

7. Strengthening accountability and redress

7.1 Introduction

This Chapter develops perspectives on the barriers rights-holders face in seeking accountability and redress for discrimination in healthcare and discusses strategies identified by respondents for improving access to justice.

7.2 Barriers to accountability and access to redress

Chapter 3 highlighted the views of NGO and CBO respondents on why rights holders may be constrained in accessing legal redress through the formal court process. Chapter 6 set out how sex workers, LGBT persons, women living with HIV, and persons with disabilities felt they were inhibited in accessing accountability and redress following experiences of discrimination in healthcare. Key informant interviews with respondents from the select complaints bodies indicated their views on what some of the barriers are that healthcare users and rights-holders might face in lodging complaints relating to discrimination in healthcare. In some instances, these respondents' views corresponded with concerns raised by focus-group participants. In others, these respondents raised issues insightful of difficulties that complainants may face in accessing their particular complaints processes. However, in a few instances, the responses of complaints bodies illustrated a deficit of understanding on the diverse barriers that key populations and vulnerable populations face in accessing accountability and redress.

Botswana

In Botswana, complaints body respondents emphasised the importance of cultural norms as inhibiting justice-seeking behaviour by healthcare users, stating that Botswana tended to display deference to medical professionals. Combined with illiteracy and a loss of faith in the effectiveness of complaints processes, the cultural inhibition to complain was emphasised as significantly inhibiting healthcare users from seeking accountability and redress. These views were confirmed by NGO and CBO respondents who emphasised that power disparities between healthcare workers and healthcare users make it difficult to challenge health professionals' authority.

Complaints body respondents also noted the social stigma that complainants may face as contributing to fear of seeking redress. Complaints body respondents did not, however, mention the impact of criminalisation or legal and policy regimes on the accessibility of accountability

processes in healthcare for key populations and vulnerable populations.

Botswana complaints body respondents stated further that complainants may have access constraints, considering the long distances they may need to travel, and the financial restrictions impeding redress.

In particular, with reference to their own processes, Botswana complaints body respondents noted that complainants may have difficulties relating to the tendencies of medical professionals to protect each other and in obtaining evidence sufficient to prove their cases. In relating the difficulties faced by complainants who experience abuse during childbirth one respondent remarked:

“When evidence during the investigation to prove such a complaint becomes a challenge, I often encourage complainants to ‘be happy that they and their off-spring survived!’” (Complaints body respondent – Gaborone, Botswana)

Malawi

In Malawi, complaints body respondents most frequently stated that lack of knowledge and illiteracy were the most significant barriers to making complaints. Respondents further made repeated reference to fear of consequences as inhibiting complaints, particularly if the healthcare user would need to return to the same service-provider for care. These two factors – lack of information and knowledge on rights and complaints processes and fear of treatment withdrawal – were similarly cited by NGO and CBO respondents as being the most significant barriers to healthcare users complaining of healthcare discrimination. In addition, many NGO and CBO respondents independently stated that Malawians tend to “suffer in silence”, inferring a cultural and political disinclination to complain.

Complaints body respondents further noted accessibility constraints in terms of distances to be travelled to lodge complaints and related financial expenses. Malawi complaints body respondents were open to offering examples of barriers internal to their own processes, including that there is insufficient support for complainants from complaints bodies and healthcare institutions as well as rights bodies. The Malawi Ombudsman respondent stated that the absence of the body’s enforcement powers – that respondents simply refuse to comply with its recommendations – was a barrier to complainants.

Zambia

Ignorance of processes and rights were cited by all complaints body respondents in Zambia as being barriers to complainants seeking redress. Accessibility constraints were identified by respondents as including the costs associated with complaining, distances from complaints bodies, and language barriers. One complaints body respondent noted that healthcare users may fear secondary victimisation by nurses if they complain. Barriers identified by the complaints body respondents as internal to their complaints processes included difficulties in proving one’s case due to healthcare workers being protective of one another and that complainants are likely to experience undue delay in their cases being disposed of.

In contrast, NGO and CBO respondents tended to emphasise structural barriers as inhibiting

access to accountability and redress for healthcare discrimination. These respondents mentioned barriers that included the absence of a legal and policy framework on healthcare complaints, narrow communication channels, and failures to equip complaints bodies with knowledge and skills sufficient to fulfil their mandates.

7.3 Strategies for change

Legal and policy reform

States are obliged under international human rights law to ensure that legal frameworks are in place domestically to give effect to human rights guarantees.³⁹⁸ In the legal and policy frameworks in Botswana, Malawi and Zambia set out in Chapter 4, discrimination is outlawed constitutionally in all three countries in broad terms. Efforts at reform may focus on the following issues:

- It may be useful to develop a direct prohibition on discrimination in the context of healthcare and to particularise the prohibition on discrimination to grounds that include discrimination on the grounds of health and HIV-status, gender, sexual orientation, occupation, socio-economic status, and rural location.
- It was strongly emphasised by sex worker and LGBT respondents that perceived criminalisation of their work and sexual orientations respectively stood as the most rigid barriers to effective healthcare access and access to justice.
- In all three countries, the obligations on healthcare workers not to discriminate against healthcare users, including on the grounds mentioned above, needs to be clarified, and which protections should extend to preserving the confidentiality of not only healthcare users' health status, but also their personal information.
- To the extent that complaints processes are inadequate, legal and policy reform must ensure that these processes are transparent, accessible, independent and capable of providing meaningful redress for complainants. Such reform should include measures to enable complainants to access information, including their own medical records, to ensure their objective prospects of success in proving their case.³⁹⁹
- All complaints bodies need sustainable and adequate funding, guaranteed independence, and government support in order to execute their mandates. A statement from the NMBC respondent interviewed for this study is illustrative:

³⁹⁸ See: article 2(2) ICCPR; Articles 2 (a)-(g) CEDAW. See, also: General Comment 3, note 68 above; RC General Comment No. 31, note 66 above, at para 7; Committee Against Torture *General Comment No.2, Implementation of Article 2 by States Parties* (24 January 2008); CEDAW *General Recommendation 28, The Core Obligations of States Parties under Article 2 of the Convention on the Elimination of all Forms of Discrimination against Women* (2010); Committee on the Rights of the Child *General Comment No. 5, General Measures of Implementation of the Convention on the Rights of the Child* (27 November 2003).

³⁹⁹ See: *Zheludkov v Ukraine* (Decision of the Human Rights Committee) Communication No. 726/1996 CCPR/C/76/D/726/1996 (October 29, 2002), 35. Individual opinion by Ms Cecilia Medina Quiroga (concurring): "A person's right to have access to his or her medical records forms part of the right of all individuals to have access to personal information concerning them. The State has not given any reason to justify its refusal to permit such access, and the mere denial of the victim's request for access to his medical records thus constitutes a violation of the State's obligation to respect the right of all persons to be 'treated with humanity and with respect for the inherent dignity of the human person,' regardless of whether or not this refusal may have had consequences for the medical treatment of the victim."

“The power dynamics between the Ministry of Health and the NMCB ultimately impacts negatively on health service delivery which by and large means the patient. Dependency on funding from the Ministry of Health also reduces the impact, efficiency and effectiveness of the Council which literally translates into reduced health outcomes for citizens. The current state of affairs in terms of control from Ministry of Health Headquarters has meant that conflicts abound and fragmentation of critical processes is a common occurrence. A case in point is the whole issue of registration and de-registration of nurses and midwives. There have been cases in which the NMCB has felt that nursing/midwifery ethics and professionalism have been breached and refuse to register a healthcare practitioner and the concerned individual takes the issue to the Ministry of Health who give favours and allows undeserving healthcare workers to continue to practice.”
(NMCB respondent – Gaborone, Botswana)

In all three countries, health system and facility-level complaints options are unclear and do not appear to have structured guarantees for independent decision-making. While these systems appear to offer higher availability and accessibility to complainants, protections for the safety of vulnerable complainants and efficiency measures need significant improvements.

In Malawi and Zambia, legal development has progressed to provide for more particular protections for persons with disabilities, while in Botswana, legislative and policy reform is urgently needed, as was acknowledged by the Office of Persons with Disability:

“There is a need for a law addressing disability and policy regulating differential treatment, stigma and discrimination in both society and the public service.” (Office of Persons with Disability respondent – Gaborone, Botswana)

Educating and empowering healthcare users

In focus-group discussions, respondents generally displayed rich and complex understandings of discrimination, however many could not recognise what should be expected from healthcare workers and how to complain effectively when violations occur. Healthcare users, in particular key populations and vulnerable populations, need to be empowered with knowledge of their rights in relation to healthcare and how they might safely and effectively access systems for accountability and redress:

“Botswana has well written rules and regulations that protect the rights of patients. Botswana as patients/citizens, however, are not conscious of their rights or clued up on the action to take if they receive inappropriate, inadequate service in health facilities.” (NGO respondent – Gaborone, Botswana)

Challenging culture

In Botswana and Malawi in particular, a variety of respondents cited cultural impediments to seeking accountability and redress against persons in positions of authority. Some studies have drawn links to political history, structure and culture as contributing to inequalities that sustain deference to justice-seeking behaviours.⁴⁰⁰ In addition, to the extent that cultural beliefs inform prejudice towards key and vulnerable groups, advocacy efforts need to include strategies to challenge these cultural impediments, in order to strengthen accountability and redress:

“[We need] more investment into building the awareness of citizens on their rights to health and proper treatment by healthcare service providers. Although this is slowly changing, Botswana generally show a tendency of not being vocal about their rights including in the key area of health.”
(Complaints body respondent – Gaborone, Botswana)

“In Malawi people fear going to healthcare centres, they either suffer in silence or go to traditional leaders.” (Civil society respondent – Lilongwe, Malawi)

Empowering stakeholders

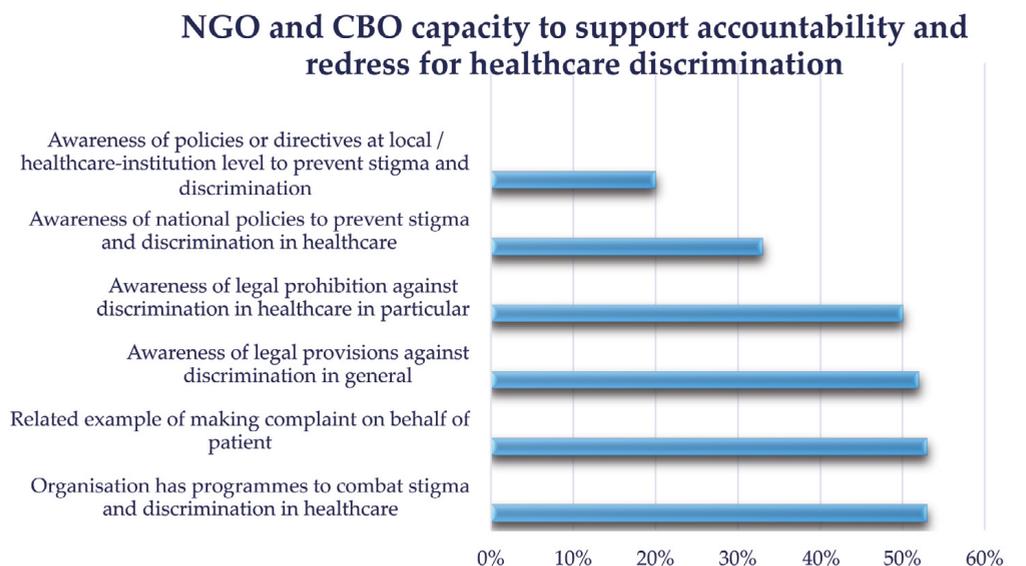
Based on interviews and questionnaires conducted with NGOs and CBOs in the three countries, over 50% had programmes in place to combat stigma and discrimination in healthcare. An equal proportion related examples of assisting beneficiaries to relate complaints of misconduct in healthcare. However, none interviewed for the present research related examples of making use of professional or human rights complaints bodies and all related disparate understandings of the processes for complaints internal to the health system or at facility level. These respondents displayed low levels and accuracy of knowledge on legal, policy, and ethical protections against discrimination in healthcare in particular whilst having generally clearer understandings of general prohibitions against discrimination. The information illustrates the value of capacity building for NGOs and CBOs to better support and assist beneficiaries to hold healthcare systems to account and to seek redress when discrimination occurs in healthcare settings.

In addition, several focus-group participants noted the importance of organisational support and having advocates who could be vocal on their interests, particularly when vulnerability to legal prosecution and abuse constrains vulnerable populations’ capacities to advocate on their own behalf. In Botswana, for example, sex worker respondents related frustrations relating to the refusal to register their sex worker organisation which makes it difficult for them to openly and effectively cooperate with health workers and the police. In Malawi, sex worker respondents stated that they needed organisational support and capacity building for sex workers to be able to represent and defend their own interests openly. NGO respondents in Botswana also stated that it is important for organisations representing the interests of key populations and vulnerable populations to work

⁴⁰⁰ See, for example, NORAD Report. note 232 above, at 20, where it is described that despite a policy-level commitment to community participation and decentralisation in the Malawi healthcare system, the political imperative to maintain central control has led to implementation retreat from effective decentralisation and entrenched inequalities especially in gender and education status.

more effectively with organisations with broader healthcare mandates.

The graph below represents the results of information gathered from interviews conducted with and questionnaires sent to NGO and CBO respondents on their knowledge and capacities in relation to supporting beneficiaries to seek accountability or redress for healthcare-related discrimination:



Educating healthcare providers and complaints body officers

The research identified a need to continue training and education for healthcare workers on stigma and discrimination in healthcare, on human rights, on the particular needs and vulnerabilities of diverse key populations and vulnerable populations, and on how ethical and legal obligations require healthcare workers not to discriminate in their work and to ensure that their conduct does not exacerbate healthcare users' vulnerabilities.

In all three countries, various respondents related the value of incorporating stigma and discrimination and key population training into the curricula of healthcare workers' training and to make these components examinable criteria, in order to ensure it is taken seriously. These recommendations came from all participants including health professions and nursing councils. Only one health professions council in Malawi stated that no further training or capacity-building was needed.

"Ongoing training and capacity building is needed on what constitutes discrimination and stigma; some medical professionals do not take patient rights seriously." (Complaints body respondent – Gaborone, Botswana)

"[We] need more training of [healthcare workers] on stigma and discrimination in relation to persons with disabilities, regulated through

healthcare training institutes, including sensitivity to language.” (Complaints body respondent – Gaborone, Botswana)

“We need to have a meeting with senior medical officers to tell them the challenges that we are facing when accessing health services.” (Sex worker respondent – Mwanza, Malawi)

“We need more training and continuous training. [There is a] need to develop training modules on the issue and to incorporate [it] into [a] continuous professional development framework to enable nurses to gain points for their certification.” (Complaints body respondent – Lusaka, Zambia)

National human rights institutions on the other hand illustrated good knowledge of human rights protections and concepts of discrimination. These bodies lacked experience in the healthcare sector, however. Officers may require capacity-building to enable effective handling of investigations and complaints determination on issues concerning healthcare discrimination.

Other

In all three countries, NGO and CBO respondents working with sex workers and LGBT persons described activities to train and identify key population-friendly healthcare workers and/or to arrange for specialised health services to be provided for key populations in safe environments. These services, as an interim measure, are vital to sustain in order to ensure that key populations and vulnerable persons can sustain access to treatment and to encourage health-seeking behaviours:

“We need our own clinic where we can be able to access all the healthcare we need as sex workers without any form of discrimination ... Pakachere has two clinics specific for sex workers which treats STIs, although they have not yet started providing [ART]. However we need more of such clinics.” (Sex worker respondent – Mwanza, Malawi)