

Alicia Ely Yamin, JD, MPH, is the Joseph H. Flom Global Health and Human Rights Fellow at Harvard Law School and an instructor at the Harvard School of Public Health.

Please address correspondence to the author at ayamin@law.harvard.edu.

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BEYOND COMPASSION: THE CENTRAL ROLE OF ACCOUNTABILITY IN APPLYING A HUMAN RIGHTS FRAMEWORK TO HEALTH

Alicia Ely Yamin

When I give food to the poor, they call me a saint. When I ask why the poor have no food, they call me a Communist.

The rich will accept talk of aid: for those of their own country and even for the Third World. But it is “not done” to talk too much about justice, rights, and structural changes.

— Dom Hélder Pessoa Câmara, late Roman Catholic Archbishop of Olinda and Recife, Brazil

ABSTRACT

Accountability is a central feature of any rights-based approach to health because it converts passive beneficiaries into claims-holders and identifies states and other actors as duty-bearers that can be held responsible for their discharge of legal, and not merely moral, obligations. This article reviews what we mean by accountability, how courts and other mechanisms are being engaged to promote accountability, and what we should understand as the central obligations of states and other actors if we are concerned with obligations of progressive realization relating to health and development goals. The first part of the article sets out a number of mutually-reinforcing dimensions of accountability, examines different duty-bearers, and discusses mechanisms for enforcement, with a focus on courts. The second part of the article explores how we might define the obligations of progressive realization for which we seek accountability. I argue that there are three aspects of accountability with which a human rights approach to health as a social policy and development issue should be concerned: 1) what the state is doing; 2) how much effort the state is expending; and 3) how the state is going about the process. Although the focus is on national obligations, I argue that donor states and other actors have parallel obligations.

INTRODUCTION

Compassion is undoubtedly a great virtue. But it is also notoriously unstable and, historically, reliance on it has ill-served the interests of the oppressed. Particularly in times of great economic crisis — like the present — the needs of the poorest and most marginalized tend to get short shrift regardless of such sentiments. Sharp economic downturns are inscribed in the bodies of malnourished children and other vulnerable members of society. Yet unfortunately, failures of beneficence and “compassion fatigue” do not trigger accountability; human rights violations do. Indeed, from anti-discrimination laws to labor protections, national struggles for human rights — civil and political as well as economic, social, and cultural (ESC) rights — have claimed as entitlements what those in power preferred to leave to largesse. Recent efforts to apply human rights to development, including health-related aspects of development, have argued that the principal added value of a rights framework lies precisely in identifying individuals as claims-holders and

states and other actors as duty-bearers that can be held to account for their discharge of legal, and not merely moral, obligations.¹

The recent United Nations' publication, *Claiming the Millennium Development Goals: A Human Rights Approach*, states that “the *raison d'être* of the rights-based approach is accountability.”² The recently-formed International Initiative on Maternal Mortality and Human Rights (IIMMHR) argues for a rights-based approach to safe motherhood on the basis that it “ensures that we can hold governments and others to account for their policies, programs, projects and pledges to reduce maternal mortality.”³ Yet it is not always clear how that “accountability” might be ensured in practice, or even what obligations governments and donor states should be held accountable for, when so much of public health programming, and social policy more broadly, is contingent upon resources.⁴

A distinction is often drawn between civil and political rights — where traditional practice has been to count cases while insisting that “just one instance of torture is too many” — and economic, social, and cultural rights, which require a methodology to ensure a consistent critique of countries with vastly different resources. If we seek to address the sources of violations, civil and political rights advocacy could also benefit from a greater emphasis on measuring the performance of systems.⁵ However, it is true that if, for example, we seek to hold a state accountable for upholding the right to be free of avoidable infant mortality, we must grapple with which deaths are really avoidable in a given context at a particular time.⁶ The dire global economic situation, with its implicit threat to both a robust international development agenda and to domestic social policies, makes it especially urgent now to refine and reiterate our calls for “accountability.”⁷

The first part of this article provides an overview of what we mean by accountability. It sets out the multiple, mutually-reinforcing dimensions of accountability, examines different duty-bearers, and discusses mechanisms for enforcement. I suggest that pursuing effective accountability in health requires moving beyond both punishing individual perpetrators and looking solely at national states. Drawing on the Critical Concepts articles in this issue as well as on other examples, I argue that the increasing role of courts in setting health policies is a critical develop-

ment that calls for contextualized empirical investigation, as well as far more attention from the public health community.

The second part of the article explores the obligations for which we should seek accountability in the context of the progressive realization of health and related rights. I argue that there are three aspects of accountability with which a human rights approach to health *as a social policy and development issue* should be concerned: 1) *what* the state is doing; 2) *how much effort* the state is expending; and 3) *how* the state is going about the process. That is, states and other actors have an obligation to adopt “appropriate” measures under international law, and a human rights approach converts that obligation from a matter of sound health policy to one of legal and political entitlement. Second, under international law, states have obligations to expend the “maximum” of their available resources — understood as including “international assistance and cooperation” — to realize health rights, together with the obligations of non-retrogression and adequate progress. Finally, a human rights approach requires accountability for the process through which development and health policy goals are reached, including meaningful participation, a functional health system, and a central emphasis on non-discrimination and equality.

DEFINING ACCOUNTABILITY IN THE HUMAN RIGHTS CONTEXT: WHAT, WHO, AND HOW?

Multiple meanings, not one

Accountability means many things to many people. There is, for example, administrative accountability, professional accountability, financial accountability, social accountability, political accountability, and legal accountability.⁸ In other languages, multiple terms are often used to capture the notions of responsibility and answerability expressed through the one English word.⁹ Realizing accountability as it is understood in a human rights framework requires monitoring and oversight by both government officials and those who are affected; such accountability demands transparency, access to information, and active popular participation. It is not enough to have access to reliable information and indicators; true accountability requires processes that empower and mobilize ordinary people to become engaged in political and social action. As several articles in this issue discuss, accountability in a human rights framework also requires

effective and accessible mechanisms for redress in the event of violations.¹⁰

These dimensions of accountability do not operate in isolation from one another. For example, in the context of governance — which is directly related to basic service provision — accountability requires being able to hold public officials responsible for their performance (obligations of conduct) as well as the outcomes of their decisions (obligations of result).¹¹ Further, political accountability through episodic elections is greatly enhanced through ongoing social accountability efforts by collective actors, such as nongovernmental organizations (NGOs), community-based organizations, and the media.¹² A prime example is India's right-to-food campaign, which is organized through a decentralized network of civil society and grass-roots organizations in which rural women have played a central role. The campaign has organized a wide range of activities, including public hearings and rallies, media advocacy, and lobbying of Members of Parliament. Their efforts have been critical in securing hot lunches in primary schools in a number of states, as well as instrumental in pushing national legislation, such as a National Rural Employment Guarantee Act.¹³

In many countries, networks and broad popular movements for social accountability relating to health issues emerged as a reaction to autocratic governments that had enacted neoliberal sector reforms and privatizations of basic services (for example, water) with virtually no consultation and often largely by executive and ministerial decrees.¹⁴ These efforts at social accountability highlight the importance of decision-making processes as well as outcomes, of increasing the voices of marginalized or excluded communities with respect not only to the diagnosis of institutional failures that most directly affect them, but also to the negotiation of social policies and health budgets. However, successful models of social accountability also point to the importance of creating coalitions and networks across class, and between grass-roots movements and NGOs.¹⁵

Similarly, it is misleading to view litigation and political strategies as entirely distinct means for attaining health rights. Although it calls for negotiation between social movements and NGOs, litigation can often be creatively used as a political tool.¹⁶ In the well-documented *Treatment Action Campaign* case in South Africa, where the South African Constitutional

Court ordered the extension of Nevirapine availability beyond pilot sites and the creation of a National Plan of Action for prevention of mother-to-child-transmission (PMTCT) of HIV/AIDS, the court case both emerged from, and in turn further promoted, social mobilization around right to access to care.¹⁷ Lisa Forman argues in this issue that the equally significant 2001 *Pharmaceutical Manufacturers Association (PMA)* case in South Africa “facilitated a tipping point [in social consciousness] for the emergence of a human right to AIDS medicines and acted as a catalyst for broader legal *and political* changes around AIDS medicines [emphasis added].”

Likewise, in India, the ongoing right-to-food campaign began in April 2001, when the People's Union for Civil Liberties of Rajasthan brought a case to the Indian Supreme Court, demanding that the government use its large food stocks to prevent mass hunger and starvation.¹⁸ Although the Supreme Court has held regular public hearings and has issued important interim orders in the case, activists quickly realized that the litigation itself was radically insufficient. The resulting public campaign has placed the right to food at the center of discourse regarding India's development policy.¹⁹ As Siri Gloppen asserts in her piece in this issue, in evaluating the impact and value of courts' roles in bringing more justice to health, “it is important to keep in mind that this is part of a larger picture,” in which multiple actors and stakeholders' behaviors and accountability processes need to be analyzed.²⁰

Who should be held accountable? Beyond individual sanctions

The use of litigation for institutional and structural change should not be conflated with a human rights advocacy that too often seeks only to identify a violation, an individual perpetrator, and a remedy, which by itself is ill-suited to advancing health rights.²¹ Although impunity is an even greater problem in the area of ESC rights than in civil and political rights, most errors in the health system are rooted in institutional and systemic defects. Even in cases of medical malpractice, a human rights perspective should focus not on the malpractice *per se*, but on the system that condones wanton disregard for patients' well-being.

Many health systems in which patients face widespread abuses are extremely punitive to front-line health care workers as well. For example, it is com-

mon practice in some countries — often those with the highest maternal mortality ratios — for health professionals who are associated with a maternal death to be summarily dismissed or reassigned, without any procedure to discern whether they were, in fact, responsible for the death.²² These often unwritten policies are ostensibly intended to promote “accountability” and quality care in obstetric cases, but, in fact, have the opposite effect. They create perverse incentives for health professionals to avoid dealing with obstetric emergencies, both as individuals and as institutions.

When there is nothing an individual provider could have done to save a woman, placing blame on him or her not only distorts incentives; it also diverts attention from the systemic institutional problems that led to the woman’s death. For example, the health facility may lack the necessary medicines and supplies; it may have no means of communicating with the village where the woman lived and no means of transportation. As Leslie London has argued, “front line health workers are frequently unable to provide adequate access to care because of systemic factors outside their control and because of management systems that disempower them from acting independently and effectively.”²³ Focusing on individual health practitioners’ conduct divorced from context in such a situation “frequently makes little headway and gives a human rights approach a bad name.”²⁴

Lynn Freedman has suggested an alternative understanding of “constructive accountability” within health systems, whereby a “new dynamic of entitlement and obligation” is established.²⁵ A system of constructive accountability recognizes that, as Laura Pautassi has argued elsewhere, the working conditions of health workers are synergistically and inextricably related to quality of care.²⁶ While “individual punishment (and knowledge that professional standards will be enforced) has an appropriate place in a constructive accountability system,” and “individual sanctioning has not been used to scapegoat a doctor, pacify the public, and cover up wider, deeper problems,” from a human rights perspective we should be concerned with the resulting gaps in constructive accountability — system failures that threaten quality of care as well as undermine adequate working conditions.²⁷

Accountability beyond borders: “International assistance and cooperation” and non-state actors

Just as it can be misguided to focus on the failures of individual health care workers in determining accountability, it is useless and counter-productive to focus exclusively on the accountability of governments in the global South for what lies beyond their control. In seeking to establish accountability, we must distinguish between what states are unwilling to do, unable to do, and simply do not know how to do. Often states’ policies can be shifted to promote ESC rights, including health, but we must locate the capacities of states to fulfill their ESC rights obligations, including their health obligations, in the context of a global political economy in which multi-national corporations, international financial institutions, and donor states are often the ones calling the shots. We need only look to the 2008 global food crisis to see how international financial, trade, and agricultural policies have left many states in the global South (especially net food-importing states) with eviscerated political institutions that are incapable of responding adequately to people’s immediate survival needs — let alone establishing proactive policies to fulfill food and health rights.²⁸

Pursuant to the ICESCR, each State party undertakes to achieve, “individually and through international assistance and co-operation,” the full realization of the rights in the covenant, including health.²⁹ However, the contours of “international assistance and cooperation” obligations are not yet well-defined under international law. Foreign assistance today is still based largely on geopolitical interests, and providing such aid is generally not perceived as a legal obligation.³⁰

Although the aid system remains fragmented and unaccountable in practice — and we may well need to create new enforcement mechanisms for accountability that stretches beyond borders — there have been increasing efforts to at least clarify donor state obligations. The Paris Principles on Aid Effectiveness, announced in 2005, were expanded upon by the Accra Agenda for Action in 2008.³¹ For its part, the ESC Rights Committee establishes that States parties to the ICESCR which are members of international financial institutions, notably the International Monetary Fund, the World Bank, and regional development banks “should pay greater attention to the

protection of the right to health in influencing the lending policies, credit agreements and international measures of these institutions.³²

A future issue of this journal will explore the scope of “international assistance and cooperation” obligations, together with strategies to promote accountability on the part of both donor states and non-state actors. However, in the second part of this article, I argue that efforts to hold donor states accountable for obligations to fulfill programmatic aspects of health rights should concentrate on the same dimensions as efforts to hold national states accountable for progressive realization. That is, such efforts should identify whether donors are providing assistance for the appropriate measures and interventions; whether they are expending sufficient effort in providing assistance; and whether their assistance is promoting equality and non-discrimination, meaningful participation, and a functioning health system.

How to hold actors accountable? Accountability mechanisms

Mapping accountability is useless if there are no consequences for failures to meet obligations. Consequences can be political, social, or even administrative. However, the notion of answerability also requires some mechanisms of legal enforceability.³³ As Forman notes, “A fundamental component of the force of rights lies in their nature, not simply as morality but as law.”

Mechanisms for legal accountability exist within both domestic and international schemes, including domestic courts as well as regional quasi-judicial bodies and international treaty-monitoring bodies authorized to monitor country situations and receive individual complaints. The Inter-American System of Human Rights and the European System of Human Rights have been especially active in providing adjudications of rights relating to health, often through an expansive interpretation of the right to life and applications of the principle of non-discrimination. The long-awaited adoption of an Optional Protocol to the ICESCR — which, when it enters into force, will permit individual petitions — may significantly enhance the possibilities for holding States parties accountable for specific laws, policies, and practices relat-

ing to their obligations under that treaty, including their right-to-health obligations.

However, the realization of all rights, including the right to health, ultimately occurs at the national level and relies primarily upon domestic institutions. National Human Rights Institutions (NHRIs) can aid in fostering systemic accountability for the progress of health and development goals, as well as for violations of health-related rights. Over the past decade in Peru, for example, the *Defensoría del Pueblo* (Human Rights Ombuds Office) has actively pursued monitoring and oversight of health rights. This has led, *inter alia*, to revised regulations and policies relating to issues ranging from informed consent to the free distribution of birth certificates to all children.³⁴ Other NHRIs, including those in India, Argentina, and Colombia, have also worked to identify practical ways to realize health-related rights.³⁵

These are the exception, however. Of the approximately 100 NHRIs in the world, only a small minority actively engage in ESC rights work, and fewer still in work relating to health rights. Moreover, an NHRI’s enforcement power rests on its legal mandate, and most NHRIs lack these powers. Therefore, the impacts of policy recommendations as well as case adjudications can be haphazard and can depend upon the independence and political authority of the NHRI in question as well as on social mobilization. Although in many countries NHRIs are theoretically more accessible than courts and can act *sua sponte* to identify laws and policies that violate health-related rights, they are too often hamstrung by limited budgets, human resources, skill sets, and mandates.³⁶

Judicial remedies: Courts, health rights, and social justice

It is no coincidence that the three Critical Concepts articles in this issue focus on judicial action. For good — and for ill — our current notion of rights, as opposed to the broader concept of justice, is, to a large extent, the product of courts’ actions and the rise of constitutionalism as a principal form of social transformation in the second half of the 20th century.³⁷ However, it is only in the last 15 years or so that we have witnessed a dramatic shift in the possibilities for enforcing health-related rights through the courts. Beginning in the 1990s with cases revolving

around access to anti-retroviral medications — which were based on arguments relating to the right to life as well as health — courts throughout the world have increasingly enforced access to health goods and services.³⁸ Although this phenomenon has far-reaching and controversial implications for health policy, as well as for broader questions about the role of courts in twenty-first century welfare states, it has until now received scant attention from the public health community.³⁹

Latin America, a region marked by deep social exclusion, robust constitutional frameworks, and systemic failures of representation by the political branches of government, has witnessed the greatest “health rights revolutions.” As Gloppen notes, in Colombia, Brazil, and Costa Rica — which are all civil law jurisdictions in which adjudication generally resolves only the instant dispute — courts enforce thousands of claims for medications and treatments each year. As Victor Abramovich and Laura Pautassi relate, Argentina, too, has experienced a wave of health rights litigation with significant implications for both policy-making and spending.

India and South Africa, as well as other common law jurisdictions where fewer holdings establish broad precedents, have also seen important cases relating to access to care as well as environmental health and the right to preconditions for health, such as food.⁴⁰ The effects of these decisions go far beyond direct impacts on litigants. Reports in Costa Rica trace an 80% decline in AIDS mortality to the constitutional chamber’s decisions to mandate the provision of ARVs.⁴¹ Moreover, the mere possibility of judicial enforcement can produce different political behavior and opportunities for negotiation for social movements.

If the question of whether courts can enforce health rights claims has been answered, many other questions remain. As Gloppen suggests, these include the advisability of judicial intervention in health policy, and whether such interventions distort priority-setting and displace democratic processes. They also include questions for activists about when court-centric strategies co-opt energies better channeled into direct action.

Assessing the role of courts, as well as when and how litigation can enhance the power of social mobi-

lization, calls for contextualized, empirical investigation.⁴² Looking beneath the broad global trends, it is possible to discern as many differences as similarities in the processes that lead up to and emerge from litigation, as well as in the ultimate impacts. For example, courts in Latin America have been most willing to issue judgments with substantial budgetary impacts. However, within South America, there are important distinctions in context and approach. Some countries — such as Peru and Bolivia — have not experienced heightened judicial intervention, despite important movements for health rights in those countries. Among the countries where courts have been active, actors, processes, and impacts have varied greatly. For example, critics allege that judicial interventions in Brazil have distorted the health budget by ordering high-cost, low-impact medications for individuals that were not included in the Sistema Único de Saúde (SUS, or unified health system).⁴³ However, in Colombia, the preponderance of *tutela* (protection writ) cases before the courts relate to goods and services which the state had already agreed to provide through the mandated social insurance scheme, and which theoretically should have been financed.⁴⁴ Courts in both Argentina and Colombia have been more willing to address broader health policy questions than is the case in other countries in Latin America, yet NGOs have fostered much of the important litigation in Argentina, while that is not the case in Colombia.

Perhaps most interesting is evidence from trends in a number of countries that suggests that courts can propose structural remedies to health and social welfare policy, and that new understandings of litigation itself are emerging from current practices.⁴⁵ For example, in an Argentine case involving the cleanup of the highly polluted Riachuelo River Basin, in which the Argentine Supreme Court had already held various public hearings, the Court’s final ruling established benchmarks and a timeline for cleanup of the river basin by multiple levels of governmental actors and involved various civil society groups, as well as the Human Rights Ombuds Office, in monitoring compliance.⁴⁶ In another structural order, in July 2008, the Colombian Constitutional Court issued a landmark judgment calling for modifications of the entire health care system and a process for implementing the decision, which is participatory (including affected persons as well as members of the medical community), transparent, and evidence-based.⁴⁷

Importantly, in these and other similar cases, redress is not confined to permutations of enforcing the status quo, such as compensation, restitution, or guarantees of non-repetition. Rather, courts have been engaged in redefining social arrangements and entitlements. Moreover, in many cases the courts have not assumed that they know best how to reform systems or answer difficult policy questions involving considerable trade-offs. Instead, they have approached remedies in innovative ways, calling for broad stakeholder participation in public hearings and the setting of benchmarks for implementation. Through this “softer” form of judicial review, courts may be better able to preserve their own legitimacy as well as foster processes that activate democratic dialogue with the executive and legislative branches of government regarding spending priorities and critical health policy questions.

Such decisions suggest that, under certain circumstances, courts may potentially promote deliberative democracy by overcoming “burdens of inertia” or “destabilizing” institutions that have been insulated from normal political accountability.⁴⁸ They are also broadly consistent with some theories of priority-setting in public health.⁴⁹ For example, Norman Daniels argues that, when it is reasonable to disagree on the grounds on which to reach a decision, justice demands “accountability for reasonableness” — that is, a fair process that includes publicity/transparency, relevant decision-making criteria, revisability, and enforceability.⁵⁰

Yet, as Gloppen rightly notes, we must go beyond applauding innovative legal decisions to investigate what impacts these decisions have in practice. Abramovich and Pautassi argue with respect to the *Viceconte* case that it “demonstrated the difficulties faced by the tribunals in executing decisions that require implementation of social impact public policies with heavy budget commitments. The process of execution took approximately ten years — until all the administrative steps had been completed and the vaccination campaigns had begun.” In other countries, enforcement of both individual and structural orders has also often been difficult and irregular.⁵¹

In assessing the role of courts — and the value of litigation in promoting health equity — the public health community might make a significant contribution by looking beyond narrow compliance questions to

map the broader structural impacts. Despite *Riachuelo* and some other notable exceptions, the majority of cases relate to access to treatments and medications, where clear duty-bearers and clear remedies exist. We do not have good data on the impact of emphasizing individualized access to treatment over public health preventive measures.⁵² Further, the impact of courts on the realization of the right to health in a given country should not be judged in isolation from their enforcement of other social rights that underpin social determinants of health, such as education and housing, and the effects of judicial decisions on questions of social exclusion and discrimination more generally. Normative evaluations of the role of courts in promoting health equity and substantive democracy more broadly should be informed by sound public health evidence.

For activists, the decision to convert social demands into legal claims entails complex strategic calculations, as well as sometimes uneasy partnerships between social movements and NGOs. The history of HIV/AIDS activism from ACT UP in the United States to Treatment Action Campaign in South Africa shows that those decisions are contingent on historical, political, and social contexts. In all cases, any role for courts in promoting social transformation must be understood in the context of other forces in society, including grass-roots social movements and political actors. As Colombian scholars Mauricio García-Villegas and Rodrigo Uprimny write, “constitutional justice can become an important tool for democratic progress, only if we think of it as part of broader social struggles. The fulfillment of the emancipation promises of many constitutions is too serious a matter to leave to constitutional justices.”⁵³

ACCOUNTABILITY FOR WHAT? DEFINING OBLIGATIONS OF PROGRESSIVE REALIZATION

Promoting accountability with respect to laws, policies, and programs that bear on health-related rights requires a variety of strategies for monitoring progress and securing redress; it also requires clearly defining normative obligations. Effectively addressing any health issue requires the protection of a wide array of both civil and political rights and ESC rights; one way to frame such obligations is to enumerate the rights entailed in resolving a given health issue.⁵⁴ In recent years, treaty-monitoring bodies and international declarations have affirmed that civil and political rights and ESC rights are truly “interdependent and indivisible.”⁵⁵

Each right, in turn, entails three dimensions of obligations: to respect, to protect, and to fulfill.⁵⁶ Under international law, the obligation to *respect* the right to health requires that states refrain from actions that interfere with individuals realizing their rights to health, such as “denying or limiting equal access for all persons . . . to preventive, curative and palliative health services.”⁵⁷ The obligation to *protect* the right to health demands that states prevent interference by third parties with the enjoyment of the right to health, including, for example, “ensuring that harmful social or traditional practices do not interfere with [women’s] access to pre- and post-natal care and family-planning.”⁵⁸ Finally, the obligation to *fulfill* requires states to “adopt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures toward the full realization of the right to health.”⁵⁹ Aside from a minimum core, which has been taken to be immediately enforceable in some but not all contexts, obligations to fulfill the right to health are subject to progressive realization.⁶⁰

Obligations of progressive realization are by far the least developed in human rights theory and practice. However, it is establishing accountability for these that potentially offers the greatest added value to public health and development practice. I argue here that three central obligations with respect to the progressive realization of health-related rights are: 1) *what* the state is doing; 2) *how much effort* the state is expending; and 3) *how* the state is going about the process. Consonant with the Paris Principles on Aid Effectiveness and the more recent Accra Agenda for Action, efforts to hold donor governments accountable should also consider whether they focus on appropriate interventions, the effort they are making, and the process they use to achieve their goals.⁶¹

Establishing accountability for obligations of progressive realization also poses the most difficult challenges to traditional human rights approaches, which tend to announce absolute principles and rely on “naming and shaming” deviations from those principles. Naming and shaming are critical; too often coercive measures that violate rights and dignity — from forced evictions to build dams to involuntary sterilizations to control population growth — have been justified in the name of economic development. Nevertheless, for human rights frameworks to contribute meaningfully to development and public health practice more generally, they must also add

something to the much messier questions of priority-setting and resource allocations. Otherwise, calls for rights-based approaches to health and development amount to little more than sloganeering.

Accountability for taking appropriate steps and measures: Linking normative obligations to the best evidence from public health

In practice, realizing civil and political rights requires both resources and progressive realization, and too often human rights practice has eschewed indicators and systems analyses that might permit a more accurate picture of whether a country is making progress. Yet standard setting in ESC rights has been slowed by the need to look beyond the traditional, law-dominated domains of human rights advocacy to different disciplines and methodologies. This is particularly true in the realm of health.

Although states are not expected to realize the right to health from one day to the next, they are not free to indefinitely defer taking steps toward the progressive realization of the right. Further, under international law a state is obligated to use all “appropriate” means to realize the right to health, including providing health facilities, goods, and services that are available, accessible (physically and economically, on a non-discriminatory basis and with respect to information), acceptable (medically and ethically), and of adequate quality (AAAQ).⁶² Paul Hunt, the first UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, clarified that “[p]rogressive realization does not mean that a State is free to adopt any measures that are broadly going in the right direction.”⁶³ On the contrary, in order to be appropriate, measures have to be deliberately calculated to bring about the fulfillment of a given aspect of the right to health. For example, in relation to maternal health, the United Nations Committee on the Elimination of Discrimination Against Women (CEDAW) requires States parties to report on the measures that they have adopted “to ensure women *appropriate* services in connection with pregnancy, confinement and the post-natal period.”⁶⁴

However, the appropriateness of services to address maternal mortality — or of measures to address any public health issue — does not spring automatically from transcendent principles of human rights law.⁶⁵

Rather, it emerges from the best evidence in clinical medicine and public health. Thus, what is normatively required must evolve with changing understandings of the epidemiology or pathology of a particular condition. For example, the advent of multidrug-resistant (MDR) tuberculosis challenges governmental responses to TB. What was once appropriate in terms of health policy as well as normative obligations — introducing one new drug at a time — can no longer be considered so.⁶⁶ Naturally, rights-based concerns can advance health policy, as in the case of provision of anti-retrovirals (ARVs) and MDR tuberculosis drugs in resource-poor settings where what is acceptable now has changed because of rights consciousness and social mobilization. Human rights can also inject concern for autonomy and dignity into health policy, such as in insistence on confidentiality, consent, and counseling in HIV testing.⁶⁷ But the question of the appropriateness of a government's or donor's response cannot be decoupled from what the evidence indicates about what works.⁶⁸

Further, monitoring progress in health and development programming — a key aspect of accountability — requires using appropriate indicators, the selection of which calls for understanding the connections between process measures and long-term outcomes. As Therese McGinn has pointed out:

For proven interventions, such as family planning and emergency obstetric care, it may be sufficient to measure utilization and rely on the evidence base for presumed long-term contribution (i.e., if it were shown that women correctly and continuously used effective contraceptives, it may be safely inferred that they will successfully space or limit their births.) For unproven interventions, such as efforts to improve psychosocial health or minimize the effects of gender-based violence, measurement at [multiple] levels [is necessary].⁶⁹

Thus, it is public health and not an immutable principle of human rights which suggests under what circumstances a government should be held accountable for specific conducts (that is, process indicators) or results (that is, outcome indicators) relating to an aspect of health for both.

How can accountability for specific policies or programs be advanced in practice? Maternal mortality as an example

After more than 20 years of frustratingly little progress on safe motherhood, Amnesty International, the Center for Reproductive Rights, and a number of other human rights NGOs, together with an International Initiative on Maternal Mortality and Human Rights, are framing maternal mortality explicitly as a human rights issue. In terms of public health, it is clear what needs to be done. There is now a consensus in public health that the key interventions to reduce maternal mortality are skilled birth attendance, emergency obstetric care (EmOC), and referral networks, together with family planning.⁷⁰ The majority of women's deaths are attributable to delays in the decision to seek care, delays in arriving at care, and delays in receiving appropriate treatment once at a facility.⁷¹ In terms of human rights, lack of access to EmOC is not a technical issue; it is, rather, one principal way in which poor women experience poverty and exclusion in societies around the globe.

Moreover, the absence of political priority on making EmOC available, accessible, acceptable, and of adequate quality is directly related to the low social status of women in these societies. Thus, as Special Rapporteur Paul Hunt stated in a report to the UN, “Preventing maternal mortality and enhancing access to maternal health care is not simply about scaling up interventions or making them affordable. It is also vital to address social, cultural, political and legal factors which influence [and indeed limit or preclude] women's decisions to seek maternal or other reproductive health care services. This may entail remedying discriminatory laws, policies, practices and gender inequalities that prevent women and adolescents from seeking good quality services.”⁷²

In addition to undertaking such multi-pronged efforts to raise the status of women, if we seek to make governments and other actors more responsive to women's health needs — that is, more accountable — a human rights-based approach must address the contextually-bound ways in which the absence of availability, accessibility, acceptability, and quality of EmOC play out in decisions to seek care, arrive at care, and receive adequate treatment (see Figure 1 on page 10).

By showing how in a specific context a failure on the part of the government to ensure the AAAQ of EmOC leads to the three delays that cause women to die — it becomes apparent that these deaths are not random biological events, but the foreseeable result of systematic policy decisions on multiple levels. For example, even the decision to seek care, which is often blamed on women’s “idiosyncratic preferences,” can be traced to failures in AAAQ. When there is a lack of availability — that is, a dearth of health facilities themselves, or an absence of transportation, communications, or trained human resources and equipment — women and their families are understandably less apt to seek care. Similarly, physical as well as economic barriers to access, such as transport costs and user fees, also factor into decisions to seek care. Perceived cultural insensitivity and lack of cultural acceptability, as well as poor quality of care at health facilities, can also lead to reluctance to seek care at a health facility. Thus, “problems” — such as women being unable to afford even emergency care because of charges for essential medicines or blood — are transformed into violations and state failures, for which the state bears responsibility.

Once failures in AAAQ and the legal and policy framework underlying those failures are identified, governments can be held accountable for making the appropriate modifications, such as eliminating fees. Donor states, which directly and through multi-lateral banks underwrite health sector reform in much of the developing world as well as achievement of MDG 5 relating to reducing maternal mortality, can, likewise, be held accountable, ensuring that the interventions they fund promote and do not create barriers to the AAAQ of emergency obstetric care.

Maternal health is but one example among many. Even while touting a given health issue as a priority, governments often are not undertaking the appropriate policies to address it — whether HIV/AIDS, maternal mortality or child survival. Likewise, every year billions of dollars in health aid are being poured into interventions that do not achieve much. These are not separate questions from human rights and dignity concerns; access to appropriate care, as well as to the preconditions of health lies at the center of the right to health.⁷³

The added value of rights lies precisely in converting what may be perceived as technical health policy questions into matters of political and legal entitlement. However, to move from rhetoric to application requires more than asserting that state failures are actionable claims. Implementation of international human rights norms relating to health at the national level must go beyond legislation, and beyond the traditional law-making and oversight bodies (such as courts and NHRIs) into the ministries (including but not limited to health) which are charged with designing social policy, and executing and monitoring programs that affect health.

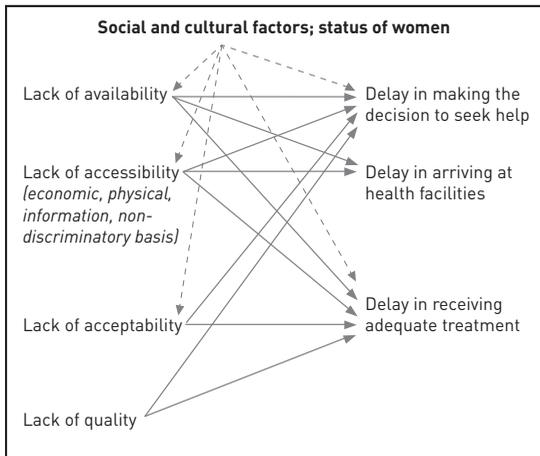


Figure 1: The three delays model and lack of available, accessible, acceptable, and quality emergency obstetric care. Adapted from D. Maine, *Safe Motherhood Programs: Options and Issues* (New York: Center for Population and Family Health, Columbia University, 1991), reproduced in A. E. Yamin, *Deadly Delays: Maternal Mortality in Peru: A Rights-Based Approach to Safe Motherhood* (Cambridge: Physicians for Human Rights, 2007), available at http://www.crin.org/docs/Physicians_hr_peru.pdf, p. 49.

Accountability for effort: “Maximum available resources,” non-retrogression, and adequate progress

States must be held accountable not just for undertaking the appropriate policies but also expending appropriate effort, including resources, in realizing the right to health. Under the ICESCR, as well as other treaties containing ESC rights, a state undertakes to take steps “to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means [emphasis added].”⁷⁴ In 2007, the ESC Rights Committee clarified that “available resources” refer to “both the resources existing

within the state as well as those available from international assistance and cooperation.”⁷⁵

Traditionally, economic policies have fallen outside of the purview of human rights advocacy.⁷⁶ In recent years, however, increasing efforts have been made to measure state effort in fulfilling the right to health, and ESC rights more generally, taking into consideration willingness and ability. For example, a newly-developed index that compares state conduct “with particular consideration for the obligation of progressive realization subject to maximum available resources” can usefully flag state underperformance.⁷⁷ Sakiko Fukuda-Parr, who led the development of the Human Development Index (HDI) at the United Nations Development Programme, together with colleagues, has created what are actually two separate composite indexes — one for low/middle income countries and one for high-income countries — by selecting indicators relating to various ESC rights, including health, on which data are available across a wide range of countries and relating them to GDP through a number of different proposed methodologies.⁷⁸

Although missing a robust evaluation of non-discrimination, these composite indexes allow for comparison of progress across countries of varying income levels as well as within one country over time, thereby highlighting states that are outliers or lagging in progressive realization. Further, disaggregating the different indicators suggests that threshold GDP levels for achieving ESC rights vary considerably. That is, it may require substantially lower GDP levels to realize universal measles immunization or dramatic reductions in child mortality than to achieve universal primary education. Such information is clearly critical to human rights advocacy in making demands for immediate accountability versus progressive realization.⁷⁹

A tool such as the index can be coupled with deeper analysis into the reasons for underperformance in a certain area. For example, Radhika Balakrishnan and Diane Elson have advocated a “human rights audit of economic policy” to identify the effects of neoliberal economic policies on multiple ESC rights in a given country.⁸⁰ In such an audit, specific economic policies — including public expenditure, taxation, monetary and fiscal policy, trade, and regulations — which may affect multiple rights, including health, are evaluated. Human rights principles that apply to those specific

economic policies are then identified, and indicators of both conduct and result (for example, expenditures and progress, respectively) are selected to assess governmental compliance with principles.⁸¹

Through these audits, it is possible to discern how lack of adequate progress due to inadequate spending, including low health spending, can often be traced, at least in part, to insufficient tax revenues. Moreover, fiscal policy affects compliance with both civil and political and ESC rights. For example, Guatemala — a country with notoriously bad fiscal policy — has health indicators that are among the worst in the region.⁸² However, Philip Alston, Special Rapporteur on extrajudicial, summary, or arbitrary executions, noted in a report to the Human Rights Council in 2007 that “[t]he reason the executive branch of the Guatemalan State has so little money to spend on the criminal justice system is that the Congress resists the imposition of all but the most perfunctory taxes. To put this in perspective, as a percentage of GDP, Guatemala’s total tax revenue in 2005 was 9.6 per cent of GDP.”⁸³ Even the International Monetary Fund — no icon of progressive social policy — argues that adequate fiscal space requires that tax revenues amount to at least 15% of GDP.⁸⁴ Thus, human rights frameworks that are concerned with policies that affect a broad range of social determinants, and not just health care, would include advocacy of progressive and non-discriminatory taxation systems as well as the abolition of user fees that are so often imposed in the wake of inadequate tax revenues.⁸⁵

If these audits allow us to discern how international instruments translate into policies, other innovative work is being done on how policies translate into budget commitments relating to obligations to fulfill specific aspects of the right to health. For example, a Mexican NGO, FUNDAR, issued a report in 2006 that exhaustively analyzed the connections between levels of maternal mortality throughout the country and the health budget.⁸⁶ The FUNDAR report established costs of providing basic emergency obstetric care. It was then able to point to specific insufficiencies in the Mexican health budget, as well as inequitable allocation of resources in that, for example, expenditures were lowest where poverty and lack of insurance was greatest.⁸⁷ Critically, the FUNDAR report highlights that increasing health spending, as happened in Mexico under the Fox administration, does not automatically result in realization of the

right to health because of *inappropriate* expenditures; that is, insofar as targeted interventions and increasing increases in the social insurance program were not accompanied by needed investments in health care workforce and infrastructure.

In the context of the current economic crisis, we need to be concerned not only with holding governments and donor states accountable for adequate progress, but also with retrogression (backsliding), which is presumed to be inconsistent with a state's obligations under international law.⁸⁸ Retrogression can refer to a specific policy change, such as a reduction in access to contraception due to ideological inclinations. At other times, however, retrogression can relate explicitly to financing and resources. For example, the Colombian Constitutional Court has long emphasized that "all retrogression is presumptively unconstitutional and therefore subject to strict scrutiny."⁸⁹ Thus, when the Executive sought to reduce spending with respect to the Subsidized Health Insurance Scheme as part of a "rationalization of public spending," the Court held that the drastic reduction of spending for the needs of the poorest segments of Colombian society was inconsistent with the government's legal obligations.⁹⁰ In Colombia, the Court has even gone further, stating that the principle of progressive realization is violated whenever there are steps taken that contradict the aim of achieving universal coverage, as set forth in both the Constitution and legislation.⁹¹

In short, as Balakrishnan and Elson have pointed out, "the realization of human rights, especially economic and social rights, requires resources as well as laws. The availability and use of resources is strongly influenced by the type of economic policies that States parties implement."⁹² Thus critically examining economic policies, far from being overly political or beyond the realm of human rights, is essential to using a rights framework to foster accountability in health and development policies.⁹³ Further, establishing accountability for utilizing maximum available resources and adequate progress demands proactive proposals which, in turn, call for instrumentalizing human rights concepts through other domains of expertise.

Accountability for process, including equality and non-discrimination, meaningful participation, and a functioning health system

A human rights approach to health and development

policy judges the process through which health goals and outcomes are reached. A fundamental difference between rights-based approaches and most other approaches to development is their emphasis on changing relationships of power, rather than exclusively on boosting levels of material well-being.⁹⁴ Thus, when governments are devising national health plans of action or donor states are providing development assistance, a rights-based approach requires that they be held accountable for how they go about the process of empowering people, as well as the end result.⁹⁵ Some of the criteria that are widely agreed to characterize a human rights framework as it is applied to health include non-discrimination/equality, participation, and an emphasis on the health system as a core social institution rather than merely a delivery apparatus for packages of goods and services.⁹⁶

Paul Hunt and Gunilla Backman devoted an entire article in the last issue of this journal to discussing the features of a health system based on recognition of the right to health, and space precludes addressing those features in depth here.⁹⁷ It is clear, however, that targeted reforms, such as those scrutinized by FUNDAR in Mexico, rarely lead to sustained advances in the enjoyment of the right to health. In contrast to health sector reforms that focus solely on the efficient delivery of health care as a market good and cast patients as "consumers," an approach grounded in human rights construes the quality of a health system, including equality and participation, as a reflection of the quality of substantive democracy in a country. From the perspective of promoting accountability, perhaps even more important than identifying whether legal and institutional arrangements conform to abstract human rights principles is strong contextualized political analysis that reveals why specific health systems are failing to meet people's basic rights.⁹⁸

Equal treatment is part of process as well as an end in itself. A future issue of this journal will be devoted to what the principles of non-discrimination and equality require in both theory and practice. It is worth noting here, however, that a human rights framework is concerned not just with instances of individual discrimination by providers who are acting as agents of the state. Under international law, such instances of discrimination are *per se* violations.

Yet if human rights is to be relevant to development and health policy, human rights advocates must be equally or more concerned with institutional

and structural forms of exclusion that result in *de facto* discrimination. For example, the ESC Rights Committee has made it clear that “[i]nappropriate health resource allocation can lead to discrimination that may not be overt,” and that a basic obligation of States parties includes ensuring “the equitable distribution of all health facilities, goods and services.”⁹⁹ Governments and donor states alike should be held accountable for ensuring structural and institutional measures to prevent *de facto* discrimination in health programs, including the use of disaggregated indicators that provide incentives to consider distributional effects and not merely aggregate advances.

As will be further examined in the next issue of this journal, participation is also key to the true realization of the health-related rights. Both states and other actors should be held accountable for ensuring that those affected have an adequate opportunity to participate in decision-making.¹⁰⁰ Even when the background assumptions about what justice requires are unclear, “accountability for reasonableness,” in the term of the ethicist Norman Daniels, demands processes that engage relevant stakeholders.¹⁰¹ In human rights circles, this is sometimes referred to as “voice accountability” because states have an obligation to listen to the voices of the very people whose views and knowledge of their own situations are so often dismissed.

Holding states and donors accountable for participation is tricky because participation is a notoriously elusive concept to measure and evaluate, as well as deeply contextual. Health programs touted as “participatory” can be completely centralized, where the “participation” of community members is a guise to improve either public relations or cost-efficiency by transferring tasks, but not control. Meaningful participation in health is dramatically limited when rights to free expression, a free press, political participation, and access to information are not respected in law and practice. Donor states and international financial institutions, in conjunction with governments wary of popular involvement, may reduce participation in poverty reduction and development programs to tokenistic consultation with select members of civil society. In contrast, a rights-based approach calls for an authentic devolution of power within and beyond the health sector, with a transfer of planning and decision-making capacities to the individuals and communities served.

CONCLUSIONS

The subversive potential — and central value — of human rights lies in placing limits on both public lassitude and private greed through a framework and mechanisms for accountability. The accountability that human rights brings to bear converts passive recipients of health goods and services into active claims-holders, and challenges systems in which people are beholden to those wielding power over them with all too much discretion. In the midst of a global economic crisis that will disproportionately affect the poor and sick — and which was precipitated by a lack of accountability — let us imagine a world, by contrast, where the rights to housing, food, and health are universally recognized and enforced. Such a world would not need to rely on the compassion of an individual sheriff who finds evictions distasteful.¹⁰² There would be no need to prove worthiness in order to receive health care from a given charity, or to elicit pity in order to receive food donations from a global philanthropy. There would be no need to plead for something that is owed to all people as a matter of right. Accountability means that states’ and donors’ obligations are just that: legal obligations, and not goodwill gestures that might be abandoned at any time.¹⁰³

Yet establishing accountability requires moving from jeremiads to engagement with the concrete questions of how to enhance existing mechanisms — and create entirely new institutional architectures — that foster legal, political, and social accountability in the world that we live in right now. Establishing accountability in our current reality requires going beyond exhortation, to signal to governments, donors, and other actors that human rights-based approaches to health and development practice can be radically pragmatic. Radical pragmatism, in turn, requires developing and applying tools to discern what part of the staggering deprivation that exists in our world is *avoidable*, without accepting failures of political will that are cloaked in claims of resource scarcity. Establishing accountability also requires fostering coalitions to mobilize consciousness and effective social action, in conjunction with or independent of legal strategies. As Forman suggests in applying an analogy from the anti-slavery movement to the international movement for access to medicines, the compassion borne of solidarity — not charity — has long been a catalyst for the recognition of our shared humanity and, in turn, the flourishing of human rights.

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REFERENCES

1. See, for example, P. Uvin, *Human Rights and Development* (West Hartford, CT: Kumarian Press, 2004), p. 131; see also, K. De Feyter, *World Development Law* (Oxford: Intersentia, 2001); see also, United Nations Development Programme, *Integrating Human Rights with Sustainable Development: UNDP Policy Document 2* (Geneva: UNDP, 1998); M. Robinson, "What Rights Can Add to Good Development Practice," in P. Alston and M. Robinson (eds), *Human Rights and Development: Towards Mutual Enforcement* (Oxford: Oxford University Press, 2005), pp. 25–43; S. P. Marks, "Human Rights in Development: The Significance for Health," in S. Gruskin, M. A. Grodin, G. J. Annas, and S. P. Marks (eds), *Perspectives on Health and Human Rights* (NY and London: Routledge, 2005), pp. 95–116; and A. E. Yamin, "Will We Take Suffering Seriously? Reflections on What Applying a Human Rights Framework to Health Means and Why We Should Care," *Health and Human Rights* 10 (2008), pp. 45–63.
2. M. Langford, *Claiming the Millennium Development Goals: A Human Rights Approach* (New York: United Nations, 2008), p. 15.
3. See "Mission Statement," International Initiative on Maternal Mortality and Human Rights. Available at <http://www.reproductiverights.org/pdf/MMHR%20brochure.pdf>.
4. As a recent Office of the High Commissioner for Human Rights (OHCHR) meeting report on incorporating human rights into development practice concluded, "[t]he devil is undoubtedly in the details." Office of the High Commissioner for Human Rights, *Monitoring Human Rights and the MDGs: The Quest for Coherence Synthesis Report from the Expert Consultation*, (Geneva: OHCHR, 2008), para. 13.
5. A. E. Yamin, "The Future in the Mirror: Constructing and De-Constructing Strategies for the Defense and Promotion of Economic, Social and Cultural Rights," *Human Rights Quarterly* 27 (2005), p. 1200.
6. Yamin (see note 1). For a more general application of the need to compare performance of states across resource levels, see S. Fukuda-Parr, T. Lawson-Remer, and S. Randolph, "Measuring the Progressive Realization of Human Rights Obligations: An Index of Economic and Social Rights Fulfillment," University of Connecticut Working Paper 8 (August 2008).
7. Moreover, the international community's engagement with the Millennium Development Goals (MDGs) — which have yet to incorporate meaningful human rights approaches to accountability — presents a strategic opportunity. Four of the eight MDGs that stand at the center of current international development efforts are directly related to the right to health: combat HIV/AIDS, malaria, and other diseases; improve child health; improve maternal health; and provide safe drinking water and sanitation (as part of sustainable development). Three others relate to social determinants of health: eradicate extreme poverty (and hunger); provide universal primary education; and promote gender equality. The eighth MDG commits donor states to a "global partnership for development" to assist states in the global South in reaching these targets. Yet, despite efforts by the OHCHR and some other groups, human rights principles and concerns — including accountability — have been largely absent from not only the development, but also monitoring of progress with respect to the MDGs thus far. P. Alston, "Ships Passing in the Night: The Current State of the Human Rights and Development Debate Seen through the Lens of the Millennium Development Goals," *Human Rights Quarterly*, 27 (2005), p. 755; Langford (see note 2). However, in the case of MDG 5, there are a number of promising signs of change in that regard, including the launch of the IIMMHR and fieldwork by

some of the largest human rights nongovernmental organizations, including Amnesty International and Human Rights Watch, on maternal health.

8. See e.g. H. Potts, *Accountability and the Highest Attainable Standard of Health* (Colchester, UK: University of Essex/Open Society Institute, 2008), p. 5. Available at http://www2.essex.ac.uk/human_rights_centre/rth/docs/HRC_Accountability_Mar08.pdf.

9. For example, in Spanish, one says *rendición de cuentas* to describe redress, while *responsabilidad* and *control ciudadano* refer to aspects of political and social accountability, respectively.

10. Langford (see note 2).

11. For an elaboration of states' obligations of conduct and result, see V. Dankwa et al., "Maastricht Guidelines on Violations of Economic, Social and Cultural Rights," *Human Rights Quarterly* 20 (1998), pp. 691–704.

12. See, for example, P. Houtzager, A. Joshi, and A. Gurza-Lavalle, "State Reform and Social Accountability," *IDS Bulletin* 38/6 (2008).

13. For more information, see Right to Food Campaign at <http://www.righttofoodindia.org/campaign/campaign.html>.

14. For a discussion of how this was the case in Peru, see C. Ewig, "Gender Equity and Neoliberal Social Policy: Health Sector Reform in Peru" (PhD dissertation, University of North Carolina at Chapel Hill, 2008).

15. See, for example, Houtzager, Joshi, and Gurza-Lavalle (see note 12).

16. See, for example, S. Gloppen, "Public Interest Litigation, Social Rights, and Social Policy," in A. A. Dani and A. De Haan (eds), *Inclusive States* (Washington, DC: World Bank, 2008), pp. 343–368.

17. *South African Minister of Health v. Treatment Action Campaign* (No. 2), 2002 (5) SA 721.

18. *PUCL v. Union of India and Others*, Writ Petition [Civil] 196 of 2001.

19. Right to Food Campaign (see note 13).

20. See also, D. Brinks and V. Gauri, "A New Policy Landscape: Legalizing Social and Economic Rights in the Developing World," in V. Gauri and D. Brinks

(eds), *Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World* (New York: Cambridge University Press, 2008), pp. 303–352.

21. See K. Roth, "Defending Economic, Social and Cultural Rights: Practical Issues Faced by an International Human Rights Organization," *Human Rights Quarterly* 26/1 (2004), pp. 63–73.

22. See, for example, A. E. Yamin, *Deadly Delays: Maternal Mortality in Peru, A Rights-Based Approach to Safe Motherhood* (Cambridge, MA: Physicians for Human Rights, 2007). Available at <http://physiciansforhumanrights.org/library/documents/reports/maternal-mortality-in-peru.pdf>.

23. L. London, "What is a Human-Rights Based Approach to Health and Does It Matter?" *Health and Human Rights* 10 (2008), pp. 63–77, at 72. Available at <http://www.hhrjournal.org/index.php/hhr>.

24. Ibid.

25. L. Freedman "Human Rights, Constructive Accountability and Maternal Mortality in the Dominican Republic," *International Journal of Gynecology and Obstetrics* 82 (2003), pp. 111–114.

26. L. Pautassi, "El Empleo en Salud en la Argentina. La Sinergia entre Calidad del Empleo y Calidad de la Atención," in M. Nieves Rico and F. Marco (eds), *Mujer y Empleo: La Reforma de la Salud y La Salud de la Reforma en Argentina* (Buenos Aires, Argentina: Siglo Veintiuno Editores, 2006), pp. 193–233.

27. Freedman (see note 25).

28. UN Human Rights Council, Report of the 7th special session of the Council on "The Negative Impact on the Realization of the Right to Food of the Worsening of the World Food Crisis, Caused Inter Alia by the Soaring Food Prices," Geneva, May 22, 2008, UN Doc. No. A/HRC/S-7/2 (July 2008).

29. International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200, (XXI), UN GAOR, 21st Sess., Supp. No. 16, at 49, UN Doc. No. A/6316 (1966), Article 2.

30. See, for example, Development Assistance Research Associates (DARA) Humanitarian Response Index 2008. Available at http://www.hri.daraint.org/what_is_hri/hri_2008.

31. OECD, *Paris Declaration on Aid Effectiveness*

(Paris: OECD, 2005). Available at http://www.oecd.org/document/36/0,2340,en_2649_3236398_34689188_1_1_1_1,00.html; World Bank, “Accra Agenda for Action,” *3rd High Level Forum on Aid Effectiveness*, September 2–4, 2008 (Accra, Ghana: World Bank 2008).

32. Committee on Economic, Social and Cultural Rights (ESCR Committee), General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. No. E/C.12/2000/4 (2000), para. 39. Paul Hunt, the first UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, repeatedly insisted that states possess such obligations independently and as members of international organizations: “In addition to obligations at the domestic level, developed States have a responsibility to provide international assistance and cooperation to ensure the realization of economic, social, and cultural rights in low-income countries. This responsibility arises from recent world conferences, including the Millennium Summit, as well as provisions of international human rights law.” UN Human Rights Council, 60th Session, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, prepared by Paul Hunt, UN Doc. No. E/CN.4/2004/49 (2004), para. 45.

33. See A. M. Goetz and R. Jenkins, “Hybrid Forms of Accountability: Citizen Engagement in Institutions of Public-Sector Oversight,” *Public Management Review* 3/3 (2001), cited in P. Newell and S. Bellaour, “Mapping Accountability: Origins, Contexts and Implications for Development,” *IDS Working Paper* 168 (Brighton, England: IDS, 2001), and R. K. Murthy and B. Klugman, “Service Accountability and Community Participation in the Context of Health Sector Reforms in Asia: Implications for Sexual and Reproductive Health Services,” *Health and Policy Planning* 19, Supplement 1 (2004); see also, Potts (see note 8).

34. “Casos Investigados por la Defensoría del Pueblo,” *Serie Informes Defensoriales* 27 (Lima, Peru: Defensoría del Pueblo, 1999). Available at <http://physiciansforhumanrights.org/library/documents/reports/maternal-mortality-in-peru.pdf>; Defensoría del Pueblo (Ombuds Office of Colombia), *Supervisión a los Servicios de Planificación Familiar IV: Casos Investigados por la Defensoría del Pueblo* (2005). Available at <http://www.ombudsman.gob.pe/>

modules/Downloads/informes/defensoriales/informe_90.pdf.

35. For example, in 2004, The Indian National Human Rights Commission (NHRC) organized public hearings for a “National Action Plan to Operationalise the Right to Health Care within the Broader Framework of the Right to Health.” In Argentina, the Human Rights Ombuds Office has been called upon by the Supreme Court for interventions and monitoring in various cases relating to public health issues (vaccine production) and environmental issues bearing on health (river pollution). In Colombia, the Human Rights Ombuds Office recently undertook a comprehensive review of monitoring and accountability mechanisms within Colombia’s health system as well as the use of judicial remedies to secure accountability for violations. The scathing report that the Human Rights Ombuds Office issued in 2007 documented the tens of thousands of judicial cases (*tutelas*) that people were filing annually as a result of the lack of oversight and accountability within the system itself. It also called upon the Constitutional Court to exercise its authority and declare the entire health system in “an unconstitutional state of affairs.” When, in July 2008, The Colombian Constitutional Court called for a dramatic restructuring of the health system, it, in turn, set up a process of reporting and stakeholder participation, which included the Human Rights Ombuds Office. See NHRC and JSA, “Recommendations of National Action Plan to Operationalize the Right to Health Care,” National Public Hearing on Right to Health Care, December 16–17, 2004, New Delhi. Available at <http://www.nhrc.nic.in/dispatcharchive.as?Fno=874>; Defensoría del Pueblo (Ombuds Office of Colombia), *La Tutela y el Derecho a la Salud. Período 2003-2005* (Bogotá: Defensoría del Pueblo, 2007).

36. Although NHRIs are potentially well-suited to monitor how development and health goals are being achieved (including “international assistance and cooperation,” regarding MDGs or otherwise in donor countries), to date this potential has not been fulfilled. Their ability to play such roles requires not only an investment in capacity, but often dramatic reconfigurations of institutional missions and legal mandates. See, for example, V. Sripathi, “India’s National Human Rights Commission: A Shackled Commission?” *Boston University International Law Journal* 18 (2000), pp. 3–46.

37. R. Gargarella, P. Domingo, and T. Roux (eds), *Courts and Social Transformation in New Democracies: An Institutional Voice for the Poor?* (Burlington, VT: Ashgate, 2006).
38. See *Courts and the Legal Enforcement of Economic, Social and Cultural Rights: Comparative Experiences of Justiciability* (Geneva: International Commission of Jurists; 2008); Gauri and Brinks (see note 20). For an early review of these cases, which focused mostly on access to ARVs, see B. C. A. Toebes, *The Right to Health as a Human Right in International Law* (Antwerp: Intersentia, 1999).
39. Much of the writing has been inaccurate, suggesting that there have only been a handful of cases. An exception is: H. V. Hogerzeil, M. Samson, J. Vidal Casanovas, and L. Rahmani-Ocora, “Is Access to Essential Medicines as Part of the Fulfilment of the Right to Health Enforceable through the Courts?” *Lancet* 368 (2006), pp. 305–311.
40. Across these very different contexts, courts have required the political branches of government to provide access to information (a key element in the right to health), as well as special protections for vulnerable groups (for example, children) and public justification for the “reasonableness” of their policies and practices. Compare: *South African Minister of Health v. Treatment Action Campaign* (see note 17) and *Soobramoney v. Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (Constitutional Court, South Africa).
41. M. Cantero, “Antiretrovirales Reducen Mortalidad de Ticos con SIDA,” *La Nación*, San Jose, Costa Rica (November 16, 2005), cited in Gauri and Brinks, “Introduction” in Gauri and Brinks (see note 20), p. 2.
42. For example, it is traditionally asserted that there is something fundamentally distinct in the nature of ESC rights, as opposed to civil and political rights, which prevents their justiciability. Yet we find across contexts that procedural adaptations — for example, changes in standing to allow for collective relief — greatly increase the enforceability of health and other ESC rights claims. They similarly increase the enforceability of certain civil and political rights claims, such as those involving prisons or elections. In a recent empirical study, Varun Gauri and Daniel Brinks similarly noted that “the popular account of judicial and legislative logic needs to be corrected.” That is, “courts are anchored in more deontologi- cal forms of reasoning and valuation but move to incorporate other logics,” such as cost-utility and cost-effectiveness, in enforcing health and other ESC rights. Gauri and Brinks, “Introduction,” (see note 20), p. 5. See also, International Commission of Jurists, *Courts and the Legal Enforcement of Economic, Social and Cultural Rights: Comparative Experiences of Justiciability* (Geneva: International Commission of Jurists, 2008), pp. 95–97.
43. See Hogerzeil, Samson, Vidal Casanovas, and Rahmani-Ocora (see note 39); see also, O. Ferraz and F. Vieira, “Direito a Saude, Politicas Publicas e Desigualdades Sociais no Brasil: Equidade como Principio Fundamental,” *Dados* (forthcoming, 2009) [English abstract: The Right to Health, Public Policies and Inequalities in Brazil: Equity as the Fundamental Principle, SSRN. Available at <http://ssrn.com/abstract=1137872>].
44. For example, although “Scientific Technical Committees” of insurance companies are authorized to determine coverage for medications not included in the POS, they have not been authorized to make such determinations regarding any other services or treatments (for example, MRI of the spine). Corte Constitucional de Colombia, Sala Segunda de Revisión, Sentencia T-760. July 31, 2008. Magistrado Ponente: Manuel José Cepeda.
45. See Limburg Principles & Maastricht Guidelines on the role of courts in social issues and social/psychological spheres of power as much as legal. Dankwa et al. (see note 11).
46. *Mendoza Beatriz Silvia y Otros C/Estado Nacional y Otros S/Daños y Perjuicios*. Corte Suprema de Justicia de la Nación. July, 2008. Available at http://www.farn.org.ar/docs/fallo_riachuelo080708.pdf.
47. Corte Constitucional de Colombia (see note 44).
48. See R. Dixon, “Creating Dialogue about Socioeconomic Rights: Strong-form Versus Weak-form Judicial Review Revisited,” *International Journal of Constitutional Law* 5 (2007), pp. 112–147; and C. Sabel and W. Simon, “Destabilization Rights: How Public Law Litigation Succeeds,” *Harvard Law Review* 117 (2004), pp. 1015–1101.
49. S. Gruskin and N. Daniels, “Process Is the Point: Justice and Human Rights: Priority Setting and Fair Deliberative Process,” *American Journal of Public Health* 98/9 (2008), pp. 1573–1577.

50. N. Daniels, “Accountability for Reasonableness,” *British Medical Journal* 321 (2000), pp. 1300–1301; N. Daniels, *Just Health: Meeting Health Needs Fairly* (New York: Cambridge University Press, 2007). Critiques of Daniels’ procedural justice have argued that it “fails to ensure the rightness of the rationales put forward” to decide on priorities, which is precisely the role that the courts are assuming, which, therefore, could suggest that these judicial processes enhance some aspects of procedural justice. For a critique of Daniels, see J. Prah Ruger, “Ethics in American Health 1: Ethical Approaches to Health Policy,” *American Journal of Public Health* 98 (2008), pp. 1751–1756, at 1753.

51. For example, implementation of the landmark Treatment Action Campaign decision has been remarkably patchy by district. Enforcement of the decisions of Colombian courts has been delayed by inordinately complex and inefficient reimbursement procedures, a fact noted by the Constitutional Court itself in its sweeping 2008 decision calling for modification in those procedures, among other aspects of the health system. Corte Constitucional de Colombia (see note 44).

52. Ferraz and Vieira (see note 43).

53. M. García Villegas and R. Uprimny, “The Constitutional Court and Social Emancipation in Colombia,” in B. de Sousa Santos (ed), *Democratizing Democracy: Beyond the Liberal Democratic Canon*, Vol. 1. (London: Verso, 2006), pp. 66–102.

54. For example, each health-related MDG implies the protection of multiple rights. Such rights include both civil and political and ESC rights. For instance, it is possible to achieve MDG 5 — improving maternal health and reducing maternal mortality — only by implicating (directly and indirectly) the rights to life, health, bodily integrity, political participation, equality before the law, and education; as well as freedoms of information, association, movement, and to found a family. See R. J. Cook, “Advancing Safe Motherhood through Human Rights,” in I. Merali and V. Oosterveld (eds), *Giving Meaning to Economic, Social and Cultural Rights* (Philadelphia: University of Pennsylvania Press, 2001), pp. 109–123; see also, S. Gruskin et al., “Using Human Rights to Improve Maternal and Neonatal Health: History, Connections and a Proposed Practical Approach,” *Bulletin of the World Health Organization* 86 (2008), pp. 577–656. Available at [http://www.](http://www.who.int/pmnch/topics/maternal/usinghuman-rights/en/index.html)

[who.int/pmnch/topics/maternal/usinghuman-rights/en/index.html](http://www.who.int/pmnch/topics/maternal/usinghuman-rights/en/index.html).

55. For example, the “inherent right to life” enshrined in the International Covenant on Civil and Political Rights (ICCPR), among other treaties, cannot be interpreted restrictively or in isolation from the positive measures required to fulfill the right to health. Human Rights Committee, General Comment No. 6, The Right to Life, UN Doc. No. A/37/40 (1982), para. 5. See also, United Nations, World Conference on Human Rights: Vienna Declaration and Programme of Action, Vienna, June 14–25, 1993, UN Doc. No. A/CONF.157/24 (Part I) (1993), reprinted in 32 I.L.M. 1661.

56. For one of the first articulations of the three dimensions of state obligations to respect, protect, and fulfill rights, see A. Eide, “Report on the Right to Food as a Human Right,” UN Doc. No. E/CN.4/Sub.2/1987/23 (1987). For application of different dimensions of obligations to civil and political rights, see also, Human Rights Committee, General Comment No. 28, Equality of Rights between Men and Women (Article 3), UN Doc. No. CCPR/C/21/Rev.1/Add.10 (2000).

57. ESCR Committee (see note 32), para. 34.

58. *Ibid.*, para. 35.

59. *Ibid.*, para. 33.

60. The South African Constitutional Court has rejected a notion of a minimum core that is immediately enforceable regardless of resources, while the Colombian Constitutional Court has taken the social insurance plan in Colombia to define a minimum core that should be immediately enforceable under the Colombian Constitution, as informed by international law. Corte Constitucional de Colombia (see note 44). *Minister of Health et al. v. Treatment Action Campaign* (Constitutional Court of South Africa, July 5, 2002). Available at <http://www.tac.org.za/Documents>. For an overview of the many interpretations and treatments of the minimum core, see K. Young, “The Minimum Core of Economic and Social Rights: A Concept in Search of Content,” *Yale Journal of International Law* 33/1 (2007), p. 113.

61. OECD (see note 31).

62. Each State party to the ICESCR “undertakes to take steps, individually and through international assistance and co-operation, especially economic

and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means.” UN General Assembly, 21st Session, Official Records, Supplement 16, “Article 2,” *International Covenant on Economic, Social & Cultural Rights*, G.A. Res. 2200, UN Doc A/6316 (1966), 993 UNTS 3 (adopted Dec. 16, 1966).

63. See UN Human Rights Council, 60th Session, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (see note 32). See also, ESCR Committee (see note 32).

64. UN Committee on the Elimination of Discrimination Against Women, General Recommendation No. 24, *Women and Health*, UN Doc. No. CEDAW/C/1999/I/WG.II/WP.2/Rev.1 (1999), para. 26.

65. Nor, as traditionally has been done in determining public international law principles, can we merely look to the practices of “civilized nations.” See, for example, D. Shelton, “Normative Hierarchy in International Law,” *American Journal of International Law* 291 (2006), pp. 291–323, at 295.

66. P. Farmer and J. Kim, “Community Based Approaches to the Control of Multidrug Resistant Tuberculosis: Introducing ‘DOTS-Plus,’” *British Medical Journal* 317 (1998), pp. 671–674.

67. UNAIDS/WHO Policy Statement on HIV Testing. Available at http://data.unaids.org/unadocs/hivtestingpolicy_en.pdf.

68. Sometimes the evidence is not clear, and in turn, normative obligations may be unclear.

69. T. McGinn, “Internally Displaced Persons in Colombia; A Public Health Analysis,” in A. E. Yamin (ed), *Learning to Dance: Case Studies on Advancing Women’s Reproductive Health and Well-Being from the Perspectives of Public Health and Human Rights*, Francois-Xavier Bagnoud Center Series on Health and Human Rights (Cambridge: Harvard University Press, 2005), pp. 63–69, at 67.

70. UN Millennium Project Task Force on Child Health and Maternal Health, “Health Status and Key Interventions,” *Who’s Got the Power? Transforming Health Systems for Women and Children* (London: Earthscan,

2005), pp. 49–94. Available at http://www.unmillenniumproject.org/reports/tf_health.htm.

71. D. Maine, *Safe Motherhood Programs: Options and Issues* (New York: Center for Population and Family Health, Columbia University, 1991).

72. Note by the Secretary-General Transmitting the Report of the Special Rapporteur on The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, UN Doc. No. A/61/338 (2006), para. 17.

73. It is worth noting that lack of access to justice also reflects this marginalization.

74. International Covenant on Economic, Social and Cultural Rights (see note 29).

75. UN Committee on Economic, Social and Cultural Rights, *Optional Protocol to the Covenant*. Available at http://www2.ohchr.org/english/law/docs/A.RES.63.117_en.pdf.

76. See, for example, Roth (see note 21).

77. Fukuda-Parr, Lawson-Remer, and Randolph (see note 6), p. 1.

78. Ibid.

79. Ibid.

80. R. Balakrishnan and D Elson, “Auditing Economic Policy in Light of Obligations of Economic and Social Rights,” *Essex Human Rights Review* 5 (2008), pp. 1–19, at 8.

81. Ibid.

82. See UNDP, “Guatemala,” *Human Development Report 2007/2008*. Available at http://hdrstats.undp.org/countries/country_fact_sheets/cty_fs_GTM.html.

83. P. Alston, Human Rights Council, *Statement by Professor Philip Alston, Special Rapporteur on Extrajudicial, Summary or Arbitrary Executions*, March 27, 2007. Available at <http://ctuhr.org/files/Alston%27s%20Statement.pdf>, page 5.

84. P. Heller, “Fiscal Space: What Is It and How to Get It?” *Finance & Development: A Quarterly Magazine of the International Monetary Fund* 2/2 (June 2005). Available at <http://www.imf.org/external/pubs/ft/fandd/2005/06/basics.htm>.

85. See, for example, IDS, *The Future State: Taxation,*

Aid and Accountability (Cambridge: Cambridge University Press, 2007); P. Nanda, *Health Sector Reforms in Zambia: Implications for Reproductive Health and Rights* (Takoma Park, MD: Center for Health and Gender Equity, 2000).

86. See, generally, D. Diaz Echeverria et al., *Muerte Materna y Presupuesto Publico* (Mexico, DF: Fundar, 2006).
87. *Ibid.*
88. ESCR Committee (see note 32).
89. C 251/97, Segunda Sala de Revisión, Constitutional Court of Colombia, 1997.
90. C 1165/2000, Segunda Sala de Revisión, Constitutional Court of Colombia, 2000; C 040/2004 Segunda Sala de Revisión, Constitutional Court of Colombia, 2004.
91. C 130/02, Segunda Sala de Revisión, Constitutional Court of Colombia, 2002. This principle was reaffirmed in Corte Constitucional de Colombia (see note 44).
92. Balakrishnan and Elson (see note 80), p. 1.
93. Contrast Roth (see note 21).
94. Compare Amartya Sen's capabilities theory relating to human development. See, for example, A. Sen, *Development As Freedom* (New York: Anchor Books, 2000).
95. When there is disagreement about the grounds for decisions regarding complex matters of health and social policy, human rights calls for what Daniels has termed in ethics "accountability for reasonableness"—a fair process that is: evidence-based, transparent, and public so that different interested persons can see and debate the reasoning for decisions; revisable in light of new evidence; and enforceable. Compare Paragraph 43(f) of General Comment 14 with Norman Daniels's accountability for reasonableness. ESCR Committee (see note 32), para. 43(f).
96. Universal Declaration of Human Rights (UDHR), G.A. Res. 217A (III), UN Doc. No. A/810 (1948), at 71.
97. P. Hunt and G. Backman, "Health Systems and the Right to the Highest Attainable Standard of Health," *Health and Human Rights* 10/1 (2008). Available at <http://hhrjournal.org/index.php/hhr>.

For a further elaborated model of right-to-health features of health systems, see G. Backman, P. Hunt, R. Khosla et al., "Health Systems and the Right to Health: An Assessment of 194 Countries," *Lancet* 372 (2008), pp. 2047–2085.

98. For this type of political analysis of health determinants and systems, see, for example, V. Navarro, *The Political and Social Contexts of Health* (Amityville, NY: Baywood Publishing Co, 2004).
99. ESCR Committee (see note 32), para. 43.
100. *Ibid.*, para. 17.
101. Daniels, "Accountability for Reasonableness" (see note 50); Daniels, *Just Health: Meeting Health Needs Fairly* (see note 50).
102. J. Leland, "Sheriff in Chicago Ends Evictions in Foreclosures," *New York Times*, October 8, 2008. Available at <http://www.nytimes.com/2008/10/09/us/09chicago.html?ref=business>.
103. Note that rights — and even justice — need not be the only ground on which we rely to determine the "right" course of action. Justice and mercy are deeply intertwined, as recognized in the common law through the provision of legal remedies (justice) and equitable remedies (mercy), as well as in Biblical texts.