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Adjudicating Health-Related Rights: Proposed Considerations for the United Nations Committee on Economic, Social and Cultural Rights, and Other Supra-National Tribunals

Alicia Ely Yamin and Angela Duger*

Abstract

This article examines how various supra-national tribunals have approached adjudication of health-related rights, and makes proposals with respect to some special considerations posed by health-related cases that the United Nations Committee on Economic, Social and Cultural Rights and other supra-national bodies will invariably face. After briefly setting out the contours of the right to health under international law, we stress the importance of an approach to adjudication that acknowledges underlying determinants, but also that defines the obligations of the health sector, explicitly acknowledging the interdependence and indivisibility of health with human rights. Second, reviewing some lessons from other supra-national tribunals, we address the question of when a supra-national tribunal should order interim measures in a health-rights related case. Third, we explore the uniquely important role

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of technical evidence in health rights cases, which are highly reliant on clinical and epidemiological determinations in establishing what reasonableness requires of the state. Fourth, we assert that achieving health equity goes beyond accounting for socio-economic marginalization or discrimination faced by certain populations, to examining priorities in relation to the “worst off” in terms of the seriousness of conditions. Finally, we argue both for the appropriateness of “dialogical” remedies in many health rights cases, and the need for developing innovative forms of monitoring and supervision of such remedies by supra-national tribunals.

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I. PROLOGUE

Camila Abuabara, a Colombian university student, was first diagnosed with acute lymphoblastic leukemia in 2010. In 2013, suffering a relapse, she went to a hospital affiliated with the Sanitas insurance company, through which she had coverage. She spent three days without receiving appropriate examinations or treatment, finally checking herself into a different hospital to get care. Her doctor determined that Camila required an allogeneic stem cell transplant, which should have been covered under the obligatory insurance scheme in Colombia (Plan Obligatorio de Salud, or POS). However, during a second remission, Camila faced a series of bureaucratic hurdles and misinformation from Sanitas, apparently in order to save \$30,000,000 Colombian pesos (approximately \$9,480 USD at 2013 currency conversion rates). This was the stated difference between the cost of the appropriate non-autologous transplant and the autologous stem cell transplant, which the company had authorized. Upon receiving a personal communication from Camila, the Colombian Minister of Health, Alejandro Gaviria, intervened on her behalf to compel Sanitas to perform the appropriate surgery. However, the inordinate delays meant that blastocysts were again detectable in her blood, making it clinically ill-advised to perform the procedure.¹

In 2014, Camila petitioned a Colombian court to order Sanitas to pay for her treatment at the MD Anderson Cancer Center in Houston, Texas, a global leader in cancer research and care. There, doctors had previously performed an experimental treatment on similarly situated patients with acute lymphoblastic leukemia in the third remission, with a 63% success rate. Colombia did not have such treatment available within the country. One court issued a protection writ (*tutela*) in favor of Camila's claim to a violation of her fundamental rights to life and health, despite some irregularities in the writ.² As such treatment abroad is not covered in the POS—and therefore Sanitas would not be expected to cover the cost—the government was provisionally ordered by the court to cover the estimated \$678,000 USD from the Solidarity and Guarantee Fund (FOSYGA).³ Minister Gaviria, who had previously advocated on Camila's behalf with Sanitas, then intervened to challenge the court decision.⁴ He argued that providing such expensive treatment for one person could end up denying many others needed

¹ See Norbey Quevedo H. y María Mónica Falla, *La Nueva Batalla de Camila Abuabara*, EL ESPECTADOR (Nov. 4, 2014), <http://www.elespectador.com/noticias/investigacion/nueva-batalla-de-camila-abuabara-articulo-525735>.

² *Abelardo de la Espriella v. EPS Sanitas S.A.*, Juzgado Vientiocho Penal Municipal Con Función Control de Garantías, Medida Provisional - Acción de Tutela 2014-00095 (Bogotá, Nov. 1, 2014) (Colom.).

³ *Id.*

⁴ *Id.* at ¶ 4.

care and distorting the system.⁵ A second court revoked the protection writ.⁶ After receiving a bone marrow transplant in Colombia in December 2014 at a Sanitas hospital, Camila passed away on February 24, 2015.⁷

What should the United Nations Committee on Economic, Social and Cultural Rights (ESC Rights Committee), or another treaty-monitoring body (TMB) or supra-national tribunal, do if it were to receive a petition in such a case, before Camila's demise, as a matter of interim or precautionary measures? What kinds of evidence would the ESC Rights Committee, or another supra-national tribunal, want to evaluate if a case were brought upon the plaintiff's death, arguing that the death was the direct result of the systematic lack of oversight and regulation of the health system? What sorts of remedies would be appropriate in such a case, if a violation were found? How might structural recommendations be effectively monitored?

II. INTRODUCTION

As in Camila's case, health rights cases often present tragic scenarios involving life and death decisions. These decisions are not only technical ones, but inexorably involve deeply contested moral values, balances between the interests of identified patients and anonymous suffering, and competing considerations among different kinds of patients and social values. Courts are increasingly involved in making such decisions as health rights are more and more frequently adjudicated at the national level across many middle income and, increasingly, low income countries.⁸ Different patterns of access to justice and enforcement, as well as the reactions of ministries of health to such litigation, mean that this phenomenon has varying equity impacts across countries.⁹

⁵ *Id.*

⁶ *Id.*

⁷ *See id.* *See also* Deicy J. Pareja M., 'Camila Tuvo Esperanzas Hasta el Día de su Muerte': Familiares Relatan los Últimos Días de la Joven que Luchó por Conseguir un Trasplante de Médula, EL TIEMPO (Feb. 28, 2015), <http://www.eltiempo.com/colombia/medellin/testimonio-de-familiares-de-camila-abuabara-tras-su-muerte/15302796>.

⁸ *See* Daniel Brinks & William Forbath, *The Role of Courts and Constitutions in the New Politics of Welfare in Latin America*, in *LAW AND DEVELOPMENT OF MIDDLE-INCOME COUNTRIES: AVOIDING THE MIDDLE-INCOME TRAP* 221–45 (Randall Peerenboom & Tom Ginsburg eds., 2014); César Rodríguez-Garavito, *The Judicialization of Health Care: Symptoms, Diagnosis, and Prescriptions*, in *LAW AND DEVELOPMENT OF MIDDLE-INCOME COUNTRIES: AVOIDING THE MIDDLE-INCOME TRAP* 246–69 (Randall Peerenboom & Tom Ginsburg eds., 2014); The Center for Health Human Rights and Development & 4 Ors v Nakaseke District Local Administration [2015] UGHC XX (30 April 2015).

⁹ *See* LITIGATING HEALTH RIGHTS: CAN COURTS BRING MORE JUSTICE TO HEALTH? (Alicia Ely Yamin & Siri Gloppen eds., 2011); COURTING SOCIAL JUSTICE: JUDICIAL ENFORCEMENT OF SOCIAL

With the entry into force of the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights (ICESCR), we will see a greater number of health-related rights presented to ESC Rights Committee, as well as other TMBs. Path-breaking cases have already been brought under the Optional Protocol to the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW).¹⁰ More will no doubt be brought under the Convention on the Rights of Persons with Disability (CRPD) and the Convention on the Rights of the Child (CRC). We are also likely to see increasing numbers of health-related claims framed in terms of the right to a life of dignity and other civil rights under other treaties, such as the International Covenant on Civil and Political Rights (ICCPR). Indeed, the European Court of Human Rights (ECtHR) and the Inter-American Court of Human Rights (IACtHR) have also already begun to adjudicate health-related claims.¹¹

This article examines how various supra-national tribunals have approached adjudication of health-related rights. It also makes proposals with respect to some special considerations posed by health-related cases that the ESC Rights Committee and other TMBs and supra-national tribunals will invariably face,

AND ECONOMIC RIGHTS IN THE DEVELOPING WORLD (Varun Gauri & Daniel M. Brinks eds., 2008).

¹⁰ See Comm'n. on the Elimination of Discrimination against Women (CEDAW), Views: Communication No. 17/2008, U.N. Doc. CEDAW/C/49/D/17/2008 (Jul. 25, 2011) [hereinafter CEDAW, Alyne da Silva] (known as the Alyne da Silva Pimentel Teixeira case).

¹¹ For cases from the European Court of Human Rights (ECtHR) see *M.S. v. Sweden*, 1997-IV Eur. Ct. H.R. 1437 (concerning the privacy of health data); *Z. v. Finland*, 1997-I Eur. Ct. H.R. 323 (concerning the privacy of health data); *K.H. & Others v. Slovakia*, 2009-II Eur. Ct. H.R. 389 (concerning access to health records); *V.C. v. Slovakia*, 2011-V Eur. Ct. H.R. 381 (concerning sterilization without consent); *N.B. v. Slovakia*, App. No. 29518/10, <http://hudoc.echr.coe.int/eng?i=001-111427> (2012) (concerning sterilization without consent); *Cyprus v. Turkey*, 2001-IV Eur. Ct. H.R. 1, ¶ 219 (holding that a violation of the right to life occurs “where it is shown that the authorities . . . put an individual’s life at risk through the denial of health care which they have undertaken to make available to the population generally”); *Nevmerzhitsky v. Ukraine*, 2005-II Eur. Ct. H.R. 307 (concerning the denial of health care to detainee amounting to degrading treatment); *D. v. The United Kingdom*, 1997-III Eur. Ct. H.R. 777 (concerning consideration of access to medications under the right to life if petitioner were deported); *Yakovenko v. Ukraine*, App. No. 15825/06, <http://hudoc.echr.coe.int/eng?i=001-82987> (2007) (concerning prisoners’ access to AIDS and TB treatment). For cases from the Inter-American Court of Human Rights (IACHR) see *Suárez Peralta v. Ecuador*, Inter-Am. Ct. H.R. (ser. C) No. 261 (May 21, 2013) (concerning state regulation of health care provision); *Ximenes-Lopes v. Brazil*, Inter-Am. Ct. H.R. (ser. C) No. 149 (July 4, 2006) (concerning the treatment of a patient in a mental health facility); *Caesar v. Trinidad and Tobago*, Inter-Am. Ct. H.R. (ser. C) No. 123 (Mar. 11, 2005) (concerning corporal punishment of prisoner); *Juvenile Reeducation Institute v. Paraguay*, Inter-Am. Ct. H.R. (ser. C) No. 112 (Sept. 2, 2004) (concerning the care and wellbeing of juvenile inmates in a detention center). See also *Case of Suárez Peralta v. Ecuador*, Inter-Am. Ct. H.R. (ser. C) No. 261, at 65 (May 21, 2013) (MacGregor Poisot, J., concurring) (arguing that the Court should have “approached the problem taking into account what really caused this case to reach the inter-American system . . . which was the implications for the ‘right to health’”).

some of which are poignantly raised in Camila's case.¹² We first briefly set out the contours of the right to health in its core formulation under international law, stressing the importance of an approach to adjudication that acknowledges underlying determinants but also defines the obligations of the health sector, explicitly acknowledging the interdependence and indivisibility of health with human rights. Second, reviewing some lessons from other supra-national tribunals, we address the question of when the ESC Rights Committee should order interim measures in a health-rights related case, and argue that such relief should focus on structural and collective cases rather than life-saving measures for individuals. Third, we explore the uniquely important role of technical evidence in health rights cases, which are highly reliant on clinical and epidemiological evidence in establishing what reasonableness requires, as illustrated by Camila's case. However, we also emphasize that technical judgments can obscure important normative contestation about values that underlie choices in health, and therefore we argue that varying types of third-party interventions are especially appropriate in many health cases that raise questions at the borders of private morality and public policy. Fourth, we examine different approaches to reasonableness standards in economic and social rights cases that have been used by constitutional and high courts, and assert that achieving substantive equality in health goes beyond accounting for socio-economic marginalization or discrimination faced by certain populations, to examining priorities in relation to the "worst off" in terms of the seriousness of conditions. Finally, we turn to remedies, arguing both for the appropriateness of structural and "dialogical" remedies in many health rights cases, and the need for developing innovative forms of monitoring and supervision of such remedies by the ESC Rights Committee and other supra-national tribunals, in order to enhance effective compliance and ultimate impact.

Throughout the article, we suggest that examining the rights of individuals, such as Camila, in a vacuum exacerbates both health and social inequity. Rather, what is called for is a purposive approach that construes the health system as a core social institution and a reflection of the normative commitments to equal dignity of all people entitled to services under that system, which the state has

¹² This article draws from research and review of the field, the experience of one author in three regions over more than a decade, advising judiciaries, and advocates bringing strategic health-related litigation (AEY). For purposes of this article, we define supra-national tribunals as the UN treaty monitoring bodies, regional courts, and regional human rights systems (including the Inter-American Commission and the African Commission). We are examining the process and procedure of adjudicating of human rights rather than the binding nature of decisions.

made under international law.¹³ As South African Constitutional Court Justice Albie Sachs noted in a health rights case,

[w]hen rights by their very nature are shared and inter-dependent, striking appropriate balances between the equally valid entitlements or expectations of a multitude of claimants should not be seen as imposing limits on those rights ..., but as defining the circumstances in which the rights may most fairly and effectively be enjoyed.¹⁴

Further, we conclude that international judgments can play a significant role in clarifying states' obligations that flow from the right to health, and encourage a greater degree of democratic deliberation relating to the normative values reflected in diverse countries' health systems.

III. PRELIMINARY QUESTIONS: DEFINING THE CONTOURS OF THE JUSTICIABLE RIGHT

Health rights cases brought before the ESC Rights Committee will predominantly be brought under the right to health articulated in Article 12 of the ICESCR, which recognizes the right of everyone to the enjoyment of “the highest attainable standard of physical and mental health.”¹⁵ Paragraph 2 of Article 12 states the four steps that States parties shall take to progressively realize the right, in accordance with maximum available resources:

- (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the 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.¹⁶

The ESC Rights Committee has subsequently interpreted these provisions in its General Comment 14.

It is clear from General Comment 14 that the right to health includes both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the

¹³ See Lynn P. Freedman, *Achieving the MDGs: Health Systems as Core Social Institutions*, 48 DEV. 19 (2005); Alicia Ely Yamin & Ole Frithjof Norheim, *Taking Equality Seriously: Applying Human Rights Frameworks to Priority Setting in Health*, 36 HUM. RTS. Q. 296 (2014).

¹⁴ *Soobramoney v. Minister of Health (KwaZulu-Natal)* 1998 (1) SA 765 (CC) ¶ 54 (S.Afr.) (Sachs, A., concurring).

¹⁵ International Covenant on Economic, Social and Cultural Rights art. 12(1), Dec. 16, 1966, 993 U.N.T.S. 3.

¹⁶ *Id.* art 12(2).

right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.¹⁷

Governmental obligations with respect to health include respecting the right and refraining from direct contravention; protecting the right from interference by third parties, including through regulation and sanctioning of private actors (such as pharmaceutical companies, polluters, or domestic abusers); and fulfilling the right through appropriate legislative and other measures directed at its progressive realization, in accordance with maximum available resources.¹⁸

At national levels, the right to health has often been construed as the right to medical care, as in Camila's case and in the overwhelming majority of the over one million *tutela* (protection writ) cases that have been brought in Colombia since 1999.¹⁹ However, the right to health under the ICESCR includes the underlying determinants of health as well.²⁰ These underlying determinants, including such public health measures as water and sanitation, and the even broader social determinants of health—which go to the rights upon which health is interdependent, including freedom of information, housing and education—are responsible for a far greater share of the patterns of health and illness than access to medical care. The WHO Commission on the Social Determinants of Health explains that “lack of health care is not the cause of the huge global burden of illness . . . The main action . . . must therefore come from outside the health sector.”²¹ Thus, while there is obviously no right to be healthy under international law, there is also a recognition that the right to health includes public health preconditions, and that it is inextricably related to other rights.

Other TMBs, such as the CEDAW Committee and CRC Committee, have also interpreted important dimensions of health-related rights for women and children, respectively.²² These TMBs have also consistently noted that the equal

¹⁷ Comm'n on Econ., Soc. and Cultural Rights [CESCR], General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12 of the Covenant), ¶ 8, 22nd Sess., U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter CESCR, General Comment No. 14].

¹⁸ *Id.* at ¶¶ 33, 35–37.

¹⁹ JORGE ARMANDO OTÁLORA, DEFENSORÍA DEL PUEBLO, LA TUTELA Y LOS DERECHOS A LA SALUD Y LA SEGURIDAD SOCIAL 2013 (2014).

²⁰ See CESCR, General Comment No. 14, *supra* note 17, at ¶¶ 9, 11.

²¹ World Health Organization [WHO] Comm'n on Soc. Determinants of Health, *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health: Final Report of the Commission on Social Determinants of Health* 35 (2008).

²² See Comm'n on the Elimination of Discrimination Against Women [CEDAW], CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health), ¶ 1, 20th Sess., U.N. Doc. A/54/38/Rev.1, chap. I (Apr. 20, 1999) (affirming that “access to health care . . . is a basic right under the Convention on the Elimination of All Forms of Discrimination against Women); Comm'n on the Rights of the Child [CRC], General Comment No. 15 on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (art. 24), ¶ 1, 62nd Sess., U.N. Doc.

and effective enjoyment of the right to health relates to other social determinants in society. For example, the CEDAW Committee recognized that “there are societal factors which are determinative of the health status of women and men . . .” such as nutrition, education, and adequate living conditions.²³ The CEDAW Committee also recognized the power imbalances between women and men that affect access to information and increased exposure to violence and abuse.²⁴ Given the implications for both the normative definition and legitimacy of the treatment of rights by supra-national tribunals, through both their jurisprudence and their selection of cases, it will be critical for the ESC Rights Committee, as well as other bodies, to underscore the importance of construing the right to health in this broader view, stressing prevention as well as the inter-connectedness of health with other rights.

At the same time,

it is important to guard against an approach whereby the right to health is conceived of as a repository for everything that impacts upon the health of an individual . . . the right to health should not be inflated to such an extent that the rights relevant to these matters are subsumed within the right to health and denied their *lex specialis* status and capacity for a content which exists independently of the right to health.²⁵

The right to health should not be utilized as a catch-all approach to realizing other social rights; health is not the only important input in a life of dignity. When domestic courts begin enforcing access to disposable diapers, live-in caretakers, and the like as part of “integral treatment” under the right to health, as has occurred in Colombia²⁶ and Brazil,²⁷ they may not be doing a service to the cause of social inclusion and equity in the long run. Under this approach, funds may be taken from health baskets, potentially distorting priority-setting in health, while political pressure to devise universal policies regarding social protection that afford a minimum vital standard and life of dignity may at the same time be displaced.

CRC/C/GC/15 (Apr. 17, 2013) (urging state parties to “respect[], protect[], and fulfill[] children’s right to the enjoyment of the highest attainable standard of health); CRC, General Comment No. 3: HIV/AIDS and the Rights of the Child, ¶ 5, 32nd Sess., UN Doc. CRC/GC/2003/3 (Mar. 17, 2003) (stating that children’s enumerated rights should be “guiding themes in the consideration of HIV/AIDS at all levels of prevention, treatment, care and support”).

²³ CEDAW General Recommendation No. 24, *supra* note 22, at ¶ 6.

²⁴ *Id.* at ¶ 12(b).

²⁵ JOHN TOBIN, *THE RIGHT TO HEALTH IN INTERNATIONAL LAW* 132 (2012).

²⁶ See RODRIGO UPRIMNY & JUANITA DURÁN, *EQUIDAD Y PROTECCIÓN JUDICIAL DEL DERECHO A LA SALUD EN COLOMBIA* (Santiago de Chile: Naciones Unidas, 2014).

²⁷ See Daniel W. Liang Wang & Octavio Luiz Motta Ferraz, *Reaching out to the Needy?, Access to Justice and Public Attorneys’ Role in the Right to Health Litigation in the City of São Paulo*, 10 SUR INT’L J. HUM. RTS. 159 (2013).

The interdependence of health and other rights is also important to recall in adjudications interpreting treaties in which the right to health is not explicitly guaranteed. The Human Rights Committee (HRC), the treaty monitoring body for the International Covenant on Civil and Political Rights,²⁸ has recognized that the protection of the right to life under the ICCPR requires states not just to refrain from arbitrary deprivation or interference with the right to life, but also to adopt positive measures to ensure access to basic health care and other ESC rights. For example, international legal scholar Rebecca Cook has noted that the HRC's concluding observations indicate that "persistently high levels of maternal mortality put states on notice that they may be in breach of their obligations to take effective measures to protect women's right to life."²⁹ Thus, there is a recognized indivisibility of rights denominated as civil and political—for example, the right to life—and those denominated as economic and social, including the right to health.

With respect to the American Convention on Human Rights³⁰ (American Convention), Judge Eduardo Ferrer Mac-Gregor Poisot of the IACtHR explains the implications for judicial interpretation of an approach that takes seriously interdependence and indivisibility. In his influential concurring opinion in *Suárez Peralta v. Ecuador*, he writes that capturing interdependence and indivisibility makes "it obligatory to interpret all rights together—which at times, results in overlapping contents—and to assess the implications of the respect, protection and guarantee of some rights for other rights, as regards their effective implementation."³¹

Indeed, the effective enjoyment of health rights, whether explicitly enshrined in the governing international treaty or not, often depends upon enabling rights, including freedom of expression and information. For example, the ECtHR found a violation of the right to freedom of expression and information (Article 10 of the European Convention of Human Rights³²) when the government of Ireland banned the provision of information to pregnant women seeking to go abroad to obtain an abortion.³³ The ECtHR held that "the national authorities enjoy a wide margin of appreciation in matters of morals" but that this is not unlimited.³⁴ The

²⁸ International Covenant on Civil and Political Rights [ICCPR], Mar. 23, 1976, 999 U.N.T.S. 171.

²⁹ Rebecca J. Cook, *Human Rights Law and Safe Motherhood*, 5 EUR. J. HEALTH L. 357, 361 (1998).

³⁰ American Convention on Human Rights, "Pact of San José, Costa Rica", Nov. 22, 1969, 1144 U.N.T.S. 123.

³¹ *Suárez Peralta v. Ecuador*, *supra* note 11, at 10.

³² Convention for the Protection of Human Rights and Fundamental Freedoms, Nov. 4, 1950, 213 U.N.T.S. 221.

³³ *Open Door and Dublin Well Woman v. Ireland*, 246 Eur. Ct. H.R. 68 (Ser. A) (1992).

³⁴ *Id.* at ¶ 68.

ECtHR noted that when the state takes measures, it “must do so in a manner which is compatible with [its] obligations” under the European Convention, and Article 10 only permits those restrictions on freedom of expression that are necessary in a democratic society.³⁵ The ECtHR concluded “that the restraint imposed on the applicants from receiving or imparting information was disproportionate to the aims pursued.”³⁶

In short, adjudication of health-related cases by the ESC Rights Committee, as well as other supra-national tribunals, has the potential to highlight the underlying public health preconditions of health, which are part of the right to health in addition to medical care. Further, such judgments afford the opportunity to clarify that the right to health itself does not subsume all other rights necessary for a life of dignity, but is interdependent with them. In so doing, such judgments provide an equally important opportunity for creating substantial public learning—at both national and global levels—about the imperative for policy-makers to think in terms of multi-sectorial planning, and for “circles of accountability” throughout health policy cycles, rather than appending remedies to broken health systems.³⁷

IV. SPECIAL CHARACTERISTICS OF HEALTH TO CONSIDER IN APPROACHES TO INTERIM/ PRECAUTIONARY MEASURES

Much health rights litigation, as in the case of Camila at the opening of this article, will involve irreparable injury or death to the petitioner if the TMB fails to intervene immediately. As Manuel Jose Cepeda, former justice and President of the Colombian Constitutional Court, has aptly noted, “the passage of time has an ethical dimension.”³⁸ The circumstances under which TMBs utilize interim (or precautionary) measures³⁹ to prevent further alleged harm to the petitioner, and the types of measures they use, will not only have direct effects upon the petitioner, but will also likely have indirect effects on others—as well as on the legitimacy of the supra-national body itself.

³⁵ *Id.* at ¶ 69.

³⁶ *Id.* at ¶ 80.

³⁷ See Alicia Ely Yamin & Fiona Lander, *Implementing a Circle of Accountability: A Proposed Framework for Judiciaries and Other Actors in Enforcing Health-Related Rights*, 14 J. HUM. RTS. 312 (2015); ALICIA ELY YAMIN, POWER, SUFFERING, AND THE STRUGGLE FOR DIGNITY: HUMAN RIGHTS FRAMEWORKS FOR HEALTH AND WHY THEY MATTER (2016).

³⁸ Manuel José Cepeda, Professor and Former Chief Justice of the Colombian Supreme Court, Presentation for the Harvard FXB Center, Health Rights Litigation Course at the Global School on Socio-Economic Rights (Sept., 2013).

³⁹ Interim measures are also referred to as “precautionary measures” or “provisional measures” in some jurisdictions.

Under the Optional Protocol to the ICESCR, the ESC Rights Committee may issue interim measures only “as may be necessary in exceptional circumstances.”⁴⁰ Therefore, the ESC Rights Committee has discretion in determining what amounts to exceptional circumstances and will likely set that precedent at the outset of its jurisprudence. Indeed, many are waiting to see how the ESC Rights Committee will use this authority.⁴¹ Other international human rights tribunals, such as the HRC and Committee Against Torture do not have the burden of determining whether a case has an exceptional nature when deciding whether to issue interim measures.⁴² In civil and political rights cases, precautionary and interim measures have most often been used to prevent the state from engaging in further harmful action. However, precautionary measures have also been used to compel positive state action related to health (for example the provision of emergency medical care, food or water). We argue here that it is possible to elaborate criteria in order to establish a principled approach to interim measures.

Across national jurisdictions, courts have been asked to override denials of medical care and treatment to individuals, which more often than not fall within the health scheme (i.e., “quality-skipping” as opposed to judicial activism) and sometimes do not—but are nevertheless alleged to be protected as a matter of fundamental rights.⁴³ This is likely to occur with increasing frequency in the era of the Sustainable Development Goals, as schemes to achieve universal health coverage are adopted, which may not always be well aligned with constitutional principles, or international normative commitments.⁴⁴

An important preliminary distinction in such cases, which will arise in the issuance of interim measures, is that between “life-saving” and “emergency” care, the latter of which is sometimes guaranteed without reference to progressive realization in national law. For example, in the 1997 South African case of

⁴⁰ Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, G.A. Res. 63/117, art. 5(1), U.N. Doc. A/RES/63/117 (Dec. 10, 2008) [hereinafter Optional Protocol to ESC Rights Committee].

⁴¹ See, for example, Malcolm Langford, et al., ESCR-Net Draft Background Note, *Supporting Strategic Litigation under the Optional Protocol to ICESCR Rights Committee*, 8 (Aug. 30, 2010), http://www.escr-net.org/sites/default/files/OP_SLI_Background_Note_FINAL_0_0.pdf.

⁴² See Optional Protocol to the International Covenant on Civil and Political Rights, U.N. Doc. A/RES/21/2200 (Dec. 16, 1966); Resolution, Convention Against Torture, U.N. Doc. A/RES/39/46 (Dec. 10, 1984).

⁴³ See *Litigating Health Rights: Can Courts Bring More Justice to Health?*, *supra* note 9; *Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World*, *supra* note 9.

⁴⁴ See U.N. General Assembly, *Transforming Our World: the 2030 Agenda for Sustainable Development*, U.N. Doc. A/RES/70/1 (Sept. 25, 2015).

Soobramoney,⁴⁵ petitioner sought state-funded dialysis treatment for his incurable chronic renal failure after exhausting his personal funds in private care. The state-funded treatment center denied dialysis treatment on the basis that he did not meet the eligibility criteria for the treatment, namely because his diagnosis was chronic and he suffered an array of associated conditions.⁴⁶ Further, the state of KwaZulu Natal argued that to expand treatment criteria would exhaust its budget.⁴⁷ In that case, the South African Constitutional Court found that chronic kidney failure was not an “emergency condition”, and therefore not subject to Section 27(3) of the Constitution, which would have required immediate protection.⁴⁸ The Court found that the state’s policy and budgetary claims were reasonable,⁴⁹ and Mr. Soobramoney died shortly thereafter. If the ICESCR’s Optional Protocol had been in effect and South Africa had been a party to it, such a case could have been filed before the ESC Rights Committee for interim measures seeking to compel the state to provide immediate treatment.

While the deferential standard of scrutiny of the budgetary claims has been justifiably criticized in the *Soobramoney* case, we believe that the distinction between emergency care and chronic care is an important one to consider in terms of defining the “exceptional circumstances” under which the ESC Rights Committee should order interim measures. Evidence from national contexts suggests that when individuals seek the equivalent of interim measures from courts to provide immediate entitlements to life-saving or life-prolonging care, including treatment abroad as happened in Camila’s case, it can potentially distort health policy-making and priorities within health systems. That can, in turn, exacerbate inequities.⁵⁰ While granting true “emergency care” to individuals through interim measures potentially has some of the same adverse consequences, and calls for carefully defining the contours of what constitutes an “emergency,” its scope will likely be far more limited. Moreover, the lack of effective access to “emergency care,” as defined under most jurisdictions⁵¹—including trauma care and attention

⁴⁵ *Soobramoney v. Minister of Health (KwaZulu-Natal)*, *supra* note 14.

⁴⁶ *Id.* at ¶ 1–4.

⁴⁷ *Id.* at ¶ 2–3.

⁴⁸ *Id.* at ¶ 19–21.

⁴⁹ *Id.* at ¶ 29.

⁵⁰ See Octavio Ferraz, *The Right to Health in the Courts of Brazil: Worsening Health Inequities?*, 11 HEALTH & HUM. RTS J. 33 (2009); Coleen M. Flood & Aeyal Gross, *Litigating the Right to Health: What Can We Learn from a Comparative Law and Health Care Systems Approach*, 16 HEALTH & HUM. RTS J. 62 (2014); Yamin & Lander, *supra* note 37.

⁵¹ See, for example, *Soobramoney v. Minister of Health (KwaZulu-Natal)*, *supra* note 14, at ¶ 20 (stating that “Section 27(3) itself is couched in negative terms—it is a right not to be refused emergency treatment. The purpose of the right seems to be to ensure that treatment be given in an emergency, and is not frustrated by reason of bureaucratic requirements or other formalities . . . What the

to active labor—almost always reveals structural violations of the right to health or systematic discrimination, including on the basis of cost, within a health system, which are often worthy of being brought to light.

Examining the experience of other supra-national tribunals, and in particular the Inter-American system, provides additional guidance for what may be appropriate to consider as “exceptional circumstances.” First, the Inter-American Commission (IACHR) frequently uses precautionary measures and the Inter-American Court (IACtHR) uses provisional measures; both have done so regularly for health-related cases in custodial situations, where the responsibilities of the state are appropriately heightened and the cases reflect institutional failures with effects on health-related rights. The Inter-American Commission has ordered precautionary measures for cases where hospital and prison conditions have been deplorable, requiring the state to provide medical care and to implement medical and sanitation measures to protect the personal integrity and dignity of patients and inmates. For example, in the case of “460 patients living in a Neuropsychiatric Hospital in Paraguay,” the Inter-American Commission “requested that, given the grave health risks presented, the state urgently adopt the sanitary and medical measures necessary to avoid harm to the personal integrity of the patients of the hospital.”⁵² The IACHR has issued precautionary measures on behalf of prison inmates to compel state provision of medical examinations,⁵³ proper medical

section requires is that remedial treatment that is necessary and available be given immediately to avert that harm.”); Emergency Medical Treatment and Labor Act [EMTALA], 42 U.S.C. § 1395dd(e)(1)(A)(i) (2012) (“A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in . . . placing the health of the individual . . . in serious jeopardy.”).

⁵² Tara J. Melish, *Rethinking The ‘Less as More’ Thesis: Supranational Litigation of Economic, Social, and Cultural Rights in the Americas*, 39 N.Y.U. J. INT’L L. & POL. 171, 284–85 (2006) (citing OEA/Ser.L/V/II.118, doc. 5 rev. 2 (2003), ch. III.C.1, ¶ 60 (Paraguay)).

⁵³ Ananías Laparra Martínez v. Mexico, Provisional Measure, Inter-Am. C.H.R., 351/11, (Jan. 18, 2012); Egberto Ángel Escobedo Morales v. Cuba, Provisional Measure, Inter-Am. C.H.R., 179/10 (June 28, 2010); Alberto Patishtán Gómez v. Mexico, Provisional Measure, Inter-Am. C.H.R., 77/12 (May 24, 2012); Niurka Luque Alvarez v. Cuba, Provisional Measure, Inter-Am. C.H.R., 153/2012 (May 16, 2012); Luis Álvarez Renta v. Dominican Rep., Provisional Measure, Inter-Am. C.H.R., 393/10 (Dec. 15, 2011).

treatment,⁵⁴ and to improve conditions, as has the IACtHR for proper medical treatment⁵⁵ and to improve conditions.⁵⁶

Second, supra-national tribunals also issue interim measures for larger structural issues that impact health outcomes of defined populations. For example, both the Inter-American Court and Commission have issued provisional and precautionary measures, respectively, requiring a state party to establish or complete health programs for marginalized or disadvantaged populations, such as specific indigenous groups, affected by egregious pollution or other actions of the respondent.⁵⁷ In *300 Inhabitants of Puerto Nuevo, Peru*,⁵⁸ the Inter-American Commission required Peru to suspend warehouse and transport activities in a port because of the environmental contamination and health consequences for the population living nearby. In addition to suspending activities until a measure could be issued to address the issue, the Inter-American Commission also required the state “to adopt the necessary measures to provide specialized medical diagnostic services for the beneficiaries as well as appropriate and specialized medical treatment” when there appeared to be an irreparable risk of injury to bodily integrity or life itself.⁵⁹

Third, the Inter-American Commission has also issued precautionary measures to compel the provision of specific medical care to stigmatized populations whose treatment in the health system reflects and reinforces societal discrimination, such as persons living with HIV/AIDS. In some cases, the Inter-American Commission has specified that treatment should “include

⁵⁴ *Esquina Mendoza v. Guatemala*, Inter-Am. C.H.R., OEA/Ser.L/V/II.102, Ch. III, ¶ 24 (1998); *People Deprived of Their Freedom at Professor Aníbal Bruno Prison*, Inter-Am. C.H.R., PM 199/11, Braz. (2011); *Egberto Ángel Escobedo Morales v. Cuba*, *supra* note 53; *31 Undocumented Immigrants Residing in Atlanta, Ga. v. U.S.*, Provisional Measure, Inter-Am. C.H.R., 385/09, (Jan. 29, 2010).

⁵⁵ *Cesti-Hurtado v. Peru*, Inter-Am. Ct. H.R. (ser. E) No. 56 (Sept. 29, 1999).

⁵⁶ *Las Penitenciarias De Mendoza*, Inter-Am. Ct. H.R. (ser. E) (Nov. 22, 2004).

⁵⁷ *See* *Communities of the Maya People (Sipakense and Mam) of the Sipacapa and San Miguel Ixtahuacán Municipalities in the Department of San Marcos v. Guatemala*, Provisional Measure, Inter-Am. C.H.R., 260/07 (May 20, 2010) (The Inter-American Commission asked the State “to address the health problems that are the subject of these precautionary measures, in particular to begin a health assistance and health care program for the beneficiaries aimed at identifying those who may have been affected by the consequences of the contamination, so as to provide them with appropriate medical attention.”); *Indigenous Communities of the Xingu River Basin v. Paraguay & Brazil*, Inter-Am. C.H.R., 382/10 (Apr. 1, 2011) (The Inter-American Commission issued precautionary measures in a case concerning dam construction, requiring the state to adopt measure to protect the health of communities living close to the construction and communities affected by the project, including the implementation of previously issued health programs.).

⁵⁸ *300 Inhabitants of Puerto Nuevo v. Peru*, Provisional Measure, Inter-Am. C.H.R., 199/09 (Dec. 27, 2010).

⁵⁹ *Id.*

comprehensive treatment and the antiretroviral medications necessary to prevent death, as well as the necessary hospital, pharmacological, and nutritional care needed to strengthen their immunological systems and prevent the development of infections.”⁶⁰ For example, in the case of *Jorge Odir Miranda Cortez y Otros* (El Salvador),⁶¹ the Commission recommended precautionary measures consisting of the provision of triple therapy as well as necessary hospital, pharmaceutical and nutritional care for the petitioner and 26 others suffering from HIV/AIDS.⁶²

Fourth, the Inter-American Commission and Court have also issued precautionary and provisional measures, respectively, against a state refusing to provide abortion services to women whose lives are at risk.⁶³ The IACtHR has held that it has the authority to issue provisional measures to protect human rights even when there is no contentious case filed in the Court and when it *prima facie* will result in irreparable damage to the individual and severe impairment of human rights.⁶⁴ Under Article 63 of the American Convention, the Court must examine whether the three elements are met prior to issuing a precautionary measure. The three elements are: (1) gravity of the case, (2) urgency and (3) irreparable harm to the plaintiff.⁶⁵ In the case of *B v. El Salvador*, the plaintiff, seeking an abortion, suffered from multiple health issues, her fetus was anencephalic, and her pregnancy posed a high risk of death to the mother. The probable death of the

⁶⁰ Melish, *supra* note 52, at 283–84.

⁶¹ *Jorge Odir Miranda Cortez et al. v. El Salvador*, Provisional Measure, Inter-Am. C.H.R., (Feb. 29, 2000).

⁶² *Id.* See also *Juan Pablo Améstica Cáceres et al. v. Chile*, Provisional Measure Inter-Am. Comm’n H.R., (Nov. 20, 2001); *52 Persons, Including Two Minors, Who Are Carriers of the Human Immunodeficiency Virus (HIV/AIDS) v. Bolivia*, Provisional Measure, Inter-Am. Comm’n H.R. (Oct. 3, 2002); *Ten carriers of HIV/AIDS v. Dominican Republic*, Provisional Measure, Inter-Am. Comm’n H.R. (Aug. 14, 2002); *Six Ecuadorian Citizens who Claimed to be HIV/AIDS Carriers v. Ecuador*, Provisional Measure, Inter-Am. Comm’n H.R. (July 9, 2002); *Eight Carriers of the HIV/AIDS Virus v. Nicaragua*, Provisional Measure, Inter-Am. Comm’n H.R. (July 29, 2002); *11 Carriers of HIV/AIDS v. Guatemala*, Provisional Measure, Inter-Am. Comm’n H.R. (Aug. 16, 2002); *Four Carriers of the HIV/AIDS Virus v. Honduras*, Provisional Measure, Inter-Am. Comm’n H.R. (Aug. 16, 2002); *15 Carriers of the HIV/AIDS Virus v. Peru*, Provisional Measure, Inter-Am. Comm’n H.R. (Sept. 23, 2002).

⁶³ *See In re B*, Inter-Am. Comm’n H.R., 114/13 El Sal. (Apr. 29, 2013) (where the Inter-American Commission ordered a precautionary measure of abortion where the risk of death to the mother was high. The Commission then requested provisional measures to the Inter-American Court which were issued in *Matter of B.*, Inter-Amer. Ct. H.R. (ser. E) (May 29, 2013)); *Mainumby*, Paraguay, Inter-Am. Comm’n H.R., 178/15 (2015) (where the Court ordered that the state provide access to adequate medical treatment for a 10 year old girl impregnated by rape).

⁶⁴ *In re B.*, *supra* note 63, at 5 (“this Court has established in previous cases that, ‘owing to the protective nature of provisional measures, exceptionally, these may be ordered, even when there is no contentious case before the inter-American system, in situations that, *prima facie*, may result in a grave and imminent impairment of human rights’”) (quoting prior case law).

⁶⁵ American Convention on Human Rights, *supra* note 30, art. 63.

mother if no action were taken, and the urgency of the mother's medical condition as the pregnancy continued, balanced against the certain death of the fetus, satisfied Article 63, and the Court issued a provisional measure.⁶⁶ Specifically, the IACtHR ordered El Salvador, which has a total ban on abortion, to allow the treating physicians to take any medical measures considered timely and appropriate to ensure the protection of Mrs. B's right to life and personal integrity and health.⁶⁷

Similarly, in 2015, the Inter-American Commission issued precautionary measures in the case of *Asunto Nina Mainumby Respecto de Paraguay*, on behalf of a 10 year-old girl who had been impregnated through rape by her step-father.⁶⁸ Under Paraguayan law, abortion is legal when the life of the mother is at risk, but authorities had claimed that the pregnancy would be medically supervised so that her life would not be in grave risk. The Inter-American Commission analyzed the three elements required to issue a precautionary measure, as well as WHO technical guidelines regarding abortion. It ordered that the girl have access to adequate medical treatment, and to ensure that her best interests as a child were represented in all health decisions affecting her.⁶⁹ Despite the IACHR precautionary measures, requests from the mother, and international pressure, the government refused to administer an abortion.⁷⁰ The 11-year-old girl gave birth by caesarean section in August 2015.⁷¹

We argue these are examples of cases that meet the threshold of "exceptional circumstances." Failure to provide effective access to therapeutic abortion, even when legal, has been repeatedly found to be inconsistent with fundamental

⁶⁶ In re B., *supra* note 63, at 11–12.

⁶⁷ *Id.*

⁶⁸ Mainumby, *supra* note 63, at ¶ 23(a), (b).

⁶⁹ *Id.* (where the Court ordered that the state provide a requested abortion for a 10 year old girl holding that "the State of Paraguay to protect the life and personal integrity of the child, to ensure that she has access to adequate medical treatment for her situation and the treatment recommended by the specialists, in light of the technical guidelines of the World Health Organization and other similar sources applicable to the sexual and reproductive health of girls and adolescents, in which all the options available are assured; to ensure that the rights of the child are duly represented and guaranteed in all health decisions affecting the child, including the right of the child to be informed and participate in decisions affecting her health in accordance with her age and maturity; and take all necessary measures so that the girl has all of the technical and family support necessary to comprehensively protect her rights" [translation]).

⁷⁰ See Irma Oviedo & Jonathan Watts, *Pregnant 10-year-old Rape Victim Denied Abortion by Paraguayan Authorities*, THE GUARDIAN (May 4, 2015), <http://www.theguardian.com/world/2015/may/04/paraguay-pregnant-10-year-old-abortion>.

⁷¹ Laurence Blair, *Paraguayan 11-year-old Gives Birth After Pregnancy Sparked Abortion Debate*, THE GUARDIAN (Aug. 13 2015), http://www.theguardian.com/world/2015/aug/13/paraguay-11-year-old-gives-birth-abortion?CMP=share_btn_link.

obligations under international law.⁷² It also reflects systematic discrimination against women, because it is a denial of a life-saving service that only women and girls require; and also because abortion (including therapeutic abortion) can often be shown to be impervious to democratic “fair-minded” deliberation due to ideological or religious factors capturing the legislative process and impeding the implementation of medical protocols.

Reviewing the definition of the right to health and the use of precautionary measures by other supra-national tribunals, we propose that these examples are illustrative of the sorts of exceptional circumstances that the ESC Rights Committee should consider. That is, in health rights litigation, interim measures should not be granted solely because an individual petitioner may face imminent and irreparable harm. Utilizing precautionary measures for individual petitions may inadvertently distort incentives within systems by allowing the individual to jump queues or to access care or treatment previously denied by the state based upon legitimate, socially-deliberated policies.⁷³ The suffering of identified petitioners must be balanced against the suffering of anonymous patients, and other valid considerations in balancing rights.⁷⁴ Therefore, as we have suggested based on practice of other supra-national tribunals, additional criteria to be considered might include: (1) systemic oversight failures in custodial institutions that will cause imminent and irreparable harm, as in the cases of prisons, hospitals, psychiatric institutions and other custodial settings; (2) prevention of imminent and irreparable harm to a defined population due to discrimination or abuse within the health system, as in discrimination against sexual minorities or people living with HIV; (3) prevention of imminent and irreparable harm due to policies or activities beyond the health system that have an impact on the health of a defined population directly, such as pollution, dams, etc.; or (4) evidence of prima facie failures of democratic deliberation with regard to setting priorities and

⁷² CEDAW, Communication No. 22/2009, Views Adopted by the Committee at its Fiftieth Session, 3 to 21 October 2011, U.N. Doc. CEDAW/C/50/D/22/2009 (Nov. 25, 2011)[hereinafter CEDAW, L.C. v. Peru](known as L.C. v. Peru); HRC, Communication No. 1153/2003, Views Of The Human Rights Committee Under Article 5, Paragraph 4, Of The Optional Protocol To The International Covenant On Civil And Political Rights, U.N. Doc. CCPR/C/85/D/1153/2003 (Nov. 22, 2005) [hereinafter HRC, K.L. v. Peru](known as K.L. v. Peru). *See also* HRC, Communication No. 1608/2007, Views of the Human Rights Committee under Article 5, Paragraph 4, of the Optional Protocol to the International Covenant on Civil and Political Rights, U.N. Doc. CCPR/C/101/D/1608/2007 (Apr. 28, 2011) (known as L.M.R. v. Argentina); Execution of the Judgment of the European Court of Human Rights, A, B and C against Ireland (Dec. 4, 2014)[hereinafter Council of Europe, Execution of the Judgment of the European Court of Human Rights, A, B and C against Ireland].

⁷³ *See IDENTIFIED VERSUS STATISTICAL LIVES: AN INTERDISCIPLINARY PERSPECTIVE* 3 (I. Glenn Cohen, et al. eds., 2015) (stating that, with respect to government actions that privilege one citizen over another, “[a] genuine question exists as to whether we should give some priority to identified persons over statistical ones”).

⁷⁴ *See generally id.*

guaranteeing access to health services on the basis of non-discrimination, such that there is a significant risk of imminent and irreparable harm, as in the cases of abortion mentioned above.

V. SPECIAL CHARACTERISTICS OF HEALTH TO CONSIDER IN APPROACHES TO TREATMENT OF EVIDENCE

As illustrated by Camila's case, health litigation often requires supra-national tribunals to weigh highly technical information. These cases can present unique challenges to evidence production and evidentiary burdens because of the technical nature of the evidence and the systemic nature of health care delivery. For example, data regarding both clinical and cost-effectiveness, epidemiological evidence, and budgetary and resource allocation information is relevant to the consideration of normative issues relating to the state's obligations. The ESC Rights Committee will need to determine what evidence or information it will accept under the Optional Protocol, and from which parties. These decisions will in turn be crucial to the ability of the TMB to effectively adjudicate complex health-rights related litigation. We argue here that the ESC Rights Committee and other supra-national tribunals that hear health rights cases should take full advantage of evidentiary production procedures to include the ability to call for independent experts, as well as to receive amicus briefs that permit the adjudicating body to consider different interpretations of the disputed norms.⁷⁵

A. Third Party Interveners to Address Knowledge Gaps

Litigation on whether the state, as a matter of reasonableness, is obligated to provide access to a certain medicine in its health scheme may require inquiry into the pharmacological composition of the medicine, analysis of studies testing its efficacy, and its utility to treat certain conditions.⁷⁶ Health care treatment procedures and standards of care are based upon extensive studies and testing, requiring knowledge of both epidemiological, clinical, and public health data. This focus on evidence-based medicine requires complex, nuanced knowledge with respect to kinds of information not generally within the purview of adjudicators hearing health rights cases.

⁷⁵ See Bruce Porter, *The Reasonableness of Article 8(4) – Adjudicating Claims from the Margins*, 27 NORDISK TIDSSKRIFT FOR MÆNNESKERETTIGHETER 39, 53 (2009) (arguing that in such cases, the ESC Rights Committee should “hear the evidence of rights claimants, access independent experts, or hear from NGO interveners”).

⁷⁶ See Ole Frithjof Norheim & Bruce M. Wilson, *Health Rights Litigation and Access to Medicines: Priority Classification of Successful Cases from Costa Rica's Constitutional Chamber of the Supreme Court*, 16 HEALTH & HUM. RTS. J. 47 (2014).

Further, the mere presentation of statistical evidence and data may not be sufficient, as the interpretation of data itself is complex. Without some technical assistance adjudicators may misconstrue what statistics indicate, what sorts of confidence intervals they entail, and what sorts of “uncertainty absorption” are involved in their collection.⁷⁷ Similarly, the organization and functioning of health systems may lie beyond the normal expertise of international lawyers, and yet without understanding how health systems function in general and in specific contexts, sentences and recommendations may not be easily translated into regulations and effective enjoyment of rights in practice. For example, skilled birth attendance rates may be close to meaningless, and increases in some forms of mortality may be due to improved surveillance rather than worsening situations.⁷⁸ Thus, expert testimony may be necessary to enable the accurate interpretation of data and to translate what truths the numbers represent. In general, establishing flexible procedures to allow the treaty body to hear expert testimony on technical health issues, or permitting petitioners to produce their own expert witnesses, will be essential to ameliorate the inevitable knowledge gap in highly technical health rights cases.

Regional TMBs have incorporated various rules to give themselves the opportunity to acquire technical knowledge to inform their decisions, which provide valuable models for making the ESC Rights Committee’s examinations of communications under Article 8 of the Optional Protocol effective. For example, the ECtHR is obligated to receive evidence according to the laws of each country. The ECtHR may seek additional evidence at its discretion.⁷⁹ This includes

⁷⁷ See JAMES MARCH & HERBERT SIMON, ORGANIZATIONS 186 (1993) (uncertainty absorption “takes place when inferences are drawn from a body of evidence and the inferences, instead of the evidence itself, are then communicated”).

⁷⁸ Mitike Molla, et al., *Impacts of Maternal Mortality on Living Children and Families: A Qualitative Study from Butajira, Ethiopia*, 12 REPROD. HEALTH S6 (2015); see also Corrina Moucheraud et al., *Consequences of Maternal Mortality on Infant and Child Survival: A 25-Year Longitudinal Analysis in Butajira, Ethiopia (1987–2011)*, 12 REPROD. HEALTH S4 (2015); Lucia Knight & Alicia Yamin, “Without a Mother”: *Caregivers and Community Members’ Views about the Impacts of Maternal Mortality on Families in KwaZulu-Natal, South Africa*, 12 REPROD. HEALTH S5 (2015); Brian Houle et al., *The Impacts of Maternal Mortality and Cause of Death on Children’s Risk of Dying in Rural South Africa: Evidence From a Population-based Surveillance Study (1992–2013)*, 12 REPROD. HEALTH S7 (2015); Junior Bazile et al., *Intergenerational Impacts of Maternal Mortality: Qualitative Findings from Rural Malawi*, 12 REPROD. HEALTH S1 (2015); Alicia Ely Yamin & Vanessa M. Boulanger, *Why Global Goals and Indicators Matter: The Experience of Sexual and Reproductive Health and Rights in the Millennium Development Goals*, 15 J. HUM. DEV. & CAPABILITIES 218 (2014).

⁷⁹ ECHR, Rules of the Court 49 (June 1, 2014) (The annex to the Rules of the Court states in rule A1: “1. The Chamber may, at the request of a party or of its own motion, adopt any investigative measure which it considers capable of clarifying the facts of the case. The Chamber may, inter alia, invite the parties to produce documentary evidence and decide to hear as a witness or expert or in any other capacity any person whose evidence or statements seem likely to assist it in carrying out its tasks. 2. The Chamber may also ask any person or institution of its choice to express an opinion

invitations to any person or institution to provide testimony or written reports, or provides the option for the TMB to appoint an adjudicator, with or without the assistance of an expert, to conduct its own investigation.⁸⁰ Although this function has not been utilized frequently in cases that concern health-related rights, the Court has “frequent recourse to the fact-finding capabilities of other Council of Europe bodies”⁸¹ and also uses reports from third parties or national or international organizations, either in reference to existing reports or requests from the Court to produce expert opinions. For example, the Court has noted that it:

has consistently held that it takes into account relevant international instruments and reports in order to interpret the guarantees of the Convention and to establish whether there is a common standard in the field concerned. It is for the Court to decide which international instruments and reports it considers relevant and how much weight to attribute to them.⁸²

For instance, in the case of *Kiyutin v. Russia*, a third party intervener submitted evidence concerning the consensus among international experts that travel restrictions against persons with HIV were not justified. The Court wrote that:

[i]n the present case, the Court considers undoubtedly relevant the third party’s submission on the existing consensus among experts and international organisations active in the field of public health who agreed that travel restrictions on people living with HIV could not be justified by reference to public-health concerns ... The respondent Government, for their part, did not adduce any expert opinions or scientific analysis that would be capable of gainsaying the unanimous view of the international experts.⁸³

Similarly, the CEDAW Committee permits the submission of amicus briefs through its individual complaint mechanism and has received several submissions for health rights cases.⁸⁴ For example, in the *Alyne da Silva* case, the CEDAW

or make a written report on any matter considered by it to be relevant to the case. 3. After a case has been declared admissible or, exceptionally, before the decision on admissibility, the Chamber may appoint one or more of its members or of the other judges of the Court, as its delegate or delegates, to conduct an inquiry, carry out an on-site investigation or take evidence in some other manner. The Chamber may also appoint any person or institution of its choice to assist the delegation in such manner as it sees fit.”).

⁸⁰ *Id.*

⁸¹ DAVID HARRIS ET AL., LAW OF THE EUROPEAN CONVENTION ON HUMAN RIGHTS 145 (2014).

⁸² *Kiyutin v. Russia*, 2011-II Eur. Ct. H.R. 29, ¶ 67.

⁸³ *Id.*

⁸⁴ See CEDAW, *Alyne da Silva*, *supra* note 10. Amicus received from Latin-American and Caribbean Committee for the Defense of Women’s Rights (CLADEM), the International Commission of Jurists and from Amnesty International); Comm. on the Elimination of Discrimination against Women (CEDAW), Views: Communication No. 4/2004, U.N. Doc. CEDAW/C/36/D/4/2004 (Aug. 29, 2006) (known as *A.S. v. Hungary*) [hereinafter CEDAW, *A.S. v. Hungary*] (Amicus received from the Center for Reproductive Rights, <http://www.reproductiverights.org/document/as-v-hungary-amicus-brief>); CEDAW, *L.C. v. Peru*, *supra* note 72 (Amicus received from the Health Equity and Law Clinic, International Reproductive and Sexual Health Law

Committee received three amicus curiae briefs, which provided the Committee with background information on maternal mortality in Brazil.

Another example from the IACtHR relates to the case of *Artavia Murillo* involving a petition for in vitro fertilization (IVF). There, in addition to receiving amicus briefs, the IACtHR requested the testimony of “two deponents for informative purposes, four presumed victims, and seven expert witnesses to be received by affidavit ... and summoned the parties to a public hearing”⁸⁵ to establish the existence of a scientific consensus that “there is embryonic loss in both a natural pregnancy and in the context of IVF.”⁸⁶

National case law illustrates how TMBs might utilize institutional collaborations and expertise specifically in health rights-related litigation.⁸⁷ In Costa Rica, the Constitutional Chamber of the Supreme Court (also known as Sala IV) has the power to hear health rights claims, which include many claims on access to medicines.⁸⁸ Since 2007, the Court has heard over 500 complaints per year on health of which over 150 complaints per year are on access to medicines.⁸⁹ The Court engages with medical studies and information in making determinations in these cases. In response to criticism about the Court’s ability to interpret medical studies and information, the Court sought the assistance of the Cochrane Collaboration through a technical cooperation plan.⁹⁰ The technical cooperation agreement provides “the Sala IV with access to the Cochrane Collaboration’s extensive medical databases and provide[s] training to relevant court personnel to better understand specialized medical information.”⁹¹

B. Third Party Interveners to Provide Views on Contested Claims

Health is not only a highly—and perhaps uniquely—technical domain among rights, but is also subject to enormous ethical contestation. Take for example, abortion and euthanasia rights. Thomas Keck refers to abortion as one

Programme, Faculty of Law, University of Toronto, <https://opcedaw.files.wordpress.com/2012/01/lc-v-peru-heal-clinic-amicus-brief.pdf>.

⁸⁵ *Artavia Murillo et al. (“In Vitro Fertilization”) v. Costa Rica*, 2012 Inter-Am. Ct. H.R. (ser. C.) No. 257, ¶ 11 (Nov. 28, 2012).

⁸⁶ *Id.* at ¶ 309.

⁸⁷ See Corte Constitucional [C.C.] [Constitutional Court], julio 31, 2008, Sentencia T-760/08, (Colom.); *People’s Union for Civil Liberties v. Union of India*, 2004 (12) SCC 104.

⁸⁸ See Bruce Wilson, *Costa Rica: Health Rights Litigation*, in LITIGATING HEALTH RIGHTS: CAN COURTS BRING MORE JUSTICE TO HEALTH?, *supra* note 9, at 132; Norheim & Wilson, *supra* note 76.

⁸⁹ Norheim & Wilson, *supra* note 76.

⁹⁰ *Id.*

⁹¹ *Id.* at 59.

of the “four key culture wars” in the U.S. involving “both judicial politics and democratic politics on both sides of the aisle.”⁹² The same is increasingly true in supra-national tribunals.⁹³ Thus, in addition to the need for expert testimony, it is critical that the ESC Rights Committee encourage the submission of amicus briefs, as other supra-national tribunals and TMBs have done. Amicus briefs serve the purpose of providing both factual information, but also normative arguments concerning public interest matters, most notably in relation to litigation involving a systemic issue requiring structural reforms to laws, policies or programs in the health care system. Some advocates have argued that TMBs:

have often been unable to adequately address the systemic issues raised by individual communications because of lack of information submitted on the broader issues at stake, and inability of organizations with expertise in the broader policy issues to intervene as amicus in these cases to provide information and analysis.⁹⁴

Some TMBs and other tribunals have taken steps to address these critiques. For example, many regional human rights courts also accept amicus curiae in health rights litigation, including the European Court of Human Rights, the Inter-American Court of Human Rights, and the African Court of Human and Peoples’ Rights. For example, the Inter-American Court accepts amicus briefs and has done so on health rights cases. In *Artavia Murillo*, the Court accepted numerous amicus briefs on a case examining Costa Rica’s ban on in vitro fertilization.⁹⁵ Indeed, the Court received 46 amicus curiae briefs.⁹⁶ Moreover, in addition to accepting amicus briefs, the Inter-American Court also has the option of requesting affidavits from experts. In *Artavia Murillo* it requested affidavits from seven expert witnesses, and invited four of them to speak at a public hearing.⁹⁷ The Court cited heavily to expert witnesses in its decision; when determining what

⁹² THOMAS M. KECK, JUDICIAL POLITICS IN POLARIZED TIMES 8 (2014).

⁹³ See Liiri Oja & Alicia Yamin, “Woman” In the European Human Rights System: How is the Reproductive Rights Jurisprudence of the European Court of Human Rights Constructing Narratives of Women’s Citizenship?, 32 COLUM. J. GENDER & L (forthcoming); Alvaro Paul, *Controversial Conceptions: The Unborn and the American Convention on Human Rights*, 9 LOY. U. CHI. INT’L. L. REV. 209 (2012).

⁹⁴ Langford et al., *supra* note 41.

⁹⁵ See, for example, Brief for The Human Rights Clinic at The University of Texas School of Law and The Equal Rights Trust as Amici Curiae, *Artavia Murillo et al.*, *supra* note 85, http://www.equalrightstrust.org/ertdocumentbank/ERT_Amicus_Brief_Murillo.pdf; Brief of The Program for the Study of Reproductive Justice in the Information Society Project at Yale Law School as Amici Curiae, *Artavia Murillo et al.*, *supra* note 85, http://isp.yale.edu/sites/default/files/BRIEF%20OF%20YALE%20ISP_GRETEL%20ARTAVIA%20MURILLO%20Y.%20OTROS%20v.%20COSTA%20RICA_English.pdf; Brief for Alliance Defense Fund et al. as Amici Curiae, *Artavia Murillo et al.* *supra* note 85, <http://www.adfmedia.org/files/IVF-CostaRicaAmicus-English.pdf>.

⁹⁶ *Artavia Murillo*, *supra* note 85, at ¶ 13.

⁹⁷ *Id.* at ¶¶ 11–12.

constitutes a “person” for purposes of the right to life, the Court took expert opinions into account.⁹⁸

VI. SPECIAL CHARACTERISTICS OF HEALTH TO CONSIDER IN APPROACHES TO REASONABLENESS

Under the Optional Protocol, the ESC Rights Committee decides the reasonableness of state actions to respect, protect, and adopt measures to progressively fulfill the right to health, as opposed to whether an action falls within the state’s “margin of appreciation” as under the European Convention. The Optional Protocol provides:

[w]hen examining communications under the present Protocol, the Committee shall consider the reasonableness of the steps taken by the State Party in accordance with part of the Covenant. In doing so, the Committee shall bear in mind that the State Party may adopt a range of possible policy measures for the implementation of the rights set forth in the Covenant.⁹⁹

Two issues stand out with respect to how the ESC Rights Committee, as well as other TMBs, might approach reasonableness standards in health rights cases. The first relates to how far how rigorous or deferential the scrutiny of government action will be, and applies to all rights. The second, however, relates to the fact that in health specifically, substantive equality requires assessments of other dimensions of human disadvantage than in many rights. Here, we focus on the second issue.

A. Deference to Political Organs in Assessing State Action

First, although “reasonableness” differs from “margin of appreciation” under international law, both recognize that the political organs of government have an array of options to choose from in implementing rights, all of which may be compliant with their obligations. Although some national courts following the reasonableness standard simply examine whether the state has created a law or policy, it is increasingly recognized that such formalism does not produce effective enjoyment of rights in practice; therefore, with greater frequency, domestic courts are turning to examine the reasonableness of state measures to implement policies as well.¹⁰⁰

For example, the South African Constitutional Court has established two principles for assessing reasonableness. First, the court is guided by human rights

⁹⁸ *Id.* at ¶ 178 (stating “in the instant case, the parties also forwarded as evidence a series of scientific articles and expert opinions that will be used in the following paragraphs to determine the scope of the literal interpretation of the terms ‘conception,’ ‘person’ and ‘human being’”).

⁹⁹ Optional Protocol to ESC Rights Committee, *supra* note 40, art. 8(4).

¹⁰⁰ *See* Government of the Republic of South Africa v. Grootboom 2000 (1) SA 46 (CC) (S. Afr.).

law as enumerated in the Constitution to determine whether the policy was reasonable,¹⁰¹ and second, the Court looks at the extent and effects of the implementation of the government measure, not its intent.¹⁰² In assessing the reasonableness of implementation, the Court will examine multiple aspects including, *inter alia*, adequately allocated responsibilities,¹⁰³ appropriate allocation of financial and human resources,¹⁰⁴ possible national level legislation,¹⁰⁵ policies and programs to support implementation of legislation,¹⁰⁶ and consideration of economic, social and historical factors in determining measures.¹⁰⁷ In the *Treatment Action Campaign* case, involving the roll-out of a prevention of Mother-to-Child Transmission Program for HIV/AIDS, the South African Constitutional Court systematically applied the reasonableness standards it had previously established to each rationale put forward by the government, and, echoing its earlier decisions, declined to expand a reasonableness analysis to include minimum core standards or budget allocation.¹⁰⁸

In Colombia, the Constitutional Court has established that “the constitutional obligations of *programmatic* character, derived from a fundamental right, are violated when the entity responsible for guaranteeing the enjoyment of a right does not even provide a program or a public policy that would permit the progressive advancement in the fulfillment of its corresponding obligations[. . .]”¹⁰⁹ In the *T-760/08* case, which called for restructuring aspects of the health system in keeping with the right to health, the Constitutional Court further noted that if a

judge finds a violation of the *programmatic* facet of a fundamental right, he must protect that fundamental right by adopting orders to ensure its effective enjoyment. [But such orders should be] respectful of the process of public debate, decision and policy implementation, characteristic of a democracy. Therefore, it is not his duty to tell the responsible authority, specifically, what should be appropriate and necessary to ensure the effective enjoyment of the right, but rather he must adopt the decisions and orders to ensure that such measures are taken, promoting at the same time citizen participation.¹¹⁰

¹⁰¹ See *id.* at ¶ 44.

¹⁰² See Porter, *supra* note 75; Grootboom, *supra* note 100, at ¶ 42.

¹⁰³ Grootboom, *supra* note 100, at ¶ 39.

¹⁰⁴ *Id.*

¹⁰⁵ *Id.* at ¶ 40.

¹⁰⁶ *Id.* at ¶ 42.

¹⁰⁷ *Id.* at ¶ 43.

¹⁰⁸ Minister of Health v. Treatment Action Campaign 2002 (5) SA 721 ¶ 37 (S. Afr.).

¹⁰⁹ Sentencia T-760/08, *supra* note 87, at ¶ 3.3.9.

¹¹⁰ *Id.* at ¶ 3.3.14.

In a 2014 decision relating to the Statutory Law on Health that was adopted in light of *T-760/08*, the Constitutional Court held the State's obligation to regulate pharmaceuticals and ensure affordable access includes all policies from manufacture through distribution to ultimate access to, and consumption of, the medications.¹¹¹

B. Assessing State Actions for Substantive Equality

Although there are varying levels of inquiry into the implementation of laws and policies, determinations of the reasonableness of state actions often turn on whether there are discriminatory intent or impacts, as well as whether a given policy adequately considers the most disadvantaged in society.¹¹² This is where health rights litigation becomes uniquely complex in terms of the demands of distributive justice. In addition to an assessment of the compliance of government actions with the right to health, TMBs must also assess other dimensions of human disadvantage in order to ensure substantive equality of health rights.¹¹³

Evaluating formal equality requires the TMB to evaluate whether the petitioner is treated in the same manner as similarly situated people, and that there be no arbitrary differentiation based upon race, religion, gender and the like. This evaluation is quite straightforward and one of these authors has argued elsewhere that formal equality should call for judicial inquiry into the universalizability of services.¹¹⁴ Thus, for example, ordering certain forms of care, including the treatment of cancer abroad in the case of Camila Abuabara, could be construed as granting a privilege rather than enforcing a right. Indeed, the ESC Rights Committee has noted in its General Comment 14 that inappropriate health resource allocation can lead to discrimination that may not be overt. For example, investments “should not disproportionately favour expensive curative health services which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population.”¹¹⁵

Substantive equality, however, requires the TMB to evaluate whether differently situated people are treated in such a way that they can equally enjoy the right to health.¹¹⁶ The ESC Rights Committee has stated that “[b]y virtue of

¹¹¹ Corte Constitucional [C.C.] [Constitutional Court], marzo 11, 2014, Sentencia C-131/14, (Colom).

¹¹² See Grootboom, *supra* note 100.

¹¹³ CESCR General Comment No. 14, *supra* note 17.

¹¹⁴ See Yamin & Lander, *supra* note 37; YAMIN, *supra* note 37.

¹¹⁵ CESCR, General Comment No. 14, *supra* note 17 at ¶ 18–19.

¹¹⁶ CESCR, General Comment No. 20: Non-Discrimination in Economic, Social and Cultural Rights, ¶ 8(b), 42nd Sess., U.N. Doc. E/C.12/GC/20 (July 2, 2009) (explaining that for substantive discrimination, “[t]he effective enjoyment of Covenant rights is often influenced by whether a

paragraph 2 of its article 2 and of its article 3, the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement.”¹¹⁷ However, health equality is a more multi-dimensional concept than equality with respect to many other rights. “An analysis of equality in health must consider social inequalities, but also other factors such as severity of illness.”¹¹⁸ Indeed, John Rawls was famously criticized in his *Theory of Justice* for not determining who is worse off—a very ill person or a healthy person who has fewer resources.¹¹⁹ Norman Daniels et al. explain that

[a] right to health or health care is a special case of [Rawls’s] right to fair equality of opportunity. . . . This conception of a right to health or health care starts with the assumption that we have a right to fair equality of opportunity and that the protection of our health makes a significant if limited contribution to preserving those opportunities.¹²⁰

In a similar vein, Amartya Sen has pointed out that it is important to consider the “conversion gap” that exists for certain people to enjoy health as well as other “capabilities”.¹²¹ For example, a person with a disability may require additional resources to enjoy the same level of meaningful access to care, as well as equal enjoyment of the right. Think, for instance, of the need for sign language interpretation, a ramp for access to a facility, or for prosthetics or wheelchairs so that a person with a disability can enjoy the same range of opportunities that a person of equal financial means without a disability would have. The CRPD itself states that

[i]n order to promote equality and eliminate discrimination, States Parties shall take all appropriate steps to ensure that reasonable accommodation is provided [where reasonable accommodations are] necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.¹²²

person is a member of a group characterized by the prohibited grounds of discrimination. Eliminating discrimination in practice requires paying sufficient attention to groups of individuals which suffer historical or persistent prejudice instead of merely comparing the formal treatment of individuals in similar situations.”).

¹¹⁷ CESCR General Comment No. 14, *supra* note 17, at ¶ 18.

¹¹⁸ Yamin & Norheim, *supra* note 13, at 312.

¹¹⁹ *Id.*; Kenneth Arrow, *Rawls’s Principle of Just Saving*, 75.4 SWEDISH J. ECON. 323 (1973).

¹²⁰ Norman Daniels et al., *Role of the Courts in the Progressive Realization of the Right to Health: Between the Threat and the Promise of Judicialization in Mexico*, 1 HEALTH SYSTEMS & REFORM 229, 230 (2015).

¹²¹ *See generally* AMARTYA SEN, DEVELOPMENT AS FREEDOM (1999).

¹²² Convention on the Rights of Persons with Disabilities, *opened for signature* Dec. 18, 1990, art. 5(3) 2515 U.N.T.S. 3.

The case of Camila Abuabara shows how difficult such balances can be, and how contested. Many theories of prioritarianism in relation to distributive justice require that some weight be placed upon providing for those who are worst off in the conditions from which they are suffering. As a legal matter, ethical criteria must be balanced in a manner that takes into account certain constitutional guarantees. These include those that on their face appear to give rights to children under 18 years of age that are not subject to resource constraints or progressive realization. Camila was a young adult, but she easily could have been diagnosed with acute lymphoblastic leukemia as a child. Indeed, the great majority of cases occur in children under 15.¹²³ As children are granted special consideration under both international and some domestic law, cost-effectiveness criteria and burden of disease calculations need also be balanced with legal provisions in place.¹²⁴

In short, the weighing of different criteria—including cost-effectiveness and priority to the worst off, as well as how many resources will be assigned to marginalized populations as opposed to simply trying to improve aggregate population health—are not merely technical questions. They are inherently normative—and deeply ethically contested.¹²⁵ As such, courts, and in turn supra-national tribunals, have a special role in ensuring the measures adopted by a state are consistent with fundamental normative commitments, including respect for the equal dignity of all human beings.¹²⁶ Additionally, they have a role to play in ensuring that the process whereby the priorities have been set is transparent and legitimate, and includes participation of affected communities as well as opportunities for appeal in light of new information.¹²⁷ However, we are not arguing for supra-national tribunals to define health policy priorities or implementation. As suggested by the Colombian Constitutional Court in *T-*

¹²³ NATIONAL INSTITUTE OF HEALTH: NATIONAL CANCER INSTITUTE, SURVEILLANCE, EPIDEMIOLOGY, AND END RESULTS PROGRAM (SEER), *SEER Cancer Statistics Review, 1975–2012: Percent of New Cases by Age Group: Acute Lymphocytic Leukemia*, <http://seer.cancer.gov/statfacts/html/aly1.html> (57.6% of new cases occur under the age of 20). See also NATIONAL CANCER INSTITUTE, *Childhood Acute Lymphoblastic Leukemia Treatment – for Health Professionals (PDQ)*, http://www.cancer.gov/types/leukemia/hp/child-all-treatment-pdq#link/_7_toc (“A sharp peak in ALL incidence is observed among children aged 2 to 3 years (>90 cases per 1 million per year), with rates decreasing to fewer than 30 cases per 1 million by age 8 years.”).

¹²⁴ See generally Convention on the Rights of the Child, Sept. 2, 1990, 1577 U.N.T.S. 3 (granting children numerous special protections in state action).

¹²⁵ See NORMAN DANIELS, *JUST HEALTH: MEETING HEALTH NEEDS FAIRLY* 11 (2007) (seeking to answer “how can we meet health needs fairly under resource constraints”).

¹²⁶ See Universal Declaration of Human Rights, art. 1, G.A. Res. 217A, U.N. GAOR, 3d Sess., 1st plen. Mtg., U.N. Doc. A/810 (1948) (stating that “[a]ll human beings are born free and equal in dignity and rights”).

¹²⁷ See CESCR General Comment No. 14, *supra* note 17, at ¶ 54 (upholding “the right of individuals and groups to participate in decision-making processes [regarding national health strategies]”).

760/08, in our view, judicial decisions at both national and international levels should be “respectful of the process of public debate, decision and policy implementation, characteristic of a democracy” recognizing not only the reality of resource constraints, but also that an array of different rankings of ethical criteria can be deemed “reasonable” under international law.¹²⁸

VII. SPECIAL CHARACTERISTICS OF HEALTH TO CONSIDER IN APPROACHES TO REMEDIES AND FOLLOW-UP

Remedies may take multiple forms and the ESC Rights Committee will likely consider using more than one form of remedy. Generally, TMBs and international courts consider three types of remedies: restitution; accountability mechanisms to ensure non-repetition of violations; and structural remedies, sometimes with additional provisions to assist or monitor implementation.¹²⁹ In evaluating the menu of remedies available to the ESC Rights Committee in relation to health-related rights, it is especially important that both the direct and indirect effects be considered carefully. Remedies will almost invariably affect not just the individual or group of litigants but will also have far-reaching normative and indirect impacts. Moreover, not only the framing of the recourse, but the degree of implementation on the ground, will have a bearing on the legitimacy and authority of the ESC Rights Committee, or another supra-national tribunal.

A. Restitutive Remedies

Restitutive remedies, generally in the form of reparations, are routinely provided by supra-national tribunals to complainants suffering harm from violations of their civil and political rights. Increasingly there is precedent for such

¹²⁸ Sentencia T-760, *supra* note 87. *See also* KEITH SYRETT, LAW, LEGITIMACY AND THE RATIONING OF HEALTH CARE: A CONTEXTUAL AND COMPARATIVE PERSPECTIVE 108 (2007) (“The role of the four conditions of ‘accountability for reasonableness’ as ‘connective tissue to . . . a broader democratic process’ comes about by way of the contribution which they can make to enhancing understanding . . . of the need to set limits on access to medical services and treatments, and of the types of evidence, grounds and conditions which may appropriately play a part in rationing decisions. Compliance with the model consequently serves an ‘educative function’: that is, it facilitates ‘social learning about limits.’”). *See generally* SYRETT, at 108–119.

¹²⁹ *See* CESC, An Evaluation of the Obligation to Take Steps to the “Maximum of Available Resources” Under an Optional Protocol to the Covenant, ¶ 54, 38th Sess., U.N. Doc. E/C.12/2007/1 (May 10, 2007) (recommending “restitution . . . [c]alling upon the State party to remedy the circumstances leading to a violation . . . [or] mechanism[s] to ensure the ongoing accountability of the State party) in response to violations). *See also* ESCR-NET, CLAIMING WOMEN’S ECONOMIC, SOCIAL AND CULTURAL RIGHTS: PART FOUR: OPTIONAL PROTOCOL TO THE CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN at 46–47, <http://www.escr-net.org/sites/default/files/ESCR-NET-Manual-Booklet-3.pdf> (providing a menu of options that the CEDAW Committee utilizes under its Optional Protocol).

restitution in health-related cases. In the *Alyne da Silva v. Brazil* case, the CEDAW Committee requested that Brazil “provide appropriate reparation, including adequate financial compensation” to the complainant’s family.¹³⁰ The case was filed in November 2007 and the parties to the case did not finalize an agreement outlining financial reparations until 2014, when the CEDAW Committee approved the agreement.¹³¹ On March 25, 2014, the Brazilian government held a public ceremony where it provided monetary reparations to the mother of the complainant.¹³² Monetary compensation to Alyne’s daughter, Alice, is still pending. Restitution and reparations can also take the form of services, such as special rehabilitative or other health services.¹³³

B. Structural Remedies

Structural remedies are appropriate for systematic violations, where complex orders relating to institutions and processes are involved, rather than dictating specific outcomes. Such remedies can be called for at the same time as restitution is ordered.¹³⁴ For example, in the *Alyne da Silva v. Brazil* case, the CEDAW Committee ordered seven general remedies including, *inter alia*, “reduc[ing] maternal deaths through the implementation of the National Pact for the Reduction of Maternal Mortality.”¹³⁵

When issuing general and structural recommendations, the ESC Rights Committee will be straddling concerns about meaningful engagement with the

¹³⁰ CEDAW, *Alyne da Silva*, *supra* note 10, at 21. *See also* SYRETT, *supra* note 128.

¹³¹ Press Release, Center for Reproductive Rights, Brazil Takes Step to Implement Historic United Nations Ruling in Maternal Death Case: United Nations Committee on the Elimination of Discrimination against Women (CEDAW) Approves Monetary Reparations Agreement with Brazilian Government for the Mother of Alyne da Silva Pimentel (Mar. 11, 2014), <http://reproductiverights.org/en/press-room/Brazil-Takes-Step-to-Implement-Historic-United-Nations-Ruling-in-Maternal-Death-Case%20>.

¹³² Press Release, Center for Reproductive Rights, Brazilian Government Gives Monetary Reparations As Part of Historical United Nations Maternal Death Case (Mar. 25, 2014), *available at* <http://www.reproductiverights.org/press-room/brazilian-government-gives-monetary-reparations-as-part-of-historic-united-nations-matern>.

¹³³ *See* Pueblo Bello Massacre v. Colombia, 2006 Inter-Am. Ct. H.R. (ser. C.) No. 140, at 144 (Jan. 31, 2006); M.M. v. Peru, Inter-Am. Ct. H.R., Report No. 69/14, OEA/Ser.L/V/II.151, doc. 34 (July 25, 2014) (friendly settlement); CEDAW, L.C. v. Peru, *supra* note 72; HRC, K.L. v. Peru, *supra* note 72.

¹³⁴ *See, for example*, Sentencia T-760/08, *supra* note 87; Corte Suprema de Justicia de la Nación [CSJN], 8/7/2008, «Mendoza, Beatriz Silvia c. Estado Nacional /Daños y Perjuicios» M. 1569 XL (Arg.) (*English translation available at* https://www.escr-net.org/sites/default/files/Sentencia_CSJN_2008_english.pdf); CEDAW; *Alyne da Silva*, *supra* note 10; People’s Union for Civil Liberties v. Union of India, *supra* note 87; Laxmi Mandal v. Deen Dayal Harinagar Hospital (2010) W.P.(C) Nos. 8853/2008 and 10700/2009 (India).

¹³⁵ CEDAW, *Alyne da Silva*, *supra* note 10, at 22.

state and encroaching upon the state's right to discern legislative and administrative means through which to implement rights, similar to the balanced deference required under the reasonableness standard. As Bruce Porter notes, “[r]emedies will often need to recommend a process through which compliance can be achieved, rather than recommending the precise details of the solution.”¹³⁶

However, this issue is not unique to ESC rights. Although the Optional Protocol states that the ESC Rights Committee may “decline to consider a communication where it does not reveal that the author has suffered a clear disadvantage, unless the Committee considers that the communication raises a serious issue of general importance,”¹³⁷ remedying individual violations will often require identifying underlying structural factors and such broad remedies have been effectively used by other TMBs. Under the Optional Protocol to the ICCPR, the Human Rights Committee is permitted to provide a general recommendation or remedy, “allowing the State party a certain discretion in implementation subject to its own legal or administrative system but may include, inter alia, an amendment to legislation, the provision of compensation, retrial, or release or early release of the [petitioner].”¹³⁸ Similarly, the Inter-American system uses structural remedies including “changes to policies, or implementation of measures for the protection of groups, organization of social services, public services, or the supply of goods to groups or communities, including the recognition of titles or collective rights.”¹³⁹ Even in individual cases, such as that of Camila, presumably general recommendations would address the systemic failures in oversight of the health system.

C. Monitoring Implementation of Structural Remedies

However, in the context of adjudicating cases under the Optional Protocol, the ESC Rights Committee will have to be strategic in selecting remedies that are realistic and can be monitored effectively. Low levels of implementation or efficacy of remedies may potentially undermine the credibility of the ESC Rights Committee. This is further compounded because ESC rights are subjected to the standard of progressive realization, which may be used as an explanation for slow compliance with a structural recommendation. The highly technical nature of health, as well as the powerful interests involved in the health sector, where there

¹³⁶ See Porter, *supra* note 75, at 50.

¹³⁷ Optional Protocol to ESC Rights Committee, *supra* note 40, art. 4.

¹³⁸ United Nations Inter-Committee Meeting of Human Rights Treaty Bodies, Follow-up to Decisions, 10th Inter-Committee Meeting, U.N. Doc. HRI/ICM/2009/7 (Nov. 11, 2009).

¹³⁹ Victor Abramovich, *Remedies Under the Inter-American System* 1 (unpublished manuscript) (on file with ESCR-Net), http://www.escri-net.org/sites/default/files/Abramovich_-_Remedies_Under_the_Inter-American_System_0.pdf.

are enormous asymmetries of information and power, heighten the need to carefully devise forms of effectively monitoring structural recommendations.

A review of supra-national litigation demonstrates that obstacles relating to the effective use of structural recommendations or remedies include the capacity of the TMB or supra-national tribunal to follow-up on and monitor implementation,¹⁴⁰ the lack of a role for civil society in the follow-up, and the point at which the TMB determines that a state has complied with the decision. Traditionally, TMBs have taken a formalistic approach to oversight of implementation of cases, for example through the establishment of a government committee.¹⁴¹ The rationale for this approach may have been partially attributable to a conceptual approach to the law, and partially dictated by the capacity of the TMB or supra-national tribunal.

However, differing experiences and approaches of supra-national tribunals to date provide valuable lessons for the use of innovative oversight mechanisms and more meaningful follow-up regarding substantive compliance with recommendations and decisions. For example, implementation of decisions from the European Court of Human Rights are monitored by a political body, the Committee of Ministers, whereas the Inter-American Court of Human Rights itself monitors compliance with its judgments.¹⁴² The IACtHR has increasingly utilized structural remedies in decisions but has had persistent “low levels of effectiveness” which “may lead to rethinking the entire Inter-American Human Rights System and may entail costs in terms of the Court’s legitimacy.”¹⁴³ Former member of the Inter-American Commission Victor Abramovich argued in 2007 that “[t]he truth is that the Inter-American Human Rights System has embarked on the development of a structural litigation model for the protection of groups without having first honed and discussed in depth the limits or potential of its procedural rules, its system of remedies and its mechanisms to follow up and monitor decisions.”¹⁴⁴ However, in no small measure as a response to critiques by leading scholars and practitioners such as Abramovich, the IACtHR established follow-up procedures in 2009¹⁴⁵ and it is now common practice for the Inter-American Court of Human Rights to issue reports where it outlines a state’s

¹⁴⁰ See Victor Abramovich, *From Massive Violations to Structural Patterns: New Approaches and Classic Tensions in the Inter-American Human Rights System*, 6 SUR. INT’L J. H. RTS. 7 (2009).

¹⁴¹ *Id.*

¹⁴² Alexandra Huneeus, *Courts Resisting Courts: Lessons from the Inter-American Court’s Struggle to Enforce Human Rights*, 44 CORNELL INT’L L. J. 493, 501 (2011).

¹⁴³ Abramovich, *Remedies Under the Inter-American System*, *supra* note 139, at 2.

¹⁴⁴ *Id.*

¹⁴⁵ Rules of Procedure of the Inter-American Court, art. 63 (2009).

compliance with judgments issued by the court.¹⁴⁶ The follow-up procedures authorize the Court to require state reports on implementation and to respond with observations, to seek additional information on implementation through alternate sources, to convene hearings with the State and victims, and to issue orders based upon its determination of compliance.¹⁴⁷ For example, in *Panchito Lopez*, a case brought on behalf of 4,000 children kept in inhuman conditions at a juvenile detention center, the Court inter alia ordered the State to draft a comprehensive policy on children in conflict of the law and has issued four orders since its original decision in 2004.¹⁴⁸

The IACHR has the possibility of holding informal follow-up meetings in the countries, with the presence of the countries' rapporteurs. We agree with Abramovich and other commentators that "[h]olding such working meetings in the countries facilitates the participation of victims and organizations, as well as of the relevant State agencies responsible for implementing orders, all of which expedites implementation of decisions."¹⁴⁹ Further, we believe that translating international judgments into political policies that are institutionalized and implemented in practice calls for catalyzing the active engagement of public agencies, civil society, and sometimes national courts or human rights institutions, which are in the position to monitor the situation in practice.¹⁵⁰

For example, the success of the ECtHR in utilizing what Cali and Koch term as a "deliberative compliance model" is worthy of note.¹⁵¹ The ECtHR does not provide specific details about what actions a state should take to comply with decisions requesting structural remedies. Under Article 46 of the Convention for the Protection of Human Rights and Fundamental Freedoms, states are obligated to "abide by the final judgment of the Court."¹⁵²

[T]his obligation entails, over and above the payment of any sums awarded by the Court, the adoption by the authorities of the respondent State, where required: of individual measures to put an end to violations established and erase their consequences so as to achieve as far as

¹⁴⁶ See INTER-AMERICAN COURT OF HUMAN RIGHTS, *Monitoring Compliance with Judgment*, http://www.corteidh.or.cr/cf/Jurisprudencia2/busqueda_supervision_cumplimiento.cfm?lang=en (providing a collection of reports monitoring compliance with an IACtHR judgment).

¹⁴⁷ Rules of Procedure of the Inter-American Court, art. 63 (2009).

¹⁴⁸ *Juvenile Reeduction Institute v. Paraguay*, *supra* note 11.

¹⁴⁹ Abramovich, *Remedies Under the Inter-American System*, *supra* note 139, at 5.

¹⁵⁰ *Id.*

¹⁵¹ Basak Cali & Anne Koch, Presentation at the Enforcement of ESC Rights Judgments—International Symposium: *Enforcing Civil and Political Rights: Lessons from European Court of Human Rights* (May 7, 2010).

¹⁵² Convention for the Protection of Human Rights and Fundamental Freedoms, *supra* note 32.

possible restitutio in integrum; and of general measures preventing similar violations.¹⁵³

As in the European system, states have a “margin of appreciation” as to what means they should use to ensure compliance with the judgment.¹⁵⁴ In *A, B, and C*, an Irish case before the ECHR adjudicating access to abortion, the Court simply ruled that Ireland’s criteria for legal access to abortion when the life of the mother is at risk was violated with regard to applicant 3 because there “was no accessible and effective procedure to enable her to establish whether she qualified for a lawful termination of pregnancy in accordance with Irish law.”¹⁵⁵ The state must decide how best to ensure that general measures are taken to prevent similar violations in the future. In this case, Ireland commissioned an expert group with “appropriate medical, legal, regulatory and administrative expertise” to provide recommendations on options to implement the judgment.¹⁵⁶

Second, the Convention for the Protection of Human Rights and Fundamental Freedoms provides that the Committee of Ministers shall supervise the execution of the final judgment of the Court.¹⁵⁷ The Committee of Ministers of the Council of Europe¹⁵⁸ works with states in determining what means they should pursue in ensuring compliance with individual and general measures, which constitutes a “deliberative” process¹⁵⁹ between a political body, the State and possibly the Court (if requested by Committee of Ministers¹⁶⁰). In the case of *A, B, and C*, Ireland submitted the expert report to the Committee of Ministers and then proceeded to update the Committee of Ministers of its action plan including specific timetables.¹⁶¹ After Ireland selected legislation as the method of

¹⁵³ Council of Europe, Execution of the Judgment of the European Court of Human Rights, *A, B and C* against Ireland, *supra* note 72.

¹⁵⁴ See *Greece v. United Kingdom*, 1958–59 Y.B. Eur. Conv. On H.R. 174 (featuring the first mention of the margin of appreciation doctrine in European Court of Human Rights jurisprudence). See also STEVEN GREER, *THE MARGIN OF APPRECIATION: INTERPRETATION AND DISCRETION UNDER THE EUROPEAN CONVENTION ON HUMAN RIGHTS* (2000).

¹⁵⁵ Expert Group on the Judgment in *A, B and C v Ireland*, Report of the Expert Group on the Judgment in *A, B and C v Ireland* 5 (2012), http://health.gov.ie/wp-content/uploads/2014/03/Judgment_ABC.pdf.

¹⁵⁶ *Id.*

¹⁵⁷ European Convention on Human Rights, *supra* note 32, art. 46(2).

¹⁵⁸ See generally Council of Europe, Department for the Execution of Judgments of the European Court of Human Rights, http://www.coe.int/t/dghl/monitoring/execution/Presentation/Pres_Exec_en.asp.

¹⁵⁹ Cali & Koch, *supra* note 151.

¹⁶⁰ This applies to both regular cases as well as pilot judgment cases. See European Convention on Human Rights, *supra* note 32, art. 46(3).

¹⁶¹ Secretariat of the Committee of Ministers, Communication from Ireland Concerning the Case of *A, B and C* against Ireland, DH-DD (2012)1124 (Mar. 12, 2012).

implementation, the Committee “noted with satisfaction that the authorities [had] decided to implement the judgment by way of legislation and regulations” and invited the authorities to keep it informed of developments, including on the content of the legislation and on the timetable for its adoption.¹⁶² The Committee of Ministers also permits NGOs and National Institutions for the Promotion and Protection of Human Rights (NHRIs) to submit communications concerning the action plan.¹⁶³

Lastly, the European Court of Human Rights recently introduced pilot judgments as a method to address systemic issues. The court explains that

[t]he pilot judgment procedure was developed as a technique of identifying the structural problems underlying repetitive cases against many countries and imposing an obligation on States to address those problems. Where the Court receives several applications that share a root cause, it can select one or more for priority treatment under the pilot procedure.¹⁶⁴

In these cases, the Committee of Ministers may also confer with the Department for the Execution of Judgments to work with states to identify how to implement the Court’s decisions. However, in these cases the Court may not completely defer to the State in how to implement; “[t]he Court may consider it necessary, however, under Article 46 § 1, to give Governments guidance with a view to solving a systemic or structural problem.”¹⁶⁵ During the period of implementation, the court may adjourn all related cases while the State works to implement the judgment.¹⁶⁶ “The Court can, however, resume examining adjourned cases whenever the interests of justice so require.”¹⁶⁷

The UN human rights TMBs have also established committees to monitor compliance with their decisions, including the Human Rights Committee in 1990,¹⁶⁸ the Committee on the Elimination of Racial Discrimination in 2008,¹⁶⁹

¹⁶² Council of Europe, Committee of Ministers, 1164DH Meeting of Ministers’ Deputies, CM/Del/Dec(2013)1164/13, Case No. 13 (Mar. 7, 2013).

¹⁶³ See Council of Europe, Department for the Execution of Judgments of the European Court of Human Rights, The Supervision Process, <http://www.coe.int/en/web/execution/the-supervision-process>.

¹⁶⁴ Press Release, European Court of Human Rights, Fact Sheet – Pilot Judgments 1 (Oct. 2013) [hereinafter ECHR, Fact Sheet- Pilot Judgments].

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

¹⁶⁷ *Id.*

¹⁶⁸ Human Rights Committee [HRC], Report of the Human Rights Committee: Volume 1, ¶¶ 225–226, U.N. Doc. A/67/40 (2012).

¹⁶⁹ See, for example, CERD, Report of the Committee on the Elimination of Racial Discrimination, 133–41, U.N. Doc. A/61/18 (2006) (assessing Denmark’s compliance with CERD’s recommendation that it take measures to counteract racial discrimination in the loan market).

the Committee against Torture in 2002,¹⁷⁰ and the Committee on the Elimination of Discrimination against Women through its Optional Protocol.¹⁷¹ In 1990, the UN Human Rights Committee established an entity, entitled a Special Rapporteur, with the mandate to monitor state party compliance with its views under the Optional Protocol to the International Covenant on Civil and Political Rights.¹⁷² As the recommendations and views of the ESC Rights Committee, as with other TMBs, will not be legally binding upon the States but rather are recommendations that provide an “authoritative interpretation of the treaty concerned,”¹⁷³ other TMBs have devised mechanisms to encourage compliance. In the case of the HRC, “failure by a State party to implement the Views of the Committee in a given case becomes a matter of public record through the publication of the Committee’s decisions in, inter alia, its annual reports to the General Assembly.”¹⁷⁴ Moreover, the Special Rapporteur engages with the states through written representations, personal meetings with diplomatic representatives of the State party concerned including Permanent Missions to the UN, and even follow-up missions to the State parties.¹⁷⁵ The Human Rights Committee itself may also follow-up with the State party through its periodic report.¹⁷⁶ However, these procedures have proven weak in relation to implementation of some health-related decisions. For example, the plaintiffs took the abortion case of *L.C. v. Peru* to the CEDAW Committee as opposed to the HRC, largely because of lack of implementation of the Human Rights Committee’s decision in another abortion case, *K.L. v. Peru*.¹⁷⁷

The Rules of Procedure of the CEDAW Committee permit the designation of a Special Rapporteur or working group to follow-up on its views and authorizes them to “make such contacts and take such action as may be appropriate for the

¹⁷⁰ CERD, Follow-up Procedure of the Human Rights Committee and the Committee against Torture, U.N. Doc. CERD/C/67/FU/1 (2005).

¹⁷¹ See CEDAW, Report of the Committee on the Elimination of Discrimination against Women, Annex 1: Rules of the Committee on the Elimination of Discrimination against Women, Rules 73(4), 73(6), U.N. Doc. A/56/38 (2001).

¹⁷² HRC, Report of the Human Rights Committee, *supra* note 168, at ¶¶ 225–226.

¹⁷³ Office of the High Commissioner for Human Rights, Human Rights Treaty Bodies – Individual Communications, <http://www.ohchr.org/EN/HRBodies/TBPetitions/Pages/IndividualCommunications.aspx#whathappens>.

¹⁷⁴ HRC, Report of the Human Rights Committee, *supra* note 168, at ¶ 227.

¹⁷⁵ *Id.*

¹⁷⁶ CERD, Follow-up Procedure of the Human Rights Committee and the Committee against Torture, *supra* note 170 (“Recent examples include the Russian Federation, Suriname, Colombia, the Dominican Republic and the Czech Republic”).

¹⁷⁷ See CEDAW, *L.C. v. Peru*, *supra* note 72; HRC, *K.L. v. Peru*, *supra* note 72.

due performance of their assigned functions.”¹⁷⁸ For example, the CEDAW Committee has issued views that recommend structural remedies for health rights violations. In *A.S. v. Hungary*, a case before the CEDAW Committee alleging forced sterilization of a minority Roma woman,¹⁷⁹ the CEDAW Committee recommended remedies that included legislative and policy reviews and changes concerning informed consent for sterilizations. Recommendations included reviewing domestic legislation and monitoring of health centers to ensure proper administration of informed consent and sanctions should there be violations.¹⁸⁰ While the state did take some measures, it argued that “there was no need to amend its legislation arguing, *inter alia*, that the general provisions on information were also applicable for sterilizations performed for health reasons and that, therefore, special information was not necessary.”¹⁸¹ In order to encourage compliance, the CEDAW Committee utilized Special Rapporteurs to urge compliance with the recommendations despite the state’s objections.¹⁸² However, the number and length of communications between the Special Rapporteurs, the State, the Committee, the State representative at the UN, and the Permanent Representative of Hungary to the UN, demonstrate the challenges that these follow-up procedures face. While the state notified the CEDAW Committee on April 12, 2007 of its views, the Special Rapporteurs had 6 separate formal communications with officials over 16 months.¹⁸³ The CEDAW Committee considered the communications ongoing until 2009 when the government agreed

¹⁷⁸ Report of the CEDAW, *supra* note 171, at 73(4)–(5) (“4. The Committee shall designate for follow-up on views adopted under article 7 of the Optional Protocol a rapporteur or working group to ascertain the measures taken by States parties to give effect to the Committee’s views and recommendations. 5. The rapporteur or working group may make such contacts and take such action as may be appropriate for the due performance of their assigned functions and shall make such recommendations for further action by the Committee as may be necessary.”).

¹⁷⁹ CEDAW, *A.S. v. Hungary*, *supra* note 84.

¹⁸⁰ CEDAW, Report of the Committee on the Elimination of Discrimination Against Women, Annex XII: Report of the Committee under the Optional Protocol on Follow-up to Views of the Committee on Individual Communications 110–116, U.N. Doc. A/64/38 (2009).

¹⁸¹ *Id.* at 120.

¹⁸² *Id.* at 121.

¹⁸³ *Id.* A timeline of the communications between the state and the treaty body is as follows: Views adopted Aug 14, 2006; State submitted communication to CEDAW on April 12, 2007; on June 5 2007, Special Rapporteurs met with State representative at UN; Special Rapporteurs communicated to the State a note verbal on June 6, 2007; State submitted communications to CEDAW on July 17, 2007; The petitioner submitted communications to CEDAW on July 31, 2007; The Special Rapporteurs met with State representatives at the UN on January 25, 2008; the Special Rapporteurs communicated to the State a note verbal on January 31, 2008; on 16 June 2008, the Secretariat contacted the Permanent Representative of Hungary to the United Nations (Geneva) with a view to following up on the note verbale, but there was no outcome; the Special Rapporteurs met with State representatives at the UN on October 15, 2008.

to compensate A.S., in accordance with the CEDAW Committee's recommendations.¹⁸⁴

The CEDAW Committee faced similar constraints in pursuing implementation of its views in *Alyne da Silva v. Brazil*.¹⁸⁵ In this case, in addition to reparations, the CEDAW Committee issued recommendations with respect to structural reforms to ensure equitable access to maternal healthcare and to prevent discrimination leading to maternal mortality.¹⁸⁶ The state took multiple steps to implement the CEDAW Committee decision, including the creation of an Inter-Ministerial Working Group in May 2013 and the adoption of an array of initiatives and policies.¹⁸⁷ Nevertheless, the petitioner, Center for Reproductive Rights, remained concerned with respect to the lack of effective implementation. In a ground-breaking initiative, a Technical Follow-Up Mission relating to this case, which included one of these authors (AEY), went to Brazil in July 2015, with the government's permission to assess technical issues in relation to the implementation of the structural recommendations. The goal of such a Technical Follow-Up was/is to catalyze engagement by national-level institutions in processes to further advance effective enjoyment of health rights in practice.

State-provided verification of compliance with TMBs' decisions are limited, and we agree with Abramovich and other commentators that the effective implementation of structural remedies by supra-national tribunals calls for catalyzing the engagement of domestic actors, such as national agencies, judiciaries, national human rights institutions and civil society institutions.¹⁸⁸ Moreover, just as in the adjudicatory phase, the evaluation of implementation in health rights cases often calls for technical expertise, and therefore third-party technical follow-up reviews can provide valuable support to the TMB or supra-national tribunal to enhance effective implementation. In this regard, some national courts provide potential examples for the ESC Rights Committee and other supra-national tribunals.

¹⁸⁴ See *Hungary Provides Compensation to Coercively Sterilized Romani Woman*, EUROPEAN ROMA RIGHTS CENTRE (Feb. 24, 2009), <http://www.errc.org/article/hungary-provides-compensation-to-coercively-sterilised-romani-woman/3011>; ESCR-Net, *A.S. v. Hungary*, Communication No. 4/2004, CEDAW/C/36/D/4/2004, <https://www.esr-net.org/docs/i/1053033>.

¹⁸⁵ CEDAW, *Alyne da Silva*, *supra* note 10.

¹⁸⁶ *Id.* at ¶ 8(2).

¹⁸⁷ Letter from Mónica Arango Olaya & Valentina Montoya Robledo, Center for Reproductive Rights, to Members of the CEDAW Committee (Jan. 24, 2014), http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/BRA/INT_CEDAW_NGS_BRA_16194_E.pdf. See also Press Release, Center for Reproductive Rights, *supra* note 132.

¹⁸⁸ Abramovich, *From Massive Violations to Structural Patterns: New Approaches and Classic Tensions in the Inter-American Human Rights System*, *supra* note 140. See also Abramovich, *Remedies Under the Inter-American System* *supra* note 139, at 5.

For example, the Colombia Constitutional Court appointed “voluntary independent technical experts” (including one of these authors, AEY) for the implementation phase of its structural judgment on the health system, *T-760/08*, as it did in the earlier structural judgment regarding displaced persons, *T-025/04*.¹⁸⁹ The Court has held numerous in-person and/or virtual meetings with the voluntary independent technical experts, who include groups of patients and other civil society organizations as well as academics and standard “experts” to get input from them, afford spaces for interchange of views, and to ensure that it has sufficient information to monitor effective compliance with the judgment. The involvement of these experts, and other members of civil society, has proven crucial in fostering the translation of the judicial orders into legislation and public policies. Indeed, a number of the independent experts appointed by the Court, including the civil society coalition, called the “Follow-up Commission,” and the “Alliance for the Right to Health” were engaged in drafting and lobbying for legislative proposals that were enshrined in the Statutory Law on Health, enacted in 2015, as a consequence of the original judgment.¹⁹⁰

If the ESC Rights Committee or other TMBs were to pursue the appointment of voluntary independent experts, or some sort of follow-up commission, consent would need to be obtained by the state concerned, as was the case in the ad hoc *Alyne* follow-up visit mentioned above. Further, criteria regarding qualifications would need to be established, and rigorously met. Moreover, we believe that it is fundamental that such follow-up commissions pursue aims that are not seen as part of the contentious case, but rather as catalyzing the actions and involvement of state and civil society actors at the domestic level, and fostering deliberative processes regarding the paths toward implementation of the judgments. Based upon evidence from both regional and national experiences, we believe that such “follow-up” experts or commissions, if and when they are structured with clear criteria for adjudging compliance and ends to follow-up, can potentially play an important role in closing the capacity gaps that TMBs face with respect to monitoring more than formalistic implementation of structural orders.

¹⁸⁹ Sentencia T-760/08, *supra* note 87; Corte Constitucional [C.C.] [Constitutional Court], enero 22, 2004, Sentencia T-025/2004, (Colom.).

¹⁹⁰ L. 49427, febrero 15, 2015, Diario Oficial [D.O.] (Colom.), <http://www.alcaldiabogota.gov.co/sisjur/normas/Norma1.jsp?i=60733>; Pedro Santana, Comisión de Seguimiento, T 760/08, Justice Jorge Ivan Palacio and all members of Unidad de Seguimiento Corte Constitucional de Colombia, Interviews in Bogota, Colom. (Jun. 8–13, 2015). *See also* CESAR RODRÍGUEZ GARAVITO & DIANA RODRÍGUEZ FRANCO, CORTES Y CAMBIO SOCIAL: CÓMO LA CORTE CONSTITUCIONAL TRANSFORMÓ EL DESPLAZAMIENTO FORZADO EN COLOMBIA (Centro de Estudios de Derecho, Justicia Y sociedad, Dejusticia 2010).

In sum, for reasons of capacity and resources, as well as formalistic approaches to remedies and compliance, implementation of the judgments of TMBs and supra-national tribunals have often been monitored in limited ways. Nonetheless, there are multiple examples of more deliberative remedies, as well as innovative possibilities for monitoring implementation at the regional and national level. If follow-up is to go beyond such formalism, it must have as its objective going beyond the logic of compliance to re-engage national institutions, including civil society actors, the judiciary and other accountability mechanisms, and promoting constructive deliberation at the national level.¹⁹¹ Further, in paying close attention to the implementation and impacts of their decisions at national level, the ESC Rights Committee and other supra-national tribunals can potentially strengthen the normative as well as social legitimacy of international law.

VIII. CONCLUSIONS

As Camila's case poignantly illustrates, perhaps adjudication on no other right so consistently calls for determinations of what lies within the purview of state and societal responsibility, and what matters of life and death significance may be lamented as human tragedies.¹⁹² Moreover, as technology inexorably develops and demographic and epidemiologic trends evolve constantly toward a heavier burden of non-communicable diseases, the contours of what state obligations are entailed under a "right to health" are in constant flux, and subject to contestation on ideological, ethical and economic grounds.

In this article we have set out how various supra-national tribunals have addressed different issues in the adjudication of health-related rights, and have offered proposals in relation to some special considerations posed by health-related cases for supra-national tribunals. We first argued for the importance of an approach to adjudication that both recognizes underlying determinants and delimits the obligations of the health sector by explicitly acknowledging the interdependence and indivisibility of health with human rights. Second, after reviewing some lessons from other supra-national tribunals, we proposed considerations for the ESC Rights Committee to consider as constituting "exceptional circumstances" for the order of interim measures in a health-rights related case. Third, we noted the critical role of technical evidence in health rights cases, and the need for varying types of third-party interventions to address the fundamental moral contestation presented by many health-related rights cases. Fourth, we asserted that considerations of substantive equality in relation to

¹⁹¹ Abramovich, *From Massive Violations to Structural Patterns: New Approaches and Classic Tensions in the Inter-American Human Rights System*, *supra* note 140, at 25.

¹⁹² YAMIN, *supra* note 37.

health-related rights go beyond accounting for social marginalization or discrimination faced by certain populations to examining priorities in relation to the “worst off” in terms of the seriousness of conditions, and coming to careful balances that reinforce democratic processes. Finally, we asserted the need for developing innovative forms of monitoring and supervision of structural remedies by the ESC Rights Committee and other TMBs, in line with the experiences of some national and supra-national tribunals, in order to foster effective compliance and catalyze processes to enhance the ultimate impact of judgments, which in turn bears on the legitimacy of international human rights law and institutions.