accountability on the part of health workers.

As a direct result of the Health Rights Programme, strategies to make health sector policies and institutions respond to, protect and promote the health rights of the poor and marginalised have been developed and strengthened. As a result, both civil society and health workers have a greater understanding of health rights. Participatory mechanisms for planning, provision and evaluation of health services have also been developed. To facilitate the development of an accountability process, the programme collaborates with other civil society movements in addition to the *Defensoría del Pueblo* (Ombudsman's office) and the National and Regional Health Councils.

A significant accountability mechanism has been the strengthening of citizen monitoring of health services in the Piura and Puno regions of Perú. It was recognised that there had been important advances by Peruvian civil society in the implementation of strategies to ensure that national and regional health policies reflected people's needs. However, there was still some distance to go to ensure effective implementation of the policies. The main objective therefore was to ensure there were social accountability mechanisms which could effectively monitor implementation of the policies and at the same time promote the involvement of people.

In the region of Puno, a strategic alliance was

established between ForoSalud Puno, the Regional Ombudsman's Office, and networks of community Quechua and Aymara women leaders. A call was put out to all community leaders in Azángaro, Melgar and Huancané provinces in Puno. A cycle of training was conducted on human rights, institutional responsibilities, and the existing Peruvian legal framework which supports health rights and participation. Following this capacity building, 47 women were selected from 123 women community leaders. Together with the regional representative of the Ombudsman's office, these women visit the local authorities and local health teams to introduce the initiative and its main objectives and components.

The monitoring is conducted in 3 hospitals, 3 health centres and 6 health posts. At the beginning of a monitoring day, the women, who work in pairs and carry a CARE or Ombudsman's Office personal identity card, attend the health facility and introduce themselves. The monitoring period, which can last from 3 to 8 hours, reviews the activity in admissions (including triage), maternity consultations, child health consultations and also in the administrative health insurance section. The women speak with health service users about the quality of the services and how they felt and were treated when using the services. They also speak with health care providers, watch health care procedures, observe both good and bad practice and take the names of health workers involved in each case. Once a month there is a meeting with the regional Ombudsman's office, where the women report their findings. The Ombudsman's office representative records the information. Following this, the Ombudsman's office reports the findings back to the health care facility manager and health team.

The findings have been both positive and negative. On the negative side, the monitoring has provided evidence of reduced hours of health service provision as a mechanism to deter women from using the health services and a practice of charging for medicines which should be free. This accountability mechanism is part of

a longer process and there is evidence that attitudes are changing. On the positive side, the women who conduct this monitoring have noted a distinct improvement in the quality of health service provision (e.g., treatment,

explanation of the condition and treatment prescribed).

** This case study has been prepared with the assistance of Dr. Ariel Frisancho, National Coordinator, Health Rights Program, CARE-Perú, afrisancho@care.org.pe, afrisanchoarroyo@yahoo.es.*

CASE STUDY 6

THE SPECIAL RAPPORTEUR ON THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH — SWEDEN*

Pursuant to the *Health and Medical Services Act (1982)*³⁷ county councils are obliged to treat all persons in need of 'immediate health care' regardless of legal status. However, in the case of undocumented migrant adults, 'immediate necessary care' must be paid for – effectively denying access to the Swedish health care system for this group.

To respond to the health care needs of this vulnerable group, Médecins du Monde opened the first clinic for undocumented migrants in Stockholm in 1996. Two years later in June 1998, a group of Gothenburg activists – from a variety of backgrounds ranging from faith based organisations to medical and nursing professionals to former refugees – formed *Rosengrenska* as a means of providing access to health care services for undocumented migrants. *Rosengrenska* commenced providing a weekly clinic in September 1998.

Rosengrenska's theoretical foundation is medical ethics rather than human rights. Medical ethics requires that all people be treated equally. Yet, here was a group that was specifically denied access to health care. The members of *Rosengrenska* did not know that this was a human rights issue until they became aware of the planned visit to Sweden in 2006 by the Special Rapporteur on the right to the highest attainable standard of health. *Rosengrenska* members (and other organisations) seized on the visit by the Special Rapporteur to advocate on behalf of undocumented migrants and bring to the attention of the United Nations and the

international arena the situation in Sweden.

The visit and press release by the Special Rapporteur and the subsequent report have augmented an existing movement to ensure access to health care by undocumented migrants.³⁸ The Special Rapporteur's report has been a valuable tool to advocate and lobby for a change in the law and in policy. In addition, the visit introduced the language of human rights into the debate about access to health care and has informed and enriched the public debate generally. The report is well known and is on the public record. It has been used by organisations such as *Rosengrenska* as well as members of the Swedish Parliament to claim that by denying undocumented migrants access to health care services, Sweden is in breach of its international human rights obligations. The report has contributed to a shift in the perception of the issue by health workers and local and regional officials. In addition to the general public, more health workers and government officials are supportive of the right to health care on an equal basis for all. The report was also used to assist *Rosengrenska* (and others) to lobby the Parliamentary Refugee Group hearing in February 2008 to ensure equal access to health care for all within the jurisdiction of Sweden.

** This case study has been prepared with the assistance of Dr. Henry Ascher, Associate Professor in Paediatrics (Nordic School of Public Health) and Medical Officer for Rosengrenska and Ms. Gunilla Backman, Senior Research Officer, Right to Health Unit.*

APPENDIX II : GLOSSARY

CIVIL SOCIETY

Civil Society is broadly defined to include individuals, groups and organisations that are independent of government. The groups and organisations include: formal (registered charity organisations such as non-government organisations); informal (non-registered voluntary organisations and groups); health worker organisations; and other professional organisations.

GENDER-RESPONSIVE BUDGET ANALYSIS

Gender-responsive budget analysis is the analysis of actual government expenditure and revenue spent on women and girls as compared to men and boys.

GOVERNMENT

Government is used in a broad sense. It covers the law and policy-making sections of departments, as well as the government institutions that are responsible for the implementation of policies. It also includes all levels: local/municipal, regional/state/province/territory and national government. While all levels of government have obligations to ensure that human rights are respected, it is the national government that has the final obligation.

HEALTH WORKERS

Health workers is a generic term and includes all those developing, delivering, monitoring and evaluating preventive, curative and rehabilitative health 'plans' in the private and public health sector. It also includes traditional healers whether or not they have been incorporated into the health sector. Pursuant to the obligation to protect, the State has an obligation to ensure that traditional healers are aware of, and carry out, their responsibilities regarding the right to health.

HEALTH POLICY MAKERS

Health policy makers is defined broadly and includes health policy researchers, legislators, decision-makers, and professionals concerned with developing, implementing and analysing health policy.

POLICY

Policy is used as a generic word and includes plans, programmes and strategies.

UNDERLYING DETERMINANTS OF HEALTH

Underlying determinants of health are defined broadly to include factors such as safe and potable water, adequate sanitation, an adequate supply of safe food, housing, healthy occupational and environmental conditions, access to health-related education and information, discrimination, and the impact of poverty.

APPENDIX III: RESOURCES AND WEB LINKS

Organisations, Academic Institutions and Government Bodies

Asia-Pacific Forum www.asiapacificforum.net

Commonwealth Medical Trust www.commat.org

Health Impact Assessment Unit, Deakin University, Australia www.deakin.edu.au/hmnbs/hia/publications/EFHIA%20Framework3.pdf

International Women's Rights Action Watch Asia Pacific www.iwraw-ap.org/protocol/womens_cases.htm

New Zealand Health and Disability Commissioner www.hdc.org.nz

Participatory Budgeting www.participatorybudgeting.org

The Parliamentary Centre www.parlcent.ca/index_e.php

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Reports of the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health www2.essex.ac.uk/human_rights_centre/rth/reports.shtm

Scaling-up the HIV/AIDS response: From Alignment and Harmonisation to Mutual Accountability (ODI Briefing Paper, August 2006) www.odi.org.uk/publications/briefing/bp_aug06_hivscalingup.pdf

ENDNOTES

- 1 Brinkerhoff, D. (2003) *Accountability and Health Systems: Overview, Framework, and Strategies*. Technical Report No. 018. Bethesda, MD: The Partners for Health Reformplus Project, Abt Associates Inc.
- 2 Freedman, L.P. (2003) 'Human rights, constructive accountability and maternal mortality in the Dominican Republic: a commentary', *International Journal of Gynaecology and Obstetrics*, 82:111.
- 3 Brinkerhoff, (see note 1 above).
- 4 Ibid.
- 5 The International Bank for Reconstruction and Development/The World Bank (2003) *World Development Report 2004: Making Health Services Work for the Poor*, Washington: World Bank and Oxford University Press. Online: www.worldbank.org (accessed 26 February 2008).
- 6 Hunt, P. (2008) *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* [99-101] UN Doc. A/HRC/7/11, 31 January 2008. Online: www2.essex.ac.uk/human_rights_centre/rth/docs/A-HRC-7-11.doc (accessed 26 February 2008).
- 7 Ibid, paragraph 100.
- 8 Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health* (2000) UN Doc E/C.12/2000/4. Online: www2.ohchr.org/english/bodies/cescr/comments.htm (accessed 26 February 2008).
- 9 The texts of international human rights treaties, such as the *International Covenant on Economic, Social and Cultural Rights*, *International Convention on the Elimination of All Forms of Racial Discrimination*, the *Convention on the Elimination of All Forms of Discrimination against Women*, the *Convention on the Rights of the Child*, and the *Convention on the Rights of Persons with Disabilities* (not yet entered into force), are available online: www.ohchr.org/english/law/index.htm (accessed 26 February 2008).
- 10 Kinney, E. and Clark, B. (2004) 'Provisions for Health and Health Care in the Constitutions of the Countries of the World', *Cornell International Law Journal*, 37:285.
- 11 The content of this section is a synopsis of the content of *General Comment No. 14*, (see note 8 above), and the reports of the UN Special Rapporteur on the right to the highest attainable standard of health. Online: www2.essex.ac.uk/human_rights_centre/rth/reports.shtm (accessed 26 February 2008).
- 12 *General Comment No. 14*, (see note 8 above), paragraph 12. It is important to note that concepts similar to AAAQ were developed in relation to primary health care. Primary health care was to be based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country could afford. That is, it was to be accessible, acceptable, appropriate and affordable. See the *Declaration of Alma-Ata*, adopted at the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. Online: www.who.int/healthpromotion/conferences/en/ (accessed 12 September 2007).
- 13 The Committee on Economic, Social and Cultural Rights defined 'health facilities, goods and services' in *General Comment No. 14* (above note 8), to include the underlying determinants of health as outlined in paragraphs 11 and 12(a) of the General Comment. For convenience, the term 'health facilities' will be used throughout the remainder of this document.
- 14 The United Nations Development Fund for Women (UNIFEM) website, contains a substantial number of gender budgeting resources to support gender budget analysis. Online: www.gender-budgets.org/content/view/15/187/ (accessed 25 February 2008).
- 15 *General Comment No. 14*, (see note 8 above), paragraph 11. Emphasis added.
- 16 Ibid, paragraph 32.
- 17 Hunt, P. (2006) *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* [48-49] UN Doc. E/CN.4/2006/48, 3 March 2006. Online: www2.essex.ac.uk/human_rights_centre/rth/reports.shtm (accessed 25 February 2008).
- 18 Pohjolainen, A.E. (2006) *The Evolution of National Human Rights Institutions. The Role of the United Nations*. Copenhagen: Danish Institute for Human Rights. Online: www.nhri.net/pdf/Evolution_of_NHRIs.pdf (accessed 21 November 2007).
- 19 Hunt, P. and MacNaughton, G. (2006) *Impact Assessments, Poverty and Human Rights: A Case Study Using The Right to the Highest Attainable Standard of Health*. Online: www2.essex.ac.uk/human_rights_centre/rth/projects.shtm (accessed 26 February 2008); Hunt, P. (2007) *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, [33-44] UN Doc. A/62/214, 8 March 2007. Online: www2.essex.ac.uk/human_rights_centre/rth/docs/GA%202007.pdf (accessed 25 February 2008).
- 20 Mahoney, M. Simpson, S. Harris, E. Aldrich R. and Stewart Williams, J. (2005) *Equity-Focused Health Impact Assessment Framework*, Melbourne: ACHEIA. Equity-focused impact assessment uses health impact assessment methodology to produce a structured way to determine the potential differential and distributional impacts of a policy on the health of the population as well as on specific groups within that population. Online: www.deakin.edu.au/hia (accessed 25 February 2008).
- 21 Hunt (2007), (see note 19 above), paragraph 40.
- 22 Mahoney, et al (see note 20 above), p. 6.
- 23 Mattson, I. and Strom, K. (1995) 'Parliamentary Committees' in H. Döring (ed) *Parliaments and Majority Rule in Western Europe*, Frankfurt: Campus Verlag. This review of parliamentary committees was confined to those in Western Europe. See also Caesar-Katsenga, M. and Myburg, M. (2006) *Parliaments, Politics and HIV/AIDS: A Comparative Study of Five African Countries*, Cape Town: Idasa, 2006. Online: www.idasa.org.za/ (accessed 25 February 2008).
- 24 Newell, P. (2006) 'Taking accountability into account: the debate so far' in P. Newell and J. Wheeler (eds.) *Rights, Resources and the Politics of Accountability*, London and New York: Zed Books, 37, p. 42. See also Goetz, A.M. and Jenkins, R. (2005) *Reinventing Accountability. Making Democracy Work for Human Development*, Basingstoke and New York: Palgrave Macmillan, pp. 18-20.

- 25 O'Donnell, G. (1998) 'Horizontal Accountability in New Democracies', *Journal of Democracy* 9.3: 112.
- 26 Newell, (see note 24 above), pp. 47-48.
- 27 Committee on the Elimination of Discrimination Against Women, *Report on Mexico produced by the Committee on the Elimination of Discrimination Against Women under Article 8 of the Optional Protocol to the Convention, and reply from the Government of Mexico*, [261] UN Doc CEDAW/C/2005/00.8/Mexico, 27 January 2005. Online: www.un.org/womenwatch/daw/cedaw/cedaw32/CEDAW-C-2005-OP.8-MEXICO-E.pdf (accessed 25 February 2008).
- 28 Rosengrenska is a voluntary group of Gothenburg activists who provide a weekly health clinic, held in a church, to undocumented migrants.
- 29 Heywood, M. (2003) 'Preventing Mother-to-Child HIV Transmission in South Africa: Background, Strategies and Outcomes of the Treatment Action Campaign Case against the Minister of Health', *South African Journal of Human Rights*, 19: 278, p. 300.
- 30 United Nations General Assembly Resolution, *Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law*, UN Doc A/RES/60/147, 21 March 2006. It is acknowledged that this document refers to 'gross' violations of human rights. However, *General Comment No. 14* (see note 8 above), paragraph 59, also lists restitution, compensation, satisfaction or guarantees of non-repetition as appropriate remedies for violations of the right to health.
- 31 Schedler, A. (1999) 'Conceptualizing Accountability' in A. Schedler, L. Diamond, and M. Plattner (eds.) *The Self-Restraining State*, London: Lynne Rienner Publishers, p. 15.
- 32 Section 38 of the South African Constitution provides that 'anyone listed in this section has the right to approach a competent court, alleging that a right in the Bill of Rights has been infringed or threatened, and the court may grant appropriate relief, including a declaration of rights. The persons who may approach a court are a) anyone acting in their own interest; b) anyone acting on behalf of another person who cannot act in their own name; c) anyone acting as a member of, or in the interest of, a group or class of persons; d) anyone acting in the public interest; and e) an association acting in the interest of its members'.
- 33 *HIV & AIDS and STI Strategic Plan for South Africa 2007-2011*, p. 121. Online: www.info.gov.za/otherdocs/2007/aidsplan2007/khomanani_HIV_plan.pdf (accessed 25 February 2008).
- 34 World Health Organisation (2006) *HIV/AIDS Programme Strengthening Health Services To Fight HIV/AIDS. Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants: Towards Universal Access. Recommendations for a Public Health Approach*. Online: www.who.int/hiv/pub/guidelines/pmtctguidelines3.pdf (accessed 16 January 2008).
- 35 International Treatment Preparedness Coalition, (2006) *Missing the Target #3: Stagnation in AIDS Treatment Scale Up Puts Millions of Lives at Risk. Second Six-Month Update to ITPC's AIDS Treatment Report from the Frontlines*. 28 November 2006, p. 45. Online: www.aidstreatmentaccess.org/mtt3_final.pdf (accessed 25 February 2008).
- 36 *PUCL v. Union of India and others Writ Petition [Civil] No. 196 of 2001*.
- 37 Hälso-och sjukvårdslag 1982.
- 38 Hunt, P. (2006) Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health. Mission to Sweden UN Doc A/HRC/4/28/Add.2. Online: www2.essex.ac.uk/human_rights_centre/rth/docs/sweden.pdf (accessed 25 February 2008).