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Report No. 40047 - GLB

Realizing Rights Through Social Guarantees:

An Analysis of New Approaches to Social Policy in Latin America and South Africa

Social Development Department
February 2008

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Preface

This study seeks to contribute to the consideration of social guarantees as tools for social policy design and service delivery that can advance the protection and fulfillment of social and economic rights. It suggests ways to develop and explore a range of policy options that improve the delivery of social services from a rights perspective, while furthering social inclusion and democratic governance. The application of a social guarantee framework could significantly change the way in which social policies are implemented in Latin America, and can have a direct and positive impact on poor and vulnerable groups.

Social guarantees are sets of legal or administrative mechanisms that determine specific entitlements and obligations, related to certain rights, and ensure the fulfillment of those obligations on the part of the state. The social guarantees approach, researched extensively by the Chilean Foundation for Overcoming Poverty (FUNASUPO) and pioneered in the Chilean health system, moves beyond a purely normative framework to give concrete meaning to economic and social rights by integrating a rights-based perspective into social policy.

This study investigates the social guarantee approach not as a template to replicate in programs across countries, but rather as a framework for evaluating, monitoring, and suggesting improvements in social policy in any country context. It highlights the importance of understanding and building upon the existing socio-political context of each country. To illustrate the applicability of this approach in diverse country contexts, the study draws on four case studies from Latin America and on the case of South Africa, in order to analyze how the concept of social guarantees can be made operational to improve lives, particularly of the poor.

The study was initiated at the request of the Organization of American States (OAS), and aims to serve as an input to the OAS Meeting of Ministers and High-level Authorities in Social Development in May 2008. A draft was circulated at the Second Meeting of the Inter-American Committee on Social Development in Washington DC on October 23, 2007. More broadly, this work hopes to support cross-regional learning and contribute to the policy dialogue among international development agencies and government counterparts regarding rights-based approaches to social policy and service delivery. The governments of Chile and South Africa have already initiated dialogue and exchange of practices on their distinct approaches to protecting social and economic rights.

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ABBREVIATIONS AND ACRONYMS

ANEP	National Administration for Public Education (Uruguay)
APAFA	Parent Association (Peru)
APCI	Agency of International Cooperation (Peru)
ASSE	State Health Service Administration (Uruguay)
AUGE	Acceso Universal con Garantías Explícitas (Chile)
AVISA	Años de Vida Saludable Perdidos
BPS	Social Insurance Bank (Uruguay)
CAS	Country Assistance Strategy (World Bank)
CDD	Community-Driven Development
CEIS	Centros de Educacion Inicial(Peru)
CEM	Country Economic Memorandum (World Bank)
CENACEP	Community Pre-school Learning Centers (Guatemala)
CENAN	Centro Nacional de Alimentación y Nutrición (Peru)
CES	Board of Secondary Education (Uruguay)
CETP	Council for Technical-Professional Education (Uruguay)
CGE	Commission on Gender Equality (South Africa)
CLC	Community Law Center (South Africa)
CMU	Country Management Unit
CODICEN	Board of Central Directors (education sector, Uruguay)
COEDUCA	Committee on Education (Guatemala)
CONASAN	National Council for Food and Nutritional Security (Guatemala)
CP	Civil and Political (Rights)
CSO	Civil Society Organization
DAC	Development Assistance Committee
DECRG	Development Economics Research Group (World Bank)
DFID	Department for International Development (UK)
DGA	Democracy and Governance Assessment
DHS	District Health System (South Africa)
DISSE	Office for Social Security in Case of Illness (Uruguay)
ECLAC	Economic Commission for Latin America and the Caribbean (United Nations)
ESC	Economic, Social, and Cultural (Rights)
ESSALUD	Social Security in Health (Peru)
ESW	Economic and Sector Work
FISSAL	Intangible Solidarity Fund for Health (Peru)
FLACSO	Facultad Latino Americana de Ciencias Sociales
FONADIS	National Disability Fund (Chile)
FONASA	National Health Fund (Chile)
FONDEP	National Fund for Educational Development (Peru)
FUNASUPO	Fundación para la Superación de la Pobreza (Foundation for Overcoming Poverty, Chile)
GDP	Gross Domestic Product
GOVNET	Governance Network (DAC)
IACHR	Inter-American Commission on Human Rights
IADB	Inter-American Development Bank
IAMC	Institutions for Collective Medical Attention (Uruguay)
IAMPP	Institutions for Private Medical Attention (Uruguay)
ICESCR	International Covenant on Economic, Social and Cultural Rights
IDASA	Institute for Democracy in South Africa
IGSS	Guatemalan Institute for Social Security

IIHR	Inter-American Institute for Human Rights
ILO	International Labor Organization
INICTEL	National Institute for Investigation and Training in Telecommunications (Peru)
INP	National Institute for Provisional Normalization (Chile)
ISAPRE	Instituciones de Salud Provisional (Chile)
IVS	Disability, Seniority and Survival Program (Guatemala)
JUNAEB	National Association for Educational Support and Scholarships (Chile)
JUNJI	National Association of Kindergartens (Chile)
JUNTOS	National Program for Direct Support of the Poorest
LSMS	Living Standards Measurement Survey
MAGA	Ministry of Agriculture, Cattle Raising and Food (Guatemala)
MAIS	Model for Integral Attention on Health (Peru)
MDG	Millennium Development Goal
MECAEP	Project for Improving the Quality of Primary Education (Uruguay)
MEDIR	Measuring Educational Indicators and Results (USAID project in Guatemala)
MEF	Ministry of the Economy and Finances
MEMFOD	Secondary School and Teacher Training Modernization Program (Uruguay)
MERCOSUR	Mercado Comun del Sur (Southern Common Market)
MIDEPLAN	Ministerio de Planificación (Chile)
MIDES	Ministry of Social Development (Uruguay)
MIMDES	Ministry of Women and Social Development (Peru)
MINSA	Ministry of Health (Peru)
MINSAL	Ministry of Health (Chile)
MINVU	Ministry of Housing and Urban Affairs (Chile)
MSPAS	Ministry of Public Health and Social Assistance (Guatemala)
NGO	Non-Governmental Organization
NHA	National Housing Accord (South Africa)
OAS	Organization of American States
OECD	Organization for Economic Co-operation and Development
OHCHR	Office of the High Commissioner for Human Rights
ONAA	National Office for Food Support (Peru)
PACFO	Complementary Food Program for Groups at High Risk (Peru)
PAD	Direct Assistance Program (Peru)
PAE	School Food Program (Chile)
PAIN	Program for Integral Attention to Children 0-6 (Guatemala)
PANES	National Program for Social Emergency Assistance (Uruguay)
PANFAR	Food and Nutrition Program for High-Risk Families (Peru)
PBE	Project of Bilingual Education (Peru)
PCD	Christian Democrat Party (Chile)
PHC	Public Health Care (South Africa)
PIE	Prevention of Illegal Eviction from and Unlawful Occupation of Land Act (South Africa)
PISA	Program for International Student Assessment
PMI	Program for Childhood Improvement (Chile)
PMTCT	Prevention of Mother-to-Child Transmission
PNAC	National Complementary Food Program (Chile)
PPD	Party for Democracy (Chile)
PRESA	Program for Food Security (Peru)
PREVIENE	Family Program for the Prevention of Drug Consumption. Program (Chile)
PROESCOLAR	Program for the Development of School Administration (Guatemala)
PRONAA	National Program for Food Assistance (Peru)
PRONADE	National Program for Self-managed Primary Education (Guatemala)

PRONOEIS	Programas No Escolarizado de Educacion Inicial (Peru)
PRSD	Social Democrat Radical Party (Chile)
PS	Socialist Party (Chile)
RDP	Reconstruction and Development Programme (South Africa)
RGES	Régimen de Garantías Explícitas en Salud (Chile)
SAHRC	South African Human Rights Commission
SAPU	Emergency Basic Care (Chile)
SDV	Social Development Department (World Bank)
SEGEPLAN	Secretariat for Planning and Programming (Guatemala)
SEREMI	Regional Ministerial Secretariats (Chile)
SERVIU	Housing and Urbanization Services (Chile)
SESAN	Secretariat of the Presidency for Food and Nutritional Security (Guatemala)
SINEACE	National System for Evaluation, Accreditation and Certification of the Quality of Education (Peru)
SIS	Integrated Health System (Peru)
SIVICOS	System of Community Health Monitoring (Peru)
SOSEP	Secretariat on Social Work of the Wife of the President (Guatemala)
SPP	Surplus People Project (South Africa)
TAC	Treatment Action Campaign (South Africa)
UMC	Unidad de Medicion de la Calidad Educativa (Peru)
UMD	Unit for Measuring the Quality of Education (Peru)
UN	United Nations
UNECLAC	United Nations Economic Commission for Latin America
UNDG	United Nations Development Group
UNDP	United Nations Development Fund
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UNOHCHR	United Nations Office of the High Commissioner of Human Rights
UNRISD	United Nations Research Institute for Social Development
USAID	United States Agency for International Development
WDR	World Development Report

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Executive Summary

This paper examines the experiences in four Latin American countries and South Africa in the application of a human rights approach to social policy. Developed in collaboration with the Chilean Foundation for Overcoming Poverty, the Organization of American States (OAS), the Inter-American Development Bank (IADB), and the United Nations Economic Commission for Latin American (ECLAC) at the regional level in Latin America, this work responds to a strong expressed demand from regional and national stakeholders in Latin America to look at the contribution of human rights standards and principles to the formulation of social policy. The findings of this work were presented at the Second Regular Meeting of the Inter-American Committee on Social Development in October 2007 in Washington DC. It will ultimately contribute to deliberations of the next OAS Meeting of Ministers and High Level Authorities of Social Development in Santiago, Chile in May 2008.

The South Africa case study was added in response to an expressed interest on the part of Latin American and South African policymakers to engage in south-south exchange and learning. There was a particular interest in comparing the model applied in many Latin American countries, where emphasis is placed on administrative and policy mechanisms for realizing rights, with the South African experience, where judicial mechanisms have played a major role in enforcing rights provided for in the constitution.

We understand a rights-based approach to social policy to comprise the following features:

- The definition and widespread communication of rights, entitlements, and standards which enable citizens to hold public policymakers and providers to account for the delivery of social policy;

- The availability of mechanisms of redress which citizens can utilize if they are unable to enjoy specified entitlements or social minimums;

- A commitment to the equitable delivery of the specified rights, entitlements, and standards to all on a universal basis.

The paper applies an analysis based on a social guarantees framework - an innovative approach to integrate a rights-based perspective into social policy. The social guarantees approach moves beyond a purely normative framework to give concrete meaning to economic, social, and cultural rights and hence to allow for their operationalization into policies and programs.

Ferrajoli (2001, 2004) defines a social guarantee as a set of legal or administrative mechanisms that determines specific entitlements and obligations, related to certain rights, and ensures the fulfillment of those obligations on the part of the state. As such, social guarantees contribute to bridging the structural gap that exists between legally declared norms and their effective implementation. In particular, social guarantees favor a legal articulation of rights that results in explicit state responsibilities, and a clear articulation of benefits associated with given rights. The policy mechanisms that social guarantees envision should be defined in a precise manner, as well as be flexible and revisable. Where legal or administrative mechanisms, related to human rights

obligations exist, but are not sufficiently developed to ensure the fulfillment of those obligations, this is described as a "pre-guarantee."

This document suggests that a social guarantee approach can be used to strengthen the delivery and monitoring of social programs. Firstly, it implies an institutional design that emphasizes synergy and coordination among agencies and providers to help social programs achieve their full potential. Secondly, this approach contributes to reducing gaps in opportunity among citizens by promoting universal access to, and a basic quality standard for, essential services. Thirdly, the social guarantee approach contributes to strengthening democratic governance, as it requires the achievement of a non-discriminatory agreement among all members of society as to the level of basic entitlements of each individual or collective. In other words, social guarantees are safeguards that society provides to all its members, ensuring their access to essential opportunities and wellbeing.

The study examines four Latin American case studies – Chile, Guatemala, Peru and Uruguay, and the case of South Africa. The approach to supporting the realization of social and economic rights in the case study countries is examined through a framework of "sub-guarantees" dealing with areas of access, financial protection, quality, redress, participation, and continual revision with regard to given social programs. Material from the case studies has been analyzed according to the following research questions, under each of these sub-guarantees:

Access	*Are the beneficiaries and services clearly defined?*
	Are there institutional procedures for monitoring access?
	Are there legal or institutional mechanisms that ensure non-discrimination in the access to services?
	Are services guaranteed for the amount of time needed?
	Is there a maximum waiting period for receiving the service?
	If service is unavailable within this waiting period, what is a guaranteed alternative (in the same time period)?
Financial protection	*Do beneficiaries need to contribute to the cost of service?*
	Are services accessible to those who cannot contribute to the cost?
	Is this information effectively communicated to the public?
Quality	*Are there clear quality standards?*
	Are programs evaluated on a regular basis?
	Are standards and evaluation results clearly communicated to the public?
Mechanisms for redress and enforcement	*Are there mechanisms allowing citizens to claim adequate provision of the services guaranteed?*
Participation and continual revision	*Do civil, parent, or other community organizations have a concrete role in the design, implementation, and monitoring of the program?*
	Which law or institution guarantees citizens' involvement?
	Are there mechanisms that allow for continual improvement of services?

This framework is used to evaluate the experience in health provision in all the case study countries. In various countries, the case studies also examine elements of education (Uruguay, Peru, Guatemala) social protection (Uruguay), food policy (Peru), and housing (South Africa).

The Chile case study focuses on the implementation of an explicit system of social guarantees in relation to health provision (the *Plan Acceso Universal con Garantías Explícitas,* AUGE; also known as *Régimen de Garantías Explícitas en Salud,* RGES). This plan represents an ambitious attempt to integrate a dualistic and highly unequal health sector (segmented into sections which relied both on public and on private, insurance-based, provision) under a framework of policy goals which would promote equity and the realization of health rights for all citizens. Although the program has only existed since 2004, early results are promising. Two features of this experience are worth noting: the use of detailed guaranteed minimum standards to drive change; and the explicit attention paid to establishing accessible and effective non-judicial mechanisms of redress (through the office of the Superintendent of Health, which is independent from the delivery system but has the power to ensure action by providers).

In Guatemala, following the Peace Accords of 1996, a large part of the legal framework was revised to include explicit commitments to the respect, protection, and fulfillment of human rights – civil and political, as well as economic, social, and cultural. As a result, the country has developed a comprehensive legal framework with an abundance of references to rights and obligations, on the part of both the state and citizens. However, the translation of this legal framework into functioning policies and programs is far from explicit. Few of the laws detail the institutional responsibilities and procedures for each stage of social program development – design, implementation, monitoring, redress, and enforcement. A rights perspective, applied specifically through the social guarantees framework, would point to two major areas where the institutional arrangements for social policy delivery in Guatemala could productively be strengthened. One is in explicitly designing mechanisms of redress which allow ordinary Guatemalans to make claims for service provision. Given the need for accessibility, these are likely to be non-judicial in nature. Such a design would need to be sensitive to the major social schism in the country, which leads to significant social exclusion of the indigenous population, particularly of indigenous women. Translation into local languages would be a critical component, and communication channels would require a careful, socially literate, design. The second area where progress would need to be made is in tightening the specification of institutional responsibilities in policy and legal frameworks that guide service delivery in health and education.

In Peru, the three sectors reviewed in the study all suggest different constraints to the implementation of a social policy that fulfills fundamental social and economic rights. In the education sector, the weakness of quality standards throughout the system undermines the effectiveness of a school system that delivers impressive levels of access. The capacity of Peruvians to demand improvements in quality is restricted by the lack of information about standards. In the health sector, a lack of information on rights to provision, and the absence of accessible and effective redress mechanisms are reflected in substantial inequalities in access to health care. In relation to food policy, the key programs have been designed with strong participatory mechanisms at the local level, but these are poorly articulated at the higher levels of the system. The evidence suggests that this lack of participation hampers the capacity of citizens to make claims for access and to demand more effective service delivery.

In Uruguay, the social protection system is fragmented between (i) a solid pension system, whose beneficiaries are strongly represented in policy decisionmaking, and (ii) a system of family

assistance that targets the most vulnerable groups (youth, families with unemployed heads of household, mothers and infants, the disabled) but is ineffective in alleviating poverty. An analysis of both areas of social security, using a framework of social guarantees, points to concrete differences in the way mechanisms for civil participation, quality, and access are structured in each of the two areas, which are, in turn, linked to each program's impact on maintaining equity. Even though citizens are able to claim their entitlements both judicially and administratively, the system of entitlements itself is not sufficiently pro-poor to effectively work for the rights of the poorest. This indicates that, in order to gear the allocation of resources toward the realization of rights on an equitable and universal basis, the process of continual revision of entitlements and service standards may need, on occasion, to include the rebalancing of entitlements between different social groups. A theme common to all sectors in the Uruguay study is the potential significance of political mobilization of different constituencies. This factor points to the important challenge of operationalizing the sub-guarantee of participation, in order to promote equity of voice at the national level and ensure that social groups without strong representation in the formal political system can exert pressure for the more equitable allocation of public resources.

The realization of social rights in the countries and areas discussed above is mostly at the pre-guarantee stage in the four Latin American cases. The early experience of operationalizing social guarantees in the health sector in Chile, however, demonstrates that the application of a social guarantee framework can produce strong positive results.

The South African case is striking for the very strong role that judicial mechanisms have played in supporting the realization of social and economic rights for the majority of the population, who had suffered extreme discrimination under the Apartheid system until the political transition in 1994. The strong emphasis on judicial mechanisms reflects a number of key differences between the Latin America and South Africa cases:

- The possibilities opened up by the political transition, particularly in terms of the preparation of a radically new constitution, and the establishment of the Constitutional Court staffed largely by jurists with a strong background in human rights and a commitment to promoting equity and social transformation;

- Certain key provisions in the South African legal system which make judicial action more likely to benefit the poor, including (i) the right to "locus standing" in court, that enables civil society organizations to bring cases on behalf of litigants who could not otherwise access the court system; and (ii) provisions for *amicus curiae* interventions, which allows advocacy organizations to make submissions in ongoing court cases in support of rights claims;

- The existence of an active civil society community with an interest in using the constitutional provisions to promote equity and social justice.

The South Africa case also illustrates the potential complementarity of judicial (courts), quasi-judicial (e.g., the South African Human Rights Commission), and administrative (e.g., tribunals, facility-based complaints mechanism) approaches to providing citizens with recourse and redress. Clearly the shock of the political transition created unusual conditions, but there are nonetheless

lessons which can be drawn. In particular, the importance of a “fit for purpose” Constitutional Court, and “locus standing” provisions that allow for pro-poor public interest litigation, enable the court system to promote redress and accountability more broadly, and lead to a strengthening of non-judicial mechanisms.

At the same time, the slow progress made in certain areas of social policy, particularly health care, in redressing the inequities generated by the Apartheid system, suggests that a more rigorous approach to specifying social service standards, as well as the chain of responsibilities for providing those services, could have a positive impact. A useful starting point could be an examination of why inequities in resource allocation have persisted despite the profound political, policy and institutional changes of the last thirteen years. While the politics of redistribution in service provision are always complex, the Chilean experience suggests that attempting to effect redistribution through a process of specifying in detail the guaranteed standards that should be available to all citizens, with wide public debate to generate support, can provide a way to compel hard choices to be made.

We conclude that a social guarantees approach offers a number of promising avenues to strengthen the delivery of social policy. In particular:

- The sub-guarantees framework outlined above can serve as an organizing scheme for monitoring and reforming social programs. By focusing attention on specific dimensions of service delivery, it can help to identify blockages to the realization of economic and social rights, and suggest strategic measures to correct them.
- It makes it possible to monitor progress toward the realization of economic and social rights, independent of input or outcome dimensions. The inputs and targeted outputs of social policy cannot be determined fairly on a cross-country basis due to the varying fiscal and economic capabilities of different countries. The material reviewed here suggests that sub-guarantees can provide a framework for monitoring the strength of the social, legal, and policy arrangements underpinning the realization of economic and social rights within individual countries. A social guarantees monitoring framework will simultaneously guide policy toward a stronger social contract and framework for citizenship, and provide a means of measuring the degree to which a rights perspective is considered in social policy.
- The social guarantees approach makes space for the process of social dialogue needed to reach an agreement on the concrete benefits to be associated with the fulfillment of social and economic rights. The participation of the poor and voiceless in this process is critical, and its promotion is an area where more experience and effort is needed.
- It increases transparency and accountability. Given their precise nature, social guarantees contribute to reducing administrative discretionality and patrimonialism. They contain clear definitions of rights and right holders, institutional arrangements, operational mechanisms, and budget allocation.
- It facilitates the adaptability of benefits to a country’s social, economic and political conditions. Social guarantees can be modified or updated without harming the values they protect, because they take into consideration aspects such as culture, availability of resources, public consensus, etc. Therefore social guarantees are flexible, adaptable, and make it possible to avoid falling back on standardized solutions.

As an agenda for future research and knowledge generation, the country case studies highlight the importance of understanding how a range of different institutions for recourse and redress function in different contexts. These institutions can be administrative, judicial, or quasi-judicial in character. While a solid body of literature is emerging on the role of judicial mechanisms, there are significant gaps in our understanding of how non-judicial mechanisms work, how they can best be constructed to have a positive impact for the poor, and how they could work with formal legal mechanisms in different contexts.

I. INTRODUCTION

1. This study was conducted at the request of and in collaboration with the Organization of American States (OAS) and is intended to serve as an input to the OAS Meeting of Ministers and High Level Authorities in Social Development to be held in Santiago, Chile in May 2008. A policy note, based on this work was first presented at a preparatory meeting of the Inter-American Committee of Social Development of the OAS in Washington DC on October 23, 2007. From an internal perspective, the study seeks to strengthen the Bank's capacity to support a range of activities connecting the supply and demand side of governance – in particular, the delivery of and access to social services – as a way to further its mission of sustainable and equitable development.

2. The key motivating question of this work is whether, and under what conditions, a rights-based approach can strengthen the institutional framework for delivering social policy outcomes. In seeking an answer, the paper explores how the concept of social guarantees could be used to both (i) guide operational and policy design; and (ii) assess progress in incorporating human rights approaches into social policy. Box 1 outlines the key terms in relation to human rights.

Box 1. Definition of Terms

Rights
Rights are widely understood to be legitimate claims that give rise to correlative obligations or duties.

Rights regime
A rights regime is a system of rights derived from a particular regulatory order or source of authority. In a given society, several rights regimes may coexist, all with distinct normative frameworks and means of formulation and enforcement; e.g., customary law, religious law, constitutional law, and statutory law.

Universal human rights
Universal human rights are those that apply to all human beings equally, irrespective of their membership in particular families, groups, religions, communities, or societies. Most human rights apply to the individual, but sometimes the equal worth and dignity of all can only be assured through the recognition and protection of an individual's rights as a member of a group.

In practice, human rights are best understood as moral, political, or legal claims made on the basis of common humanity. The normative basis of the United Nations system for the promotion and protection of human rights can be characterized in terms of:

- *International legal obligations:* These derive from different sources in international law, such as international treaties, international customary law, and the general principles of international law.
- *International ethical/political obligations:* These are a broader set of morally binding international obligations, derived from ethical and political statements, declarations, and commitments made at the United Nations level.

Sources: Moser and Norton (2001); United Nations Office of the High Commissioner for Human Rights (2006).

3. In the past decade, the human rights approach has received growing attention in the development community. Institutions such as the World Bank,[1] the UK's Department for International Development (DFID), and the Organization for Economic Co-operation and Development's Development Assistance Committee (OECD DAC) have highlighted the significance of human rights as an element of development dialogue which can underpin more responsive and accountable governance, and enhance aid effectiveness.

4. A rights-based approach to development is commonly understood as a conceptual framework that is normatively based on international human rights standards and principles, and is operationally directed toward promoting and protecting human rights. A key element of all rights-based approaches is the intent to empower people to act as "rights-holding citizens" in relation to the state rather than merely as beneficiaries of social services. There are two main rationales for a human rights-based approach: (a) the *intrinsic* rationale, acknowledging that a human rights-based approach is the right thing to do, morally or legally; and (b) the *instrumental* rationale, recognizing that a human rights-based approach leads to better and more sustainable human development outcomes. In practice, the reason for pursuing a human rights-based approach is usually a blend of these two. (United Nations Office of the High Commissioner for Human Rights 2006)

5. A rights-based perspective can be argued to contribute to sustainable development in two major ways. First, it reduces social and political risks through the enhancement of social justice and a focus on inclusion and non-discrimination. Second, it creates stronger and more equitable institutions – not only state, but also civil and community institutions (Moser and Norton 2001, p. ix). Furthermore, the promotion and observance of human rights are considered to be core elements in efforts to strengthen democracy and governance. This is particularly relevant in Latin America, where social and economic rights have not advanced as rapidly as civil and political rights – a situation which poses one of the greatest challenges to Latin American democracies (United Nations Development Programme 2004).

6. The paper introduces the social guarantee framework as an innovative approach through which a rights-based perspective can be incorporated into social policy. The social guarantee framework has been operationalized and in the Chilean health program, Regime of Explicit Guarantees in Health, also known as Plan AUGE, and has already produced positive results. Apart form pointing to the Plan AUGE as a good practice example, the objective of the paper is to bring attention to the broader value of a social guarantee framework in conceptualizing, implementing and monitoring social programs, arguing that it is one possible and effective approach to rights-based social planning.

7. The study is intended to contribute to the policy dialogue between international development agencies and government counterparts regarding rights-based approaches to social policy and service delivery. It is important to note that the South African Government has initiated a dialogue with counterparts in Chile and Brazil in order to share experiences on rights-based approaches to social policy. This study hopes to facilitate this cross-regional learning. From an internal perspective, the study seeks to strengthen the World Bank's capacity to support a

[1] See Palacio (2006), Danino (2005, 2006), and in particular Danino's "Legal Opinion on Human Rights and the Work of the World Bank," dated January 27, 2006, in which he discusses the relationship between law and equity, and confirms the facilitative role the Bank could play in supporting its member countries' fulfillment of their human rights obligations.

range of activities connecting the supply and demand side of governance – in particular, the delivery of and access to social services – as a way to further its mission of sustainable and equitable development.

8. The conceptual part of the report includes a brief review of international legislation in the area of social, economic and cultural rights with an emphasis on the inter-American system; a discussion of rights-based approaches to social policy, and a review of the social guarantee framework, developed by the Chilean Foundation for Overcoming Poverty (FUNASUPO). The empirical part of the study is based on five country reports, prepared by researchers from local universities in Chile, Guatemala, Peru, Uruguay, and South Africa. The country reports are based on a review of secondary sources (surveys and literature) and interviews with representatives from government, civil society (including human rights groups and organizations representing indigenous people, women and youth), academia, centers for research and statistics, and international organizations. Inputs and comments from the OAS, United Nations Economic Commission for Latin America (UNECLAC), and the Inter-American Development Bank (IADB) were incorporated into all preparation stages of the consolidated report. A draft of this report was discussed at the Workshop on Explicit Guarantees in the Implementation of the Economic, Social and Cultural Rights in Latin America and the Caribbean, organized by UNECLAC and held in Santiago, Chile on April 2-4, 2007.

9. The countries selected as case studies for this work are diverse in their economic and demographic features in order to exemplify the potential for applying a social guarantee framework in diverse environments. **Chile** is a middle–income economy with less than 10 percent indigenous population, and a progressively expanding social policy that has had an explicit human rights focus for the past two decades; **Guatemala** is a lower-income state with a high percentage of indigenous population and a relatively recent expansion of universal social programs; **Peru** is a medium-low income state with close to 82 percent indigenous and *mestizo* population, about 5 percent Afro-descendant population, and a social services system that has been evolving for half a century; and **Uruguay** is a middle-income state with an almost homogenous ethnic (European descent) composition, a small Afro-Uruguayan minority, and no indigenous population, and a strong tradition of social service delivery. The distinct historical contexts of the four countries with regard to political stability have also affected their construction of social programs and their adoption of human rights norms. In the **South Africa** case, the adoption of a human rights-based constitution was an explicit element of the political transition away from the Apartheid system of government, and the rights-based approach was part of a broader process of social transformation.

10. The report is structured as follows: Chapter II gives a brief overview of the international human rights framework with a special emphasis on the inter-American system and reviews the main concepts behind a social guarantee policy framework; Chapter III presents the findings from the country case studies, based on the sub-guarantees outlined in Table 1; Chapter IV concludes with a summary of the results, and recommendations for further steps that could be taken to improve social programming from a rights perspective. Annex A provides detailed matrices on the legal, institutional, instrumental, and fiscal aspects of the social guarantees framework for each of the Latin American cases.

II. CONCEPTUAL BACKGROUND: MAKING RIGHTS REAL THROUGH SOCIAL POLICY

11. The basic principles of human rights doctrine include the recognition of the universality, indivisibility, and interdependence of all human rights (civil, political, economic, social, and cultural); the authority of the international system to protect human rights; and the linkage among democracy, development, and human rights. In 2003 a number of core United Nations (UN) agencies issued a "Common Understanding on a Human Rights-based Approach to Development Cooperation," which was later incorporated into UN operational guidelines. In 2005 the UN General Assembly's World Summit recommended mainstreaming human rights into national development policies (United Nations 2005). Moreover, a variety of NGOs have dedicated themselves to the promotion, observance and respect of human rights, ensuring civil society's vigilant and active participation alongside governments and supranational bodies, mainly within the framework of the UN system.

12. The framework for universalism of rights has become the banner of movements that seek the expansion of the social base of citizenship (e.g. granting voting rights to women or illiterates), the inclusion of minorities, of discriminated or dispossessed social groups as members of the citizenry, and the claim of "equality before the law."[2]

13. Two key covenants form the basis of international human rights law: the International Covenant on Civil and Political Rights, and the International Covenant on Economic, Social and Cultural Rights (ICESCR). The monitoring of economic, social and cultural rights is made especially challenging by the scope of the rights, the diversity of the means by which they might be made operational, and the inevitably complex relationship between rights and resources. The challenge, then, is how to take into account in a monitoring system of the provisions in the ICESCR calling for "progressive realization" to the "maximum of available resources," while acknowledging that financial and administrative capacities vary dramatically from one state to another (Steiner and Alston 2000). The experience reviewed in this report suggests that the social guarantees framework is potentially an effective policy option for Latin American countries to move in this direction.

Box 2. Social Rights in the Inter-American System

The countries of Latin America have a long history of commitment to human rights, based on traditions inherited from both Europe and the United States – the political traditions of the European Enlightenment and the moral tradition of American individual liberty. Upon independence, most Latin American countries maintained their European-style civil code legal systems, while their constitutions were inspired by the founding documents of the United States, the rhetoric of the French Revolution, and the natural law tradition, with its central idea of the common humanity of all persons. The emphasis on human rights, rooted in both traditions, led to the region's significant contribution to the genesis of the Universal Declaration of Human Rights in 1948 (Carozza 2003, Glendon 2001)

[2] See Jelin's (1997, 2004) discussion of the role of social mobilization, politics, and economic restructuring in Latin America in the generation of citizenship and rights.

Latin American countries are also bound by specific human rights obligations through the Charter of the Organization of American States, the American Declaration of the Rights and Duties of Man, and the Inter-American Charter of Social Guarantees. In addition, states in the inter-American system are bound by the American Convention of Human Rights of 1969, known as the Pact of San Jose of Costa Rica, which came into effect in 1978; and by the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988, known as the Protocol of San Salvador. All these documents make general reference to economic, social, and cultural rights, and the Pact of San Jose states that their realization should be gradual.

Rights and Social Policy

14. This study builds on the extensive literature on human rights and the international development community (see, for example, Uvin 2004, Moser and Norton 2001, Alston and Robinson 2005). However, it focuses primarily on state responsibility and action with regard to the human rights of its citizens, which allows for a more concrete discussion of the accountability relationship in social policy. In this context, we understand a rights-based approach to social policy to comprise the following features:

- The definition and widespread communication of rights, entitlements, and standards that enable citizens to hold public policy makers and providers to account for the delivery of social policy.

- The availability of mechanisms of redress which citizens can access if they are unable to enjoy specified entitlements or social minimums.

- A commitment to the equitable delivery of the specified rights, entitlements, and standards to all on a universal basis.

15. There are multiple models of social policy. Some concern only the social sectors, while others view social policy as embodying cross-cutting concerns about equity, distribution, social justice, and livelihood security – i.e., as closely associated with economic policy. It is the latter interpretation that we follow in this study.[3] Two definitions of social policy, cited by Kanbur (2006) are: "Measures that affect people's well-being, whether through the provision of welfare services or by means of policies that impact upon livelihoods more generally" (Hall and Midgley 2004 in Kanbur 2006, p. 3); and "collective interventions directly affecting transformation in social welfare, social institutions and social relations" (Mkandawire 2001 in Kabur 2006, p. 3). Both definitions presuppose that social policy works in tandem with economic policy to ensure equitable and sustainable development. It is worth remembering, however, that in practice, the understanding of what constitutes "social policy" varies by country. Most often, the term simply encompasses policy about people's most pressing social concerns. If crime and public disorder are a major issue in the society, for example, then tackling it becomes seen as a social policy priority.

[3] United Nations Research Istitute for Social Development (2006), for example, views social policy as the edification of a state-society nexus that is developmental (facilitates and promotes economic growth and structural transformation); democratic (derives its legitimacy through popular participation and electoral processes); and socially inclusive (pursues social policies that provide equitable entitlements for all citizens, to ensure that their capacities and functioning are adequate for inclusion in societal affairs).

Box 3. Social Policy in Latin America: A Historical Perspective

There have been several stages in the evolution of social policies in Latin America, which have reflected the prevailing political, ideological, and economic conditions of each period: (i) the late 19th century to 1930, when social services were mainly the domain of the private sector and of civil associations through charitable work; (ii) 1930-1980, associated with the rising popularity of the import substitution model, an increasing state role in social service delivery, a radical increase in school enrollments, declines in child mortality, and improvements in health facilities, water and sanitation; and (iii) the 1980s, when structural adjustment saw the progressive withdrawal of the state from social service provision. At the present time (2007), (iv) social service delivery is characterized by decentralization, increased regulation, and state partnerships with private providers.

None of these approaches, however, has been successful in eliminating the persistent social inequalities in the region. Public welfare programs developed in the first half of the 20th century were characterized by generous support to the formal sector, in contrast with almost non-existent social assistance for the informal sector, and this trend continues today.

The consideration of universal social and economic rights has only recently been incorporated into public discourse in the region. For example, 19 constitutions in the region identify health and education as basic rights and commit government to their provision. The state is given responsibility for securing this universal entitlement, for formulating and implementing national health and education policy, and for promoting the integration of services offered by public and private providers.

16. Historically, social policy has been about interventions of either a socially redistributive kind (from rich to poor, young to old), a social regulatory kind (setting the ground rules for a market economy), or a social rights kind (delimiting the rights and duties of citizens with regard to access to services and incomes) (Deacon et al. 2003). Social welfare approaches have perpetuated a misperception of social policy as a set of policy prescriptions to address residual elements of economic policy. More holistic approaches, however, seek to promote policies, institutions, and programs that balance a concern for equity and social justice with a concern for economic growth.

17. A rights-based approach to social policy adds a focus on process in addition to outcomes. That is, the progressive realization of economic, social, and cultural rights is a process that reflects evolving country conditions. Ideally, rights-based social policies would be the outcome of contestations among citizens and will invariably be a compromise among what is desirable, feasible, and acceptable.

Social Guarantees: Moving from a Right to an Operational Mechanism

18. This study employs the concept of social guarantee in an effort to conceptualize the operational side of a rights-based social policy i.e. to conceptualize a set of policy mechanisms that allow for the widespread definition and communication of rights, availability of redress and enforcement mechanisms, and a commitment to equity in the delivery of services. In this way a social guarantee framework allows us to measure "the structural distance between setting norms and realizing rights" in each country context (FUNASUPO 2007, p. 68).

19. Social guarantees are defined as *sets of legal or administrative mechanisms that determine specific entitlements and obligations, related to certain rights, and ensure the fulfillment of those obligations on the part of the state*. The difference between a right and a social guarantee is that the former has an abstract and ethical content, while the latter complements this

abstract content with specific mechanisms that governments can put in place to realize a right. Where the mechanisms are insufficiently developed to ensure the fulfillment of state obligations in relation to a particular right, we characterize this as a "pre-guarantee."

20. All guarantees and sub-guarantees need an explicit formulation and clear definition (in the law) that specifies the way and conditions under which they operate. It is possible to identify five aspects of social guarantees by virtue of which they facilitate the realization of rights.[4] In short, social guarantees:

- have a judicial expression reflected in the Constitution and/or domestic laws;
- are constructed with explicit reference to specific rights holders;
- act to diminish the disparity in opportunities among social groups to access the specified rights;
- contain a clear definition of the entitlement and all procedures necessary to fulfill the guarantee, including targeted results and standards for evaluation;
- are flexible, in the sense that one guarantee can be executed through two or more policy instruments.

21. A system based on guarantees requires a normative (legal) framework that precisely defines the rights and their threshold of realization. To become operational and allow citizens to claim their rights, social guarantees also require specific institutional arrangements to design the programs, determine and secure the budget, and implement and monitor the policies that will materialize the realization of those rights. In this context the state fulfills a key role as a normative and regulatory institution. Thus, any social guarantee can be described with reference to four domains – legal, institutional, instrumental, and financial – which can be defined as follows:

- ***Legal*** – all laws and regulations that establish the obligation of states and citizens' duties related to their entitlements;
- ***Institutional*** – state institution/s responsible for the fulfillment of this norm/ guarantee and its sub-dimensions;
- ***Instrumental*** **–** policies, programs (include public-private programs), or services that ensure the practical implementation of the guarantee in question.
- ***Financial*** – economic resources allocated to and invested in the realization of the guarantee and its sub-dimensions.

22. While laws, institutions, programs, and budget allocations build the essential framework for introducing and regulating social guarantees, such guarantees alone do not ensure that all citizens are able to access and claim timely provision of good-quality services. Strong channels of information and accountability are also required. The most difficult part of constructing a social guarantee-based policy lies in defining and building a new social consensus on the level of benefits to be protected. However, it is precisely this process of consensus-building, and of

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[4] While some of these characteristics are not exclusive to a social guarantee, the manifestation of all of them is essential for the definition of a guarantee (see Ferrajoli (2001, 2004). Ferrajoli also outlines a difference between primary and secondary guarantees. Primary guarantees are those necessary to make real and effective the content of a right, while secondary guarantees consist of redress mechanisms, and come into play only when the primary guarantees are unfulfilled.

defining rights-based norms and standards, which permits citizens to become integrated in society. (FUNASUPO 2007, p. 53).

23. In the absence of such consensus-building process, on the other hand, there is a risk that entitlements will be set at a level where provision for all is not possible, where rationing occurs, and where the poor (who are generally less able to make claims) do not benefit (see Elson and Norton 2002, pp. 15-30, for a discussion of entitlements, human rights, and the budget process). To be effective, therefore, social guarantees require not only legal definition, clearly stipulated institutional responsibilities, and monitorable implementation plans, but also secured budget support (Hunt 1996).

24. We examine the country cases through a framework of five "sub-guarantees" dealing with areas of: (i) access, (ii) quality, (iii) financial protection, (iv) mechanisms for redress, and (v) participation and continual revision. To this end, a matrix is developed for each case to analyze the sub-guarantees in the programs and policies in question. Table 1 summarizes the main research questions employed in analyzing status of social programs each sub-guarantee. The study does not presuppose that any of the programs analyzed has been conceived form a social guarantee perspective. Rather, it uses the notion of social guarantee to analyze the extent to and effectiveness with which declared rights have been incorporated in and upheld through social programs in the country cases.

Table 1. Sub-Dimensions of the Social Guarantee	
Access	*Are the beneficiaries and services clearly defined?*
	Are there institutional procedures for monitoring access?
	Are there legal or institutional mechanisms that ensure non-discrimination in the access to services?
	Are services guaranteed for the amount of time needed?
	Is there a maximum waiting period for receiving the service?
	If service is unavailable within this waiting period, what is a guaranteed alternative (in the same time period)?
Financial protection	*Do beneficiaries need to contribute to the cost of service?*
	Are services accessible to those who cannot contribute to the cost
	Is this information effectively communicated to the public?
Quality	*Are there clear quality standards?*
	Are programs being evaluated on a regular basis?
	Are standards and evaluation results clearly communicated to the public?
Mechanisms for redress and enforcement	*Are there mechanisms allowing citizens to claim adequate provision of the services guaranteed?*
Participation and continual revision	*Do civil, parent, or other community organizations have a concrete role in the design, implementation, and monitoring of the program?*
	Which law or institution guarantees citizens' involvement?
	Are there mechanisms that allow for continual improvement of services?

This sub-guarantee framework is used to examine the experience with health provision in all of the Latin American cases (Chile, Uruguay, Peru, and Guatemala). It is also used to examine

elements of education (Uruguay, Peru, and Guatemala), social protection (Uruguay), food policy (Peru), and housing (South Africa). The South Africa experience on the right to shelter, which has had a significant impact on housing policy, has also been included as it reveals very relevant evidence of the use of judicial mechanisms to support social and economic rights.

III. COUNTRY CASES: APPLYING THE SOCIAL GUARANTEE LENS

25. The country case analysis uses the notion of social guarantee and related sub-guarantees to examine the link between their formal (legal, institutional, policy, or fiscal) aspects and their actual results. The analysis does not assume that the countries have used a social guarantee approach to design and implement the programs examined. Rather, it uses the approach to organize the existing information and to track the development and implementation of a specific program in order to understand how it relates to the notion of a social guarantee. While it appears to ask about the formal side of policy (i.e., whether legal, institutional, or instrumental guarantees exist or not), the analysis aims to discuss the mechanisms which these policies have or have not set in place, that allow for the exercise of rights through access to social services. Tracking the existence of sub-guarantees enables us to: (a) identify, from a rights perspective, the mechanisms through which policies and programs facilitate service delivery; (b) highlight the absence of such mechanisms; and most importantly, (c) identify key conditions for and obstacles to the functioning of sub-guarantees.

26. Many of the questions, outlined in the sub-guarantee matrix, do not have 'yes or no' answers. In most of the cases, social guarantees exist only in part. Some are codified by law but lack institutional and/or fiscal support; others are incorporated in the functions of existing programs and institutions without being subject by law to explicit standards of performance. Where sub-guarantees have been integrated into both law and policy, various factors (insufficient information, poor incentives for providers, etc.) may impede citizens from claiming and benefiting from services. These gray areas are analyzed for each sector – health (all four Latin American cases); education (Uruguay, Peru, Guatemala); social protection (Uruguay); food policy (Peru); and housing (South Africa).

27. It is important to stress that the cases do not provide a complete and detailed analysis of sub-guarantees. Certainly, the list of sub-guarantees can be deepened and expanded to include questions such as: Do citizens have a choice of providers? Are there incentives or implemented sanctions to encourage compliance of providers with established norms and standards?, etc. What this exercise highlights, however, through a limited set of questions, is that monitoring social service delivery through a detailed index of social guarantees and sub-guarantees is one way of ensuring that social programs comply with the basic principles of respecting, promoting, and protecting the fundamental rights of citizens.

Chile: Regime of Explicit Health Guarantees **(Plan AUGE)**

Context

28. Chile has long experience implementing various social policy approaches, ranging from welfare and universalistic reforms to a market-oriented system and social protection strategy (Castiglioni 2005; Raczynski 1994, 2000a, 2000b). Its social policy responses to the economic crises have been informed by a broad rights perspective, which has guided the conceptualization of many of its social programs (Abel and Lewis 2002; Filgueira and Lombardi 1995). Few of the social policies conceived with a rights perspective, however, have developed the institutional, programmatic and financial mechanisms to ensure the full protection of the entitlements that these rights imply. It is only recently that the notion of social guarantee has been introduced in Chile as a way to operationalize a rights-based perspective and translate its basic principles into the design, implementation, and evaluation of social programs.

29. Chile stands out in the region for having one of the few practical experiences in this line: the Regime of Explicit Health Guarantees (*Régimen de Garantías Explícitas en Salud,* RGES), also known as Plan AUGE, a curative health program that has been conceived and implemented within a social guarantee framework. This program has been operationalized through an explicit sub-set of guarantees to access, quality, opportunity, and redress and enforcement mechanisms. Although the RGES still faces some challenges, it is a clear case of a social guarantee program that can be used to illustrate some key implementation issues.

30. No other program in Chile has achieved the level of technical development required to be considered a social guarantee program. Most programs in other sectors have only partial characteristics of social guarantees, and have not yet developed the procedures and mechanisms needed to operationalize the notion of guarantees.

The Health System in Chile: Background

31. Prior to 1980, the Chilean health system was fundamentally public, financed through the social security and public funds. After the health reform in 1981, risk insurance was introduced and market mechanisms regulated the level of protection, as in any other insurance market. Since then, a dual system has emerged, where workers "could be affiliated either with the public health system through the National Health Fund (FONASA), whose distribution rationale favors solidarity, or with private health insurance institutions (*Instituciones de Salud Provisional*, ISAPRES) that, in spite of the obligatory nature of the insurance, operate under the logic of private insurance, which is associated with individual risk" (Sojo 2006; see also Hernandez et al. 2005, p. 21, and Drago 2006, p. 27).

32. FONASA offers a universal health plan to its beneficiaries. Given its resource constraints, however, the public system has been unable to ensure timely and quality services. On the other hand, the private system discriminates by financial means, forcing many members to seek attention in the public system when their health plan (based on income) does not cover a particular service or health condition. In the private system, the level of protection is derived, on the one hand, from the amount of monthly contribution or premium, and on the other hand, by the

medical risks associated with each individual (as estimated by their age, sex, family medical history, etc.). There is no minimum standard, and the law allows the exclusion of preexisting health conditions. Therefore, two people paying the same premium, but with different risk levels, receive different coverage and benefits.

33. This situation was criticized, in the 1990s, by civil society organizations, political parties, and professional associations in the health sector, all of which called for structural reforms that would address the needs of the population more adequately (FUNASUPO 1999, p. 33). The main criticisms included:

- The lack of a coherent and consensus-based state policy dealing with health issues;
- The structural segmentation of the health system, resulting in low-income and/or high-risk populations being treated mainly in the public system, while the high-income and/or low-risk population was treated in the private system;
- The health system's failure to account for changes in the demographic and epidemiologic profile of the population, leaving out health conditions linked to the changing lifestyles and aging of the population (see Morales 2005);
- The increasing polarization of health outcomes, with greater and faster rates of improvement among the top quintiles than among poorer sections of the population, which also had a higher prevalence of contagious diseases[5];
- The lack of coverage of certain health conditions for an important segment of ISAPRE's beneficiaries. For example, women of childbearing age were required to either pay higher premium rates or opt for health plans without pregnancy-related coverage; elderly people had lower benefits and coverage unless they opted for higher premiums; and expenses related to HIV/AIDS were also not covered by the private system;
- The over-allocation of resources to healthy and young individuals in the private system, which was resulting in superfluous use of existing resources;
- The under-investment in preventive medicine and health promotion;
- High beneficiary co-payments for services;

[5] Figueroa (1998) notes that "the morbidity and the mortality for tuberculosis respond very directly to the socio-economic determinants. The reality shows us that in health service areas where the rate of indigence is 8.5 percent of the population and that of poverty [is] 20.1 percent, the rates of mortality by tuberculosis rise to 5.5 per hundred thousand habitants, the rates of the morbidity for all the forms of tuberculosis are 56.6 percent per hundred thousand and of pulmonary bacillus tuberculosis, 31 per hundred thousand. On the other hand, in the health services where the rate of indigence is 3.4 percent and of poverty, 10 percent, the rates of mortality only reach 2.9 per hundred thousand, the rates of total morbidity 26.2 per hundred thousand and the rate of morbidity per pulmonary bacillus tuberculosis is only 10.8 per hundred thousand. In other words, where there is more poverty, the mortality of tuberculosis is double and the morbidity is triple compared to where there is less poverty."

- Referral problems in the public sector (primary network versus hospitals), as well as between the public and private sector (lack of entry mechanisms that would allow someone from the public sector to receive services in the private network);

- The lack of modernization of public sector hospitals and health clinics, and long delays in improving the quantity and quality of services available, despite significant increases in the sector's budget;

- The persistence of labor issues, resulting in frequent strikes by health workers.

Opening the Door for Reform

34. It was clear that to address these institutional, regulatory, and demographic problems, the country would have to move away from the dual health system and toward a coordinated mixed system with modern and effective state regulation. The new system would have to protect the health policy goals and objectives of the country in light of the current social context (including beneficiaries' growing awareness of their rights) and the health profile of the population.

35. Early in his term, President Ricardo Lagos established an inter-ministerial committee to study and propose changes to the health system. The committee, which included representatives of the Medical Doctors Professional Association, health workers unions, and private health providers, identified four main challenges – the progressive aging of the population, the increasing cost of health services, the inequalities in the health status of different socio-economic strata, and a health gap among social groups – which would need to be addressed by changing both the composition and quality of services and the mechanisms for their delivery. Based on these challenges, the inter-ministerial committee identified four health sector objectives for the decade 2000-2010: (a) improving existing health indicators; (b) addressing the new demands derived from aging and the changing health profile of the population; (c) closing health gaps and inequalities across socio-economic groups; and (d) improving the scope, access to, and quality of services according to the expectation of the population (Aguilera et al. 2002, p. 3).

36. In 2002 the inter-ministerial committee proposed legislation designed to achieve these objectives.[6] From the beginning of the technical-political debate about the legislation, two strong and conflicting positions emerged regarding the content of the reforms and the way they should move forward. The legislation was rejected by the Medical Doctors Association, which in turn mobilized health workers and caused significant disruption in the health system for about six months. The President stepped in to support the reform, and his involvement resulted in a series of accords with health workers, including projects on a "new institutional structure" and "status of public employees." The new vision was based on the belief that the public and private health sectors could be coordinated and could operate under a common system of rules, to achieve an optimal allocation of existing resources.

37. The reforms in the public system easily found support in the Senate. The proposed reforms to the ISAPRES were modified due to the rejection of the proposal to create a Solidarity Fund that would transfer funds from private affiliates. Thus, the terms of reform left no absolute

[6] The bills included Regime of Guarantees in Health (Plan AUGE); Modification of the Law 2726 of 1979 (Structure of the System); the Institutions of Health Provision (ISAPRE); and Financing of the Fiscal Expenditure Represented by the Plan AUGE.

winners or losers, but were acceptable to multiple stakeholders. Ultimately, all reform projects were approved in both the Senate and the Congress by large majorities.

38. The passage of the reforms can be attributed to: (a) the consistent and energetic role of the Executive Power; (b) the use of communication campaigns to counteract political opposition to the reforms; (c) the use of human rights rhetoric in the discussion of the reforms; (d) the Senate's effort to mediate the conflicting interests of stakeholders and make acceptable modifications; (e) the Government's intervention to mitigate the opposition of health professionals by confronting them directly with the demands made by citizens; and (f) the emergence of mediating actors, such as civil society organizations that managed to involve all political actors in a broader and less politicized discussion" (Drago 2006, p. 54).

Implementing the Reform with Explicit Guarantees

39. The new legal framework on health, passed between 2003 and 2004,[7] was of great significance from both a social policy and a judicial perspective, as it was the first example in the country and Latin American region of the legal installment of a rights-based social guarantee that incorporates and defines the principles of access, quality, opportunity, and financial protection. This framework promoted new mechanisms and mobilized new funding sources for health, which were agreed upon by the majority parties in Parliament; it also established responsible institutions such as the Office of the Superintendent for Health, a new ministerial-level health sub-secretariat, and local consultative councils. Most significantly, the framework included the Regime of Explicit Health Guarantees (AUGE), which guarantees a certain set of services for all users.[8] It prioritizes health problems based on the epidemiological danger they present and the feasibility of solutions; defines the medical response for each disease and condition; and emphasizes prevention, early examination of symptoms, and primary care. In addition, the Regime defines a maximum waiting period for receiving services at each stage (the sub-guarantee of "opportunity"); the set of activities, procedures, and technologies necessary for treating the medical condition (sub-guarantee of "quality"); and the maximum that a family can spend per year on health (sub-guarantee of "financial protection"). These maximums differ depending on the family's income, thus protecting the principles of equity, inclusion, and redistribution.

40. To determine the medical conditions included in AUGE, health professionals ranked all major health problems according to their frequency, seriousness, and cost of treatment. The principal ranking criterion was the number of years of healthy life lost (*Años de Vida Saludable Perdidos,* AVISA), which combines early mortality with the disability that the disease can cause to those who survive it. Mental health conditions, and conditions that generate partial disability and therefore a significant decline in the quality of life, were also considered priorities.

41. Once the priorities for the health regime were defined according to the indicator of years of healthy life lost, the possibility of affecting the outcomes of the condition through medical treatment was assessed, together with the feasibility of guaranteeing such treatment to all citizens, regardless of their geographic residence and socio-economic status. The latter necessitated a

[7] Laws Nº 19.882 and 19.888, both approved in 2003, regulate, respectively, (i) the new personnel policy for public employees, and (ii) the funancing of the health reform.

[8] The General Regime on Explicit Guarantees was established by Law 19.966. A list of 40 diseases and health conditions, and guaranteed services relating to those conditions, was established by Supreme Decree 228, issued by the Ministry of Health and the Treasury in 2005.

comprehensive analysis of the existing public and private health infrastructure. In addition, the process considered citizens' demands for attention to certain diseases, such as cystic fibrosis. As a result of this process of prioritization, 56 health conditions, accounting for approximately 70 percent of AVISA, were identified.

42. Various mechanisms were discussed for funding the new regime. Ultimately, Law 19.888 stipulated that resources will be derived from: (a) a temporary increase in the consumer tax from 18 to 19 percent between October 1, 2003 and October 1, 2007 (although President Bachelet has extended the tax increase for a longer period)[9]; (b) the tobacco tax; (c) customs revenues; and (d) sale of the state's minority shares in public health enterprises. As additional sources of funding, the reform also considered pre-existing FONASA funds, potential increases in co-payments, budget increases from economic growth, and potential reallocations of resources from other sectors.

43. To mitigate fiscal pressures, the reform was implemented at stages, and considered the progressive addition of medical conditions to the list of priority diseases. The new Health Superintendency absorbed the functions of the previous Superintendent of ISAPRES, and was also placed in charge of the FONASA budget regarding the treatment and services of the guaranteed list of conditions. Thus, this new institution is the first body to supervise public and private funds together.

44. A bill on the "Rights of the Person in the Health System," which included the rights to information, respectful treatment, and similar provisions, was briefly supported in Parliament, yet ultimately not codified in law. The bill was controversial because of its provisions on euthanasia, a living will, and the possibility of refusing therapeutic treatment.

45. Table 2 summarizes the guarantees in the health sector that have existed since the adoption of AUGE.[10]

Table 2. Explicit Social Guarantees in Health Provision – the AUGE Scheme in Chile	
Health	
Access	
Are the beneficiaries and services clearly defined?	Yes, for the 40 diseases listed in the Plan AUGE. The Plan defines explicitly all sub-guarantees of access, quality, opportunity and financial protection, explained above (paragraph 39).
Are there institutional procedures for monitoring access?	The procedures for monitoring access are not sufficiently developed, even though there are ways, in which compliance with access requirements can be verified.
Are there legal or institutional mechanisms that ensure non-discrimination in the access to services?	There are no specific mechanisms. However, access is defined as universal, so it includes the principle of non-discrimination. Furthermore, all individuals, regardless of age, sex, ethnicity, socioeconomic status, etc., have access to the same redress mechanisms.

[9] It should be noted that the one percent increase in the consumer tax constitutes regressive financing and raises serious questions of equity, given that it raises the cost of food and other basic items.
[10] The annex summarizes the legal, institutional, programmatic, and financial dimensions of the guarantees for AUGE and the other cases. In this table and in the other case studies, health services refer mainly to treatment, recovery, and rehabilitation, unless otherwise noted.

	Only illegal immigrants and citizens without identity documents cannot access the services.
Are services guaranteed for the amount of time needed?	Even though there is no explicit guarantee on continuous provision, the Law on AUGE stipulates that treatment services should be provided for the time necessary for the recovery of health. Only for some services is the duration of treatment defined more precisely.
Is there a maximum waiting period for receiving the service?	Yes. The maximum waiting period is specified for all services related to the 40 priority diseases/conditions.
If service is unavailable within this waiting period, is there a guaranteed alternative (in the same time period)?	Yes, an alternative provider is assigned for the priority diseases and conditions defined in AUGE.
Financial Protection	
Do beneficiaries need to contribute to the cost of service?	Yes. The maximum required payments are explicitly defined for each of the 40 medical conditions.
Are services accessible to beneficiaries who cannot contribute to the cost?	Yes, and this is stated explicitly for the 40 priority conditions.
Is this information effectively communicated to the public?	In general, the population knows of the existence of Plan AUGE, mainly from the media, but not all details associated with its services. Health workers inform patients about service options on a case-by-case basis, but there are problems with communicating service options to the public.
Quality	
Are there clear quality standards?	No, because the systems for quality certification, accreditation, and compliance with quality standards have not yet been implemented. The regime considers the establishment of explicit standards, but this guarantee is not yet functional.
Are programs being evaluated on a regular basis?	AUGE considers procedures for accreditation, certification, evaluation, and budgeting, but they are not yet operational and are not codified in written rules. User evaluations have been collected.
Are the standards and evaluation results effectively communicated to the public?	Evaluation results are communicated through the internet and occasionally through the mass media. Information on quality standards is not communicated.
Mechanisms of Redress and Enforcement	
Are there mechanisms allowing citizens to claim adequate provision of the services guaranteed?	Yes. There are institutions, mechanisms, and procedures for claiming the access, quality, opportunity, and financial protection entitlements stipulated in AUGE. Maximum waiting periods for the resolution of claims are also specified.
Participation and Continual Revision	
Do civil, parent, or other	There are no clearly established mechanisms of social accountability and/or

community organizations have a concrete role in the design, implementation, and monitoring of the program?	social monitoring of the program. In the case of public providers of primary health care, there are some mechanisms of participation. In addition, periodic public opinion surveys, conducted at the request of the Superintendent of Health, provide an opportunity for beneficiaries to voice their views.
Which law or institution guarantees citizens' involvement?	There is no specific law to guarantee or regulate citizens' involvement.
Are there mechanisms that allow for continual improvement of services?	Yes. There are institutions, mechanisms, and procedures to revise and modernize services in view of changes in the health/epidemiological profile of the population, the availability of resources, and technological advances, among other criteria.

Results

46. The study found that AUGE has been beneficial to all socio-economic groups, and has been used by more than 3.2 million people (19.6 percent of the population). Lower-income groups (A and B in FONASA) have used the system more (75 percent) than higher-income groups (24.2 percent). ISAPRE subscribers have used AUGE mostly for high-cost treatments; and the middle-income stratum (with incomes between 300,000 and one million pesos) have used it the most (53.3 percent), compared to 24.5 percent of subscribers with incomes higher than 1 million, and 22.2 percent of those with incomes less than 300,000 pesos. Savings from using AUGE reach up to 500,000 pesos per year for diabetes patients and up to one million pesos for patients with severe depression (*Superintendencia de Salud, Chile* 2005).

47. To date, the National Budget Office (*Dirección de Presupuestos de la Nación*)[11] has not conducted a nationwide evaluation that would allow us to estimate the extent to which the objectives of the guarantees regime have been met, given that the regime is relatively recent. However, studies conducted in 2006 by the Initiative for Equity in Health and the Ministry of Health (see, e.g., Barrio 2006) show that despite achievements in maternal and infant health, there have been alarming increases in smoking, obesity, and suicide. While AUGE can be expected to have some impact on reducing these problems, it has yet to have a discernible impact on the mortality rate.

48. Recent surveys of public opinion of the new health system, carried out for the Superintendency of Health,[12] had more positive results. The surveys found that:

- A large percentage of the population is still not aware of the guarantees included in the AUGE. Only 48 percent of respondents were aware of at least one of the explicit guarantees, and 29 percent knew of the existence of all four guarantees;

[11] The National Budget Office, a part of the Treasury, is responsible for allocating resources to ministries and services. It conducts evaluations of spending (and spending controls) for the regular provision of services.

[12] *DataVoz* (2007). The study was conducted by the consulting firm *DataVoz*. The final results are based on interviews with 1,304 persons in their households. The study used a method of sampling and probability, with a level of precision ± 3,0 percent considering maximum variance; 95 percent level of trust; and an estimated error of 1.2. The sample of 1,304 respondents comprised subscribers and other contributors to FONASA and ISAPRES, and Group A beneficiaries of the Health Fund.

- About 80 percent of respondents did not know which diseases are listed in the guarantees regime; and 45 percent said that their physicians did not recommend the use of the guarantees regime, even though they are obliged to do so by law. This constitutes an important obstacle to citizens exercising their right to health care;

- Despite the obstacles mentioned above, 69 percent of interviewees said that health care in the country had improved greatly (21 percent) or somewhat (48 percent) since AUGE's introduction;

- About 39 percent said their health was more protected than before the introduction of AUGE, and 51 percent said it was protected neither more or less. Only 5 percent felt they were protected less than previously;

- According to the survey, the most valued guarantee is access (ranked first by 34 percent), followed by opportunity (23 percent), quality (21 percent), and financial protection (18 percent). Access was ranked first in each socio-economic group;

- Twenty-eight percent of the respondents replied that at least one member of their household has been diagnosed with one of the 40 medical conditions covered by AUGE. The most frequently mentioned were primary arterial hypertension, type 1 diabetes mellitus, depression among adults (15 or older), moderate or severe asthma, and type 2 diabetes mellitus. Of these 28 percent, only 50 percent (14 percent of the total sample) decided to use the services of AUGE[13]. Sixty-four percent of those who were eligible but did not take advantage of the new regime pointed lack of information as the reason. This constitutes an important breach of the right to health;

- Out of the portion of the population who did use AUGE services, 42 percent noticed a difference between the quality of services covered by the regime and those that are not covered. On a scale of 1 to 7 (where 7 represents the highest quality), AUGE services were generally assessed at 5.9 in terms of quality of professionals and personnel, 6.1 in infrastructure, and 6 in terms of hospital/clinic equipment. Subscribers to FONASA gave higher evaluations than did ISAPRE subscribers in two of the three categories. In the third category (equipment), their evaluations were the same;

- In terms of the areas of highest satisfaction with AUGE, both FONASA and ISAPRES subscribers pointed out that the new regime resulted in faster and higher-quality services (60 percent and 59 percent respectively). FONASA clients also mentioned the higher level of personal attention to patients (30 percent), and ISAPRES clients mentioned the reduction in costs (20 percent).

49. These results indicate that AUGE has had some important preliminary impacts on access, efficiency, and people's perceptions of the health system – a satisfactory result given that the regime has only been in force since 2005. From a rights-based perspective, what makes AUGE a rights-based regime – apart from the universal guarantees of access, quality, opportunity, and

[13] Services under AUGE can be provided either in the same same health facilities or different ones, as assigned. The difference is that services under the Plan AUGE are subject to very specific standards and regulations for access, quality, redress, etc.

financial protection – is the presence of an administrative mechanism that allows for the redress and enforcement of health entitlements if and when these guarantees are not being fulfilled (see Box 4)

Box 4. Mechanisms for Redress in Health Provision in Chile – Role of the Superintendent of Health

A survey initiated by the Office of the Superintendent of Health in 2007 analyzes the opinion of AUGE users regarding mechanisms for redress, which are regarded as secondary guarantees that seek to enforce the primary guarantees and correct any violations (Government of Chile 2007). The survey found that:

- For the most part, citizens who have used AUGE have been informed of its mechanisms for redress through the mass media. Five out of ten learned of the redress mechanisms through "general knowledge"; two out of ten learned about it from a health worker, and one out of ten learned from a friend, parent, or acquaintance. Only 48 percent of interviewed persons who have used a redress mechanism consider that sufficient information is available on the system of redress.
- In terms of the waiting period for resolving claims, half of the respondents said they were informed of how long the redress process would take. Thirty-one percent noted that their claims took longer than one and a half months. These results were consistent with the 51-day average set by the Superintendence of Health. The average waiting period for resolving arbitration cases was 74 days, and for administrative cases it was 48 days.
- Fifty-seven percent noted that their cases were delayed beyond the 51-day limit to an average of 99 days. Of the cases that were delayed, arbitration cases took an average of 117 days to resolve. For middle and low-income respondents, the average was 121 days; while for higher-income interviewees, it was 88 days. This gap sheds light on possible inequities in the attention to and resolution of claims on the part of the Superintendence staff.
- Forty-eight percent of respondents considered that the delay in the resolution of their cases was reasonable; 44 percent thought that it was too long, and 6 percent considered the waiting period short. This marks an improvement in perceptions from an earlier survey of August-September 2006.
- Fewer than half of respondents (38 percent) said they had been told how to check on the status of their claims. The system is designed to allow citizens to check on their claims by telephone and internet. The lack of guidance in this respect diminishes the system's effectiveness.
- There are observable differences in the evaluations of different segments of the redress system: citizens who had arbitration cases gave better evaluations than those who used administrative channels for redress.
- A positive aspect of the system is the capacity of the Superintendent of Health's office to communicate with claimants. Nine out of ten respondents indicated that the letter they received about the result of their claim was easy to understand; eight out of ten indicated that it was clear on the steps to be followed to make the resolution effective; seven out of ten said that the letter contained solid arguments supporting the decision
- Six out of ten respondents were satisfied with the resolution of their claims, while four out of ten were not satisfied. Claimants in arbitration cases, men, seniors, high-income claimants, and ISAPRES affiliates were more likely to be satisfied with the results. This issue deserves further research, as it could indicate certain discriminatory practices toward young people, women, and middle and low-income groups. Regardless of the outcome, seven out of ten respondents thought that it was worthwhile to have made the claim, and only three out of ten reported it was not.

Conclusions and Lessons

50. Chile has developed a comprehensive rights-based system (with both access/quality and redress/enforcement dimensions) that avoids solely judicial protections of health rights. Rather than introducing more services for the poor, this system integrates the poor into a universal system; i.e., those who require the most support are enabled to access goods and services on equal terms with the rest of the population. In the first public opinion survey, 42 percent of respondents believed that AUGE benefited mainly public system (FONASA) subscribers, and only 32 percent considered it to be of benefit to the entire population. Two years later, 53 percent of interviewees were convinced that the explicit guarantees regime works in favor of both public and private users, while only 31 percent held that it is primarily a program for the benefit of FONASA users (DataVoz, 2007). Further analysis of AUGE's functioning will provide more specific information about which groups are benefiting most from the program, as well as possible areas of discrimination.

51. In the words of the former Minister of Health, Osvaldo Artaza, a key actor in the approval of the guarantees regime, "A health system based merely on purchasing power or targeted and paternalist assistance programs generates inequity, inefficiency and quality discrepancies. On the contrary, a system that is able to offer universal (basic and modern) services in priority areas, defined through cost-benefit analysis, can promote greatly the sustainable exercise of the human right to health….The guarantee of the right to health, similar to other social guarantees, has meaning only in a democratic society. Democracy is increasingly conceived not only as a political but also a social and economic system that allows simultaneously for growth and equity, for economic development and quality of life.…" (Artaza, 2002).

Guatemala: Striving to Implement the Peace Agreements

Context

52. In Guatemala, the 36-year armed conflict directly impacted the Government's recognition of human rights and its response to specific social needs. The Peace Accords of 1991-1996, drafted with support from the international community, acknowledged that the state was responsible for addressing poverty and for fostering the participation of civil society in policymaking. The Peace Agreements marked the start of a human rights-based approach to social policy design, with particular attention to the needs of women, indigenous people, children, youth, the elderly, and people with disabilities.

53. Since 1996, slow progress has been made toward the fulfillment of these agreements. Economic and social rights, including the obligation of the state to protect and fulfill them, were included in the new Constitution, and during the 1990s were integrated extensively in the country's legislation. The Agreement on Socio-Economic Aspects and the Agrarian Situation (1996) declared the obligation of the state to "provide effective enjoyment, without any discrimination, of the rights to work, to health, to education, to housing, and to the rest of social rights [defined in the Constitution]." These commitments were reiterated in the Law on Social Development (2001) and, operationally, in the Population and Social Development Policy (2002),

which is the only policy in the country for which monitoring and annual reporting is required, in the form of reports to Congress by the Presidential Secretariat for Planning and Programming (SEGEPLAN).

54. The progressive influence of these legal and institutional reforms on social policy has become most evident in the area of civic participation. Channels of participation were formally created in 2002 through the Law on Urban and Rural Development Councils, the Law on Decentralization, and the Municipal Code. To assist local government and community engagement in policymaking, Guatemala has also promoted transparent public financial management and procurement, and extended a real-time internet based system to nearly all central government agencies and more than a third of municipalities (World Bank 2007, p. i). While significant progress has been made in improving budget transparency and ensuring the capacity for informed participation by local actors, major challenges remain to the effective fulfillment of social rights.

55. First, social programs in Guatemala tend to be temporary and targeted to specific groups or issues rather than universal and long term. The Government's strategy for fostering socio-economic development and social cohesion for 2004-2008, *Vamos Guatemala*, reflects the targeted nature of social policy (Gomez 2007). The social component of this strategy, *Guate Solidaria*, has four main objectives: (a) reduce malnutrition, specifically chronic child malnutrition in the municipalities at highest risk; (b) formulate programs to fight extreme poverty; (c) assist out-of-school youth who have not found formal employment; and (d) ensure that the cultural and ethnic diversity of Guatemala's population is reflected in social policy. Under this strategy, the social programs that best capture rights-based principles – e.g., raise awareness of citizens' entitlements, and provide opportunities for participation and redress – cover only selected groups and are not reflective of a larger commitment to achieving equity in the access to basic services. Such programs, including the National Program for Self-Managed Education (PRONADE), and the Program on Reproductive Health, will be discussed below.

56. Second, despite the Government's obligation under the Peace Accords to restructure the national budget in accordance with socio-economic priorities, total public spending is relatively low in Guatemala – 10.5 percent of GDP (due in part to the Government's limited fiscal space; it has the lowest tax base in Central America, at only 9.5 percent of GDP, according to Fukuda-Parr 2007). Further, spending in the major public sectors is not yet progressive with 21 percent of education spending going to children of the poorest quintile of the population, and 11 percent — to the richest quintile (Fukuda-Parr 2007, p.31). Social safety assistance is also regressive in absolute terms, with the richest quintiles receiving a larger percentage of total transfers (Fazio 2002, p.49).

57. In sum, the reforms in the normative social framework in Guatemala over the past decade have not been translated into universal social guarantee programs, although they have contributed to wide awareness of social rights and entitlements. Limited budgets and the fragmented nature of social programming are two major challenges to the fulfillment of social and economic rights in the Guatemalan context. The discussion of social guarantees is not of immediate relevance to increasing the social policy budget, given that adequate funding for social programs is contingent on economic growth, a stronger tax base, and an inter and intra-sectoral redistribution of resources toward public programs. The structure of social programs, on the other hand, can be

analyzed and revisited from a social guarantee perspective, in order to suggest a more coherent and universal design of social service delivery that communicates better economic and social entitlements to all citizens, maintains a focus on equity, and gives citizens the opportunity to claim their entitlements.

58. Table 3 illustrates social guarantees in the education and health sectors; and the following analysis brings in examples from the education, health, and food and nutrition sectors to illustrate breaches in access, quality, financial protection, and redress/enforcement guarantees in social programs that could be remedied if programs were redesigned with a rights-based focus.

Table 3. Assessing Social Guarantees in Education and Health in Guatemala

Sub-Guarantees	Education	Health
	Access	
Are the beneficiaries and services clearly defined?	Yes, for all programs for children 0-16: initial education (2 yrs); pre-primary (3 yrs.); primary (6 yrs.); middle/secondary (3 yrs.). The beneficiaries are also defied for the scholarship, literacy, and special education programs.	Health services through the Ministry of Health are provided for all, though by law priority is given to women, children, youth, seniors, and patients with HIV/AIDS and chronic diseases. Priority is also given to affiliates of the Guatemalan Social Security Institute and their spouses and dependent children.
Are there institutional procedures for monitoring access?	Yes, through enrollment statistics of September 30th and March 30th of each academic year. Access is still limited, particularly in pre-primary (45.2 percent enrolled) and in secondary grades (31.3 percent enrolled); enrollment in the primary grades is 92.41 percent.	No information on regular monitoring mechanisms. Access is low, close to none in rural areas, especially in the north and west, mostly inhabited by indigenous groups. Vaccination programs and programs for control of vector-borne diseases have the widest coverage.
Are there legal or institutional mechanisms that ensure non-discrimination in the access to services?	Bi-lingual schools to provide primary education to indigenous children are administered by the Ministry of Education. There are no specified mechanisms to ensure that this education is obligatory, or to ensure universal coverage.	Medical services cannot be denied. In case of non-compliance, citizens can file claims with the Guatemalan Institute for Social Security (IGSS).
Are services guaranteed for the amount of time needed?	No mechanism guarantees continuous provision. Many students stop attending after the primary grades.	Not specified.
Is there a maximum waiting period for receiving the service?	Not specified.	Immediate emergency attention is guaranteed, yet in reality depends on the capacity of the health center. The IGSS guarantees attention in 2-6 months for general illnesses.
If service is unavailable within this waiting period, what is a guaranteed alternative (in the same time period)?	Not specified.	Private providers are contracted if the IGSS cannot provide care in the specified period or in cases where surgery is urgently needed.

Financial Protection		
Do beneficiaries need to contribute to the cost of service?	There are implicit costs in transportation/ clothes/books that may prevent children from rural areas or low-income families to attend.	Formally, health care and specialized medications are free or at very low cost. In reality, 73 percent of spending for medications is personal spending.
Are services accessible to those who cannot contribute to the cost?	Access is limited due to implicit costs (e.g., transport), lack of school infrastructure at some locations, scarce state funds.	Access is limited due to implicit costs (e.g., transport), lack of school infrastructure at some locations, scarce state funds.
Is this information effectively communicated to the public?	There is no regular information system on the right to education and on the services it entails for citizens.	There is no regular information system on the right to health and on the services it entails for citizens.
Quality		
Are there clear quality standards?	Yes, based on international quality standards (in reading, writing, mathematics) in the pre-primary and primary grades, and in mathematics in the secondary grades.	Yes, based on international standards and "protocols of attention."
Are programs being evaluated on a regular basis?	Yes, term and annual tests are conducted in the primary and secondary grades. Teachers' evaluations are not conducted regularly. The program for self-managed education, PRONADE, has been evaluated.	No information.
Are standards and evaluation results clearly communicated to the public?	No information.	No information.

Mechanisms of Redress and Enforcement		
Are there mechanisms allowing citizens to claim adequate provision of the services guaranteed?	- Prosecutor for Human Rights. No information on cases regarding education. - Services can also be claimed through the Ministry of Education. - Judicially, based on the Protection Law (*Ley de Amparo*)	Prosecutor for Human Rights. No information on specific cases. Judicially, based on the Protection Law (*Ley de Amparo*)
Participation and Continual Revision		
Do civil, parent, or other community organizations have a concrete role in the design, implementation, and monitoring of the program?	The program for self-managed education (PRONADE) allows participation of parents and community members in decision-making regarding teachers' contracts and other education expenses. Parents, teachers and students are obliged to participate.	The Constitution obliges the community to participate in the design, implementation and evaluation of health programs. The Program for Reproductive Health is created with a "participatory character" – not specified concretely.
Which law or institution guarantees citizens' involvement?	Not specified.	The Municipal Code promoted participation through Municipal Councils, represented in the Commissions of Health and in the Development Councils in the Ministry of Education.
Are there mechanisms that allow for continual improvement of services?	There are no formal standard review procedures.	Restructuring and modernization of medical services, as well as administrative reforms, are undertaken but there is no institutional mechanism that guarantees continual revision.

Education

59. The Guatemalan state formally guarantees eight years of minimum education. In practice, however, the large inequities in access that exist among regions and ethnic groups are addressed by a variety of targeted programs, most of which have been introduced and financed by international donors (Box 5). Programs on bilingual education, community-managed schools, scholarships, as well as innovative learning and evaluation projects, have had a notable impact on increasing the access, quality, and civic engagement in education for vulnerable groups (namely women and indigenous). However, in their totality they do not represent a coherent mechanism to guarantee the entitlement to eight-year education of adequate quality to all Guatemalans.

60. The normative framework on education in Guatemala is guided by human rights principles, as well as by the discourse on increasing the country's economic competitiveness by developing a qualified work force for the economy. The Guatemalan Constitution (1993) declares literacy a national priority and states that in areas with predominantly indigenous population priority should be given to bilingual teaching methods.[14] The education strategy,

[14] "*Articulo 74: …En las escuelas establecidas en zonas de predominante población indígena, la enseñanza deberá impartirse preferentemente en forma bilingüe."*

Visión Educación, has two distinct policy aims: (i) to improve the quality, efficiency, and coverage of primary and secondary education; and (ii) to increase the participation of various social groups in decisionmaking for and monitoring of education programs. The Accords on the Resettlement of Displaced Persons and on the Rights and Identity of Indigenous People committed the state to implement decentralization in education in order to respond to various cultural needs and to increase civil participation. One expression of this commitment has been the evolution of the National Program for Self-Managed Education (PRONADE) since 1992 (World Bank 2005b).

Box 5. Inovation in Education through Donor and State-funded Programs

True to the principles of *subsidiariedad* (subsidiarity) and *gradualidad* (progressive achievement), which are at the heart of *Visión Educación*, progress in education in Guatemala has been achieved through a variety of targeted programs: the Program of Multi-grade Schools, combining more than one grade in a single classroom, which has been successful in rural areas with indigenous populations (Fazio 2002, p. 54); the programs APRENDO and Saving the First Grade, seeking innovative ways to raise the quality of learning; and the National Program of Self-Managed Education (PRONADE), functioning with active community participation, among others. These targeted programs have brought flexibility to the education system, and helped it to adapt its services to various cultural and geographic environments. The USAID programs on bilingual education and on measuring educational results (MEDIR) are a crucial component for increasing equity in access and quality for indigenous children.

However, funding for many education programs has often been temporary. Such was the case with BECATON, the scholarship program for children of low-income families, launched in 2005, as well as with the 2006 REDODEO DE CAMBIO campaign for installing computers in secondary schools. Even longer-term programs, for which government funding is formally guaranteed, have found themselves dependent on international donors. Examples include the program for school tools (*útiles escolares*), financed by the European Union in 2005, with a small contribution by the Ministry of Education; Saving the First Grade, established with USAID funding; and PRONADE, which was founded and is still strongly reliant on funds from the German Financial Cooperation/KfW (*Kreditanstalt für Wiederaufbau*). Another set of programs has never been budgeted; these include the program for curriculum reform, learning evaluation programs in mathematics and language skills, sports schools, scholarships for academic excellence, program for adults for out-of-school education, municipal centers for capacity building, family education centers for development, and the Mobile Youth Program.

61. The education reforms have partly been impeded by language inconsistencies between the new and old legislation, which has created problems in the way norms and obligations are transferred from the legal to the institutional and instrumental domains. The current Law on Education, for example, is applied through a set of institutional rules corresponding to the old legislation. This set of rules refers to legal norms that are not yet valid and to institutional entities that no longer exist, resulting in a process of "overruling" inconsistencies through new administrative resolutions that affect the efficiency and quality of education, and increase confusion among providers (Gomez 2007).

62. An analysis of some of the most essential sub-dimensions of the right to education – access, quality, financial protection, participation, and continual revision — highlights the areas in which the reforms in Guatemala have advanced, and the aspects in which the sector still lacks the mechanisms necessary to deliver education from a rights perspective (i.e., universally and without discrimination, giving citizens the opportunity to claim their right to education, raising awareness of and complying with established standards of learning).

63. **Access** to education, including basic primary education, is limited. The Net Schooling Rate (*Tasa Neta de Escolaridad*) was estimated from enrollment records at 90 percent in 2005, with coverage of primary education at 93 percent; yet the rate of completion of primary school was only 65.1 percent. The rates of completion fall even more for pre-secondary and secondary school. Only six out of ten children who enroll in the first grade of pre-secondary school (*promedio*) complete the year; for girls the figure is five out of ten. Literacy in 2005 was 82.2 percent, though further research is necessary to determine whether this is predominantly due to lack of access or to low educational quality.[15]

64. The closest approximation of a rights-based approach to providing education is the PRONADE program, introduced in rural indigenous areas, which is strongly participatory and gives communities the freedom to select the language of learning, modify the curriculum, and monitor results. According to a KfW evaluation, PRONADE resulted in a steady growth in enrollment and, to a lower degree, in a drop in grade repetition and drop-out rates, compared to other schools in the country (Di Gropello 2006; KfW 2004).

65. **Quality** of learning appears to be lower in self-managed schools, however, and has not risen by much even when education takes place in a group's native language (Di Gropello 2006). The PRONADE program, acclaimed as a best practice in terms of enrollment, participation, and cultural sensitivity, has a lower quality of learning compared to regular schools because of the limited technical and financial capacity of the responsible communities to monitor quality in the prescribed manner. Further, parents and community leaders lack information on educational standards and methods of evaluation. In addition, many qualified teachers have preferred to work in regular schools, because community involvement in the hiring process is perceived as an infringement on their power.

66. Some innovative methods for measuring quality have been introduced by the USAID project, Saving the First Grade, which trains teachers to track students' progress using standardized tests and assessments, which are recorded on progress charts and shared with parents (USAID 2007).

67. **Continual revision** of educational services has occurred through innovative projects within these programs, even in the absence of legal or administrative mechanisms in place to guarantee updates in the curriculum or teaching methods. For example, Saving the First Grade program has introduced local materials such as corn kernels and "magic worms" made of flexible wire to form letters and incite an interest in learning. It has also a system of inviting parents and community members to share cultural traditions and knowledge, as well as teach children how they can apply the material learned in school to their life at home (USAID 2007). In addition, the Government's APRENDO program has introduced education in citizenship values, as well as innovative learning methods (enhancing students' capacity to absorb new knowledge). At the same time, however, the National Program on Curriculum Reform has been given no budget and is practically inactive.

[15] The estimated literacy rate in 2003 was 70.6 percent (female: 63.3 percent/male: 78 percent) (USAID Guatemala 2004). See also http://www.dsgonline.com/Documents/CountryProfiles/English/GuatemalaEdProf.pdf.

68. **Civic participation** in education, as promoted by the Peace Accords and *Visión Educación*, has increased notably, particularly within PRONADE, which operates through community-based Committees on Education (COEDUCAs). These committees provide for the organized participation of parents, community leaders, and local government authorities in all decisions relevant to their assigned schools – hiring of teachers, maintenance, curriculum development, etc. The program has mobilized significantly parents, educators, and community leaders to engage in decision-making and monitoring of education in the pre-primary and primary grades.

Health

69. The Guatemalan Constitution declares that health is a fundamental human right and that the state is responsible for ensuring access to health services for all citizens without discrimination. The community has the right and responsibility to participate in the planning, implementation, and evaluation of health projects. As in the education sector, multiple laws and Congressional decrees have been issued regarding health care; yet, the lack of clearly defined institutional responsibilities that derive from this normative framework makes it difficult to claim the existence of clear guarantees in health.

70. As in the education sector, the Government's efforts in health care have emphasized civic participation, yet have devoted less attention to establishing nationwide quality standards and evaluations, guaranteeing universal access to an established set of services (entitlements), and strengthening mechanisms for claiming access to those services.

71. The Program on Reproductive Health is an example of a program that reflects some elements of a rights-based perspective within the health sector as it incorporates strongly civil society participation and raises public awareness on health issues. This program has both legal[16] and administrative[17] grounding, which ensures its sustainability across changes in government. Its services include information and education regarding family planning, prenatal care, and the prevention of cervical and breast cancer. It also provides medical services in these areas in coordination with the Guatemalan Institute for Social Security.

72. **Access** to the program is limited, due mainly to lack of sufficient funding (it is financed partly by the Ministry of Health and Social Assistance and partly by international donors). There is a large gap in access to medical services – 65.6 percent in urban areas as opposed to 29.5 percent in rural areas; as well in access to medical attention during birth – 57 percent among *mestizo* women and 19.5 percent among indigenous. Access to family planning options shows similar discrepancies: 56.7 percent urban versus 34.7 of rural population. The use of contraceptives among indigenous women is 23.8 percent. There is unmet demand for family planning services among 39.3 percent of indigenous women, 32.3 percent of rural women, and 20.2 percent of urban women.[18]

[16] Law on Social Development (Art. 26); Law on the Dignity and Integral Promotion of Women; Law on Universal and Equitable Access to Family Planning Services and Their Integration in the National Program on Sexual and Reproductive Health (Gomez 2007, p. 50).

[17] Social Development and Population Policy; National Policy for Promotion and Capacity-building of Guatemalan Women; Equity Plan, 2001-2006 – Component on Health. (Gomez 2007, p. 50).

[18] Pan-American Health Organization, *Salud Integral de la Mujer, Salud Sexual y Reproductiva con Énfasis en la Reduccion de la Mortalidad Materna* http://www.ops.org.gt/SFC/Sim/SIM.htm (website accessed on June 20, 2007).

73. In terms of **quality**, the program defines clear norms, sanctions, and enforcement system in cases of bad medical practice. Yet, limited access and financial protection prevent women from utilizing these mechanisms.

74. The success of the program has been mainly in prevention and in raising awareness on reproductive health issues through civil society involvement. Even though the preventive aspect is important, the most frequent causes of maternal mortality in the country have had to do with lack of infrastructure or qualified personnel: 53 percent of maternal deaths occur as a result of hemorrhage, 14.4 percent are caused by infections, 12.1 percent are from hypertension during pregnancy, and 9.5 percent are from abortions (Gomez 2007, p. 51). There is no current information on the program's achievements regarding actual access to services or reduction in maternal mortality.

75. Finally, the Program of Reproductive Health was designed with a **participatory character** – civil society groups play a key role in identifying the issues to be tackled by the program. Women's groups have been instrumental in exerting political pressure for the program to be protected by law and policy so that it is not dependent on the current administration.

Conclusion and Lessons

76. In conclusion, temporary and targeted social programs prevail in Guatemala, making it difficult to discuss social policy results from a rights-based perspective, which would involve an analysis of universal access to entitlements. Following the Peace Accords of 1996, a large part of Guatemala's legal framework was revised to include explicit commitments to the protection and fulfillment of human rights – civil, political, economic, social, and cultural. As a result, the country has developed a comprehensive legal framework with an abundance of references to the rights and obligations of both the state and citizens. Yet, the translation of this legal framework into functioning policies and programs is far from explicit. Few of the laws detail the institutional responsibilities and procedures for each stage of social program development – design, implementation, monitoring, redress, and enforcement.

77. A rights perspective, applied specifically through the social guarantees framework, points to two major areas where the institutional arrangements for social policy delivery in Guatemala could be strengthened. One would be the explicit design of mechanisms of redress to enable citizens to make claims for service provision. The design would need to be sensitive to the major social schism in the country and the high level of social exclusion of the indigenous population, and particularly indigenous women. Communication and mediation into local languages would be a critical component, and communication channels would require a careful, socially literate design. The other would be the more clear definition of institutional responsibilities for the delivery of health and education services.

Peru: The Role of Civil Society

Context

78. Peru's social policy has been directly influenced by its political history, which for almost a century has been characterized by political and social instability, military coups, fragile democracy, and weak institutions. Though the state established and implemented a variety of legal, institutional, instrumental, and financial measures to meet specific social needs during those periods, there was no systematic approach to social service delivery or coherent vision of creating a system of social guarantees. Nevertheless, some of the key normative, institutional and programmatic decisions have resulted in important social improvements and created a potential foundation for a rights-based policy.

79. Peru faces stark poverty and inequality, reflected in drastically different social development indicators between urban and rural areas and racial/ethnic/cultural communities. Indicators measuring child mortality and children's nutritional levels reveal the urban/rural disparities: In 2004, UNICEF determined that child mortality was 24 in every thousand live births in urban areas versus 45 per thousand in rural areas, while 63.4 percent of children under 5 had adequate nutrition in urban areas, versus only 30 percent of their rural counterparts (UNICEF 2004). Urban/rural population distribution also corresponds with racial and ethnic identity, with white/*mestizo* communities more likely to be urbanized than indigenous and Afro-descendant Peruvians (most concentrated on the coast)[19] comprising proportionally more of the impoverished, rural populations. Indigenous populations, 30 percent of whom speak no functional Spanish, occupy the lowest socio-economic position, and half of them live in the five southern Andean regions (Schneider and Zúniga-Hamlin 2005, p. 573). Gender inequality also persists, with women comprising 64 percent of Peru's total illiterate population, the majority of whom are indigenous women.

80. Since the 1990s, social spending in Peru has steadily increased, with the central government significantly enlarging its social expenditures, consolidating federal management of social programs, and encouraging direct engagement by users as a means to mitigate the structural adjustment-induced hardships confronting the population, particular the poor (Cotlear 2006, p. 31). Following Fujimori's ouster in 2000, the transitional government and the new president, Alejandro Toledo, began to explicitly prioritize implementation of a social agenda. The Government broke new ground by initiating the Roundtable for Poverty Reduction, which brought together government, civil society, the private sector, and international donor agencies to reach a multi-sector agreement on social policies, improve efficiency in service delivery, and institutionalize citizen participation in design, decisionmaking, and financial planning for state-sponsored social policy.

81. In the context of stabilizing the country and creating a more just society, the Toledo Government employed the language of human rights and social protection in its social policy legislation. The social policy was based on four main pillars: (a) the Peruvian Social Charter, which established the objectives of creating jobs for everybody, guaranteeing access to health,

[19] Inequality also exists among excluded groups. Afro-descendant Peruvians (between 5-10 percent of the population) are, overall, less poor and have greater access to social services and than do Indigenous Peruvians, when the aggregate populations are compared. Yet both groups are disadvantaged in comparison with white/mestizo Peruvians, and both face ongoing in discrimination that affects their ability to realize their social rights. See Benavides et al. (2006, p. 13).

education, and culture, and creating a state at the service of its people; (b) the Millennium Development Goals; (c) the National Assembly, which brought together political forces and set specific policies for the achievement of equity and social justice; and (d) the Strategy to Overcome Poverty and Develop Economic Opportunities for the Poor (elaborated in 2004), which aimed at creating economic opportunities for the poor and a social protection network; strengthening human, social, and institutional capacities; and promoting transparency and citizens' participation.[20]

82. Of the new social policies implemented, the legislation requiring that local governments formulate budgets in a participatory manner has significant potential to be transformative. Along with ongoing processes to decentralize governance, the new policies fostering participation and local empowerment are increasing the percentage of households that participate in local decisionmaking and the sense of entitlement to be part of the decisionmaking process, particularly among women and youth.[21] However, these laws face significant implementation challenges, such as lack of municipal capacity, opposition from municipalities or traditional community leaders, and the misalignment of community-developed projects with long-term development goals.

83. Since 2006, the new administration of Alan Garcia has enacted additional legislation that has the potential to significantly affect social welfare and human rights. The administration's National Plan for Human Rights 2006-2010, drafted in partnership with representatives from government and civil society, and with inputs from public hearings, frames strategic guidelines to institutionalize rights-based policies and implement affirmative action policies favoring the most vulnerable populations. At the same time, the revision to the NGO Law, approved in December 2006, gives the state Agency of International Cooperation (APCI), the power to supervise NGOs, including human rights NGOs, "in accordance with national development policy and the public interest." As will be demonstrated in the analysis below, much of the programmatic realization of social policy, particularly in the health sector, has relied on NGOs. Therefore, depending on how it is implemented, this law could be an obstacle to the realization of social rights in Peru.

84. Table 4 captures key elements of existing social guarantees and pre-guarantees in Peru relating to education, health and nutrition. Utilizing the sub-guarantees discussed above, the analysis explores how rights-based norms and procedures have, or have not, been integrated into the delivery of social services in each of these areas.

[20] Significant outcomes of this reformulated social policy have included the National Accords (2002), Peru's response to the Millennium Declaration, which continued the efforts of the transitional government and engaged political, religious, civil society, and government organizations in planning to improve equity and social justice; the Organic Laws of Regions and Municipalities (2002), which created minimum standards and participatory institutions to govern local authorities; legislation in 2004 (with complementary norms in 2005) requiring all regions and municipalities to produce participatory budgets; and a cash transfer program for Peru's poorest to develop human capital and break the inter-generational poverty cycle.

[21] See Cotlear (2006) for a discussion of participatory budgeting and laws on decentralization, regional governments, and municipalities.

Table 4. Accessing Social Guarantees in Education, Health and Food in Peru			
Sub-Guarantees	**Education**	**Health**	**Food**
Access			
Are the beneficiaries and services clearly defined?	Yes — children aged 4-16; Basic education (initial, primary and secondary) is guaranteed	Yes for most health programs and strategies.	Yes, for all food programs.
Are there institutional procedures for monitoring access?	By law, the parent associations, APAFAs, are responsible to watch for it. There is no information on actual procedures or statistics of APAFAs intervention.	No, not on a regular basis. (Coverage achieved by the Integrated Health System, SIS was measured in 2006.)	An institutional framework for monitoring food programs exists.[22] The state does receive information on breaches to access.
Are there legal or institutional mechanisms that ensure non-discrimination in the access to services?	APAFAs are responsible for ensuring that no one gets excluded (their effectiveness to this end is questionable, since the parents of excluded children generally have less opportunity to participate in such associations).	The right of access to health is legally guaranteed for all citizens, and an emphasis is placed on citizens with disabilities. There are no special procedures/mechanisms that ensure non-discrimination.	Not specified.
Are services guaranteed for the amount of time needed?	Yes, by law, though there is a high incidence of drop-outs.	Not clearly, and not for all treatments. For hospitalization there is a maximum period of 10 days.	There is no definition of the "amount of time needed."
Is there a maximum waiting period for receiving the service?	Not clearly specified.	No.	No.
If service is unavailable within this waiting period, what is a guaranteed alternative (in the same time period)?	None: Alternative education programs exist for adults who did not complete basic education but they are not a replacement of timely education.	None.	No.
Financial Protection			
Do beneficiaries need to contribute to the cost of service?	Yes, about one-third.	Yes, although Law 26842 declares that services for the poorest will be free and subsidized by the state.	Labor contribution is required.

[22] Unified Regional Registry for Beneficiaries of Social Programs, created by Law 28540. Through it the state is supposed to monitor under-coverage.

Are services accessible to those who cannot contribute to the cost?	Yes by law, though incidence of drop-outs is higher in low income families.	No clear information.	Yes. There are problems of access, discussed below; however they are not related to cost contribution.
Is this information effectively communicated to the public?	Education Ombudsman (*Defensorías Escolares)* APAFAs are also supposed to communicate information to parents.	Some is communicated through NGOs.	Yes, through Mothers' Clubs, People's Canteens/Soup Kitchens, NGOs, community organizations, as well as through women's organizations and social workers.
		Quality	
Are there clear quality standards?	No. While Article 6 of the new *Ley General de Educación* Nº 28044 (Cotlear, 2006) provides a quality education based on standards and norms determined by the Ministry of Education, Peru in fact does not have an operational system of educational standards by which students can measure performance or progress (Guigale et al., 2007, p. 22).	No information, although there are programs and institutions that have an explicit function to ensure quality.[23]	Yes. Ex.: min 207 kcal of milk or equivalent nutrient per ration in the Glass of Milk program.[24]
Are programs being evaluated on a regular basis?	Not by the new evaluation s/m SINEACE. Otherwise the Ministry of Education has performed evaluations for '96, '98, '01, and '04.[25]	Through PANFAR (targeted health and nutrition program for high-risk families) and National Institute of Health. This is not performed in a regular manner and does not encompass all basic health care services.	There is minimum supervision on the ground. Some evaluations are performed by CENAN (*Centro Nacional de Alimentación y Nutrición*).
Are standards and evaluation results clearly communicated to the public?	The Ministry of Education publishes information on results of learning evaluations. Yet, such results are not made available to parents and teachers in each district and school. Many parents and teachers, especially in rural areas, are not aware of how their students perform relative to other schools.	No.	No, many beneficiaries are not aware if the food rations they or their children receive adhere to the nutritional minimum.

[23] Program "Coverage with Quality" – started by USAID and continued by the Government.
[24] See discussion about various actors setting quality standards in the analysis below.
[25] Ministry of Education, Office for Measuring the Quality of Education (*Unidad de Medicion de la Calidad Educativa,* UMC) www.minedu.gob.pe/umc/.

Redress and Enforcement			
Are there mechanisms allowing citizens to claim adequate provision of the services guaranteed?	Yes: - Parent Associations (APAFAs) – not very effective for lack of information and/or resources; - Ombudsman (created in 1993; has offices in every region; attended 46,227 cases Apr-Dec 2005, 4.8 percent of whom were indigenous).	No, despite existing institutions: - INFOSALUD created by the Ombudsman for Health and Transparency; - judiciary[26]; - Ombudsman.	Only as far as informing civil society actors on options for redress through workshops, conducted by the Ombudsman.
Participation and Continual Revision			
Do civil, parent, or community organizations have a concrete role in the design, implementation, and monitoring of the program?	Yes. Parent's Associations and the NGO *Foro Educativo*.	NGO *Foro Salud* (an umbrella NGO for health advocacy organizations).	Mothers' Clubs; Self-Managed Canteens – both have rights of representation and vote in the management and financial decisions of the National Program for Food Assistance (PRONAA).
Which law or institution guarantees citizens' involvement?	Law 28628 regulates the participation of Parents' Associations in educational institutions, including in their evaluation and certification. No institutional body is responsible for guaranteeing participation.	Ministry of Health General Law on Health 26842 (Art. 14) – the state guarantees that everyone has the right to participate individually or collectively in programs for the improvement of health.	Law 27731 (Art. 2) establishes the rights of the above organizations to participate in management and budget decisions regarding food programs. The responsible institution for guaranteeing this right is the Ministry of Women and Social Development.
Are there mechanisms that allow for continual improvement of services?	Not explicitly guaranteed. Programs with related functions are: *Huascarán*, PROMOLIBRO Program for Educational Infrastructure Investments. The incorporation of new technologies in education is guaranteed by law only: Law 28044, Art. 21.	None. Improvements can occur in each hospital through physician's protocols but this process is not guaranteed.	The Unified Registry of Beneficiaries of Social Programs is regularly revised under the supervision of regional governments, and technical support from the Ministry of the Economy and Finances and System for Household Focalization. There is no information whether this mechanism has led to any actual improvements in food programs.

[26] Three cases of judicial redress have become known: two of poor people to whom HIV treatment was refused, and one of a group of women, supported by two NGOs, to whom access to oral contraception was not provided (Vasquez 2007, p. 32). It is impossible to extract information on health cases (unless they become public from other sources) because court registries show only the number of cases presented and whether they have been resolved, but do not desegregate them by sector.

Education

85. The Peruvian state guarantees its citizens a pre-school through secondary education, and has introduced legal, institutional, instrumental, and financial mechanisms to actualize that guarantee. The 1979 Constitution introduced education as a social right (Vásquez 2007, p. 13) and the General Law of Education[27] of 2003 codified that right, charging the Ministry of Education with implementation and managerial responsibilities and establishing that the education provided would be accessible, of measurable quality, equitable, intercultural, inclusive, and available to all regardless of economic means.[28] While this law established commitment in all five areas covered by the sub-guarantees in the above matrix, not all of them are being equally realized.

86. Peru has been successful in providing open educational **access** to its populace, demonstrated by high rates of school enrollment and completion. Since 1970, Peru has consistently provided comprehensive education coverage above the Latin American average, and can tout impressive statistics, particularly for a country of Peru's per capita GDP, with 94 percent primary school completion and 88 percent secondary school completion (Vásquez 2007, p. 21). This locates Peru, in terms of coverage, close to developed country standards (Cotlear 2006, p. 4). This educational availability and accessibility across a widely diverse population is a significant change from the past, and the visibility of school attendance and grade promotion has been a strong indicator for educational attainment. Drop-out rates, however, are significantly higher for children from poor families compared to the non-poor.[29]

87. The fulfillment of the right to access, however, has not corresponded with the availability of **quality** education (Cotlear 2006, p. 4). The General Law of Education considers it a key priority to decrease disparities in quality among public schools; yet it is unclear how that goal is being pursued in practice. During the same 30-year period that Peru's educational coverage has steadily expanded, student achievement has been markedly low (Cotlear 2006, Guigale 2007).[30] The World Bank's 2006 study, "A New Social Contract for Peru," asserts that the low achievement of Peruvian students has resulted in large part from the Government putting a higher priority on expanding coverage than on improving the quality of the education provided (Cotlear 2006, p. 4).

88. A study by the Ministry of Education also revealed a bleak picture (Ministry of Education 2004). For graduates of primary school, fewer than 8 percent of students possessed adequate basic language and mathematical skills; and language and math skills fell far below basic levels for 75 percent and 43 percent, respectively. For secondary school graduates, fewer than 24 percent tested satisfactory in language skills, and fewer than 5 percent exhibited sufficient math skills (Vásquez 2007, p. 16). These evaluations show that while Peru is actively realizing the sub-guarantee of access, the education provided is not of sufficient quality for adequate skill-

[27] *ibid.*

[28] Peru's General Law of Education 28044 http://www.educared.edu.pe/general/mundo2/243/conozca-la-nueva-ley-general-de-educacion-n-28044/.

[29] See World Bank (2005c).

[30] International education measurement tools, such as the Program for International Student Assessment (PISA), ranked Peruvian students below the Latin American average for reading and overall academic performance. Among the 41 countries participating in the assessment, Peru ranked last (Guigale 2007, p. 21).

building, with the result that Peruvians are "very well schooled but very poorly educated" (Guigale 2007, p. 21).

89. As noted above, the General Law of Education states that the Ministry of Education will establish "standards and norms for each level and modality of the Peruvian educational system…in order to provide a quality education" (Article 3).[31] Yet, Peru has not created or implemented a unified standard for measuring and monitoring educational quality. Ministerial Resolution 168 provides that education centers "have the autonomy to disseminate indicators, criteria and instruments of auto-evaluation to measure learning … in order to make adequate decisions for improving quality and equity." However, it does not *oblige* them to do so, and because there are no national standards against which these centers can manage learning, it is unclear how they even would measure performance. To address these problems and operationalize the guarantee of quality, two programs with overlapping functions were consequently created to operationalize the guarantee of quality – the Unit for Measuring Quality of Education, and the National System for Evaluation, Accreditation and Certification of the Quality of Education (SINEACE). SINEACE, the more comprehensive mechanism of the two, is not yet functional. This lack of operational standards has serious implications for Peru's realization of education as a social guarantee.

90. With regard to the guarantee of **financial protection**, Article 16 of the 1993 Constitution makes education a priority for public spending, and Article 3 of the General Law of Education establishes the government's duty to ensure that no citizen be prevented from receiving adequate education for reasons relating to his/her economic status. However, there appears to be insufficient budget allocation to effectively fulfill this guarantee. Peru's public educational expenditure for 2002-2004, as a percentage of total government expenditure, was low for the region (Vásquez 2007, p. 22). For pre-primary and primary education in 2002-2004, it was 17.1 percent of total government expenditure, compared to 18.1 percent in Bolivia, 18.5 in Chile, and 20 percent in El Salvador – though it is still higher than in Colombia, Argentina, Nicaragua, and Paraguay (World Development Report 2006). Of this minimal budget allocation for education, 90 percent of the budget for primary and secondary education has been channeled to payroll expenses, leaving only 10 percent for investment in educational resources, educational facilities (school buildings, classrooms, maintenance) teacher training, monitoring and evaluation, and other areas necessary for the provision of high quality educational services.[32] The minimal resources have translated in some parts of Peru into providing fewer instructional hours in poorly maintained facilities, especially for the most isolated populations (Vásquez 2007, p. 22). Yet, even with such a high proportion of financial resources allocated to payroll, teacher salaries have decreased as coverage has increased. Between 1982 and 2002, an 85 percent increase in teacher hiring was accompanied only by a 5 percent increase in education spending (Vásquez 2007, p. 18).

91. The government funding available appears to cover only about two-thirds of actual public education spending, meaning that parental contributions must cover one third or more, depending on the area of Peru, of public education costs. This raises doubts about the reality of open access for low-income students, since financial hardship might hinder their ability to attend school over

[31]Peru's General Law of Education 28044 http://www.educared.edu.pe/general/mundo2/243/conozca-la-nueva-ley-general-de-educacion-n-28044/.

[32] See *The Education Sector in Peru*. Public Expenditure Tracking Survey, p. iii (Instituto Apoyo 2002).

the long term. Indeed, there is a clear difference between continued school attendance in urban and rural areas, with 76.2 percent of urban youth between 12-16 years old attending secondary school, versus 48.9 percent of rural youth (Ramirez 2004, p. 346). Even within rural communities, there are notable discrepancies in enrollment rates between non-indigenous and indigenous youth, and for children from female-headed households (Sanchez-Paramo 2007).

92. The primary **mechanisms for redressing** inadequacies within the school system include Parent Associations (APAFAs) and an Ombudsman, created in 1993, who has offices in each region. The APAFAs, authorized by Law 28628 (Law on the Participation of Parents' Associations in Public Educational Institutions),[33] were created to offer both a mechanism to rectify problems within the education system and a means for community participation. Though these associations give parents the unlimited right to pursue grievances, the majority of APAFAs have not been active in addressing quality concerns. Parental inaction has been attributed to the fact that Peru possesses neither a culture of evaluation nor a set of official achievement standards by which to assess student progress. This lack of established standards impedes the ability of both parents and officials to understand and assess student performance (in relation to grade level and subject area); as well as how funds are invested (regarding management, administration, teacher training, etc.). As expressed by Guigale et al. (2002), in *An Opportunity for a Different Peru,* "since there is no official literacy standard, or actual official data to compare against the standard, there is no social pressure to improve reading skills." Even with the implementation of some domestic evaluations, such as the 2004 Ministry of Education study mentioned above, the lack of established standards against which the results can be measured limits the ability of students, parents, and even government to hold the system accountable for the services it provides. This helps to explain why many parents surveyed have expressed little or no dissatisfaction with students' low educational achievement and skill level, and why few APAFAs have mobilized to use the mechanisms available to them to address the problem.

93. The lack of nationwide scholastic standards also contributes to inequality, since parents' ability to interpret scholastic performance relies on their own capacity to obtain educational information. This situation privileges higher-income and urban groups, which will more likely have independent means of assessing their children's performance in the context of their communities' educational provision, and therefore are better able to use the redress and revision mechanisms available through their APAFA to advocate for improvements.

94. Recent decentralization within public education has the potential to offer new opportunities for participation and local power-sharing in monitoring and addressing quality issues. Yet in the absence of a culture of evaluation and national standards against which results can be measured, decentralization carries with it the risk of exacerbating quality disparities. Those communities with the lowest educational achievement are less likely to have the means to access resources by which they can begin to hold schools and teachers accountable.

95. Bilingual education programs have been one way to address problems of access and, to a lower degree, quality. Since the 1970s, there has been normative recognition of the need for bi-lingual and intercultural education for Peru's sizeable indigenous population. Beginning in 1972 with the Education Reform Law and the National Policy for Bilingual Education, and re-confirmed by the 1993 Constitution and the General Law of Education, Peru has committed to

[33] EDUCARED, Peru, http://www.educared.edu.pe/directivos/gestion.asp?id_articulo=806.

providing intercultural and bi-lingual education at all education levels. An important part of this commitment is a dedication to preserve indigenous cultural traditions within the curriculum, while also providing skill-building equal to that which the rest of the population accesses (Vásquez 2007, p. 74-76). Article 19 of the General Law on Education specifically uses rights language, asserting that Peru's mandated right to education will be ensured for its indigenous communities, specifically by "establishing special programs"[34] that meet their unique needs, such as text books in the vernacular and instruction in Spanish as a second language.

96. While institutions such as the Ministry of Education and initiatives such as the Program for Bilingual and Intercultural Education were created to implement this mandate, bilingual and inter-cultural education and schooling for indigenous youth in Peru remains, in reality, at a pre-guarantee level. At most, 10 percent of students whose mother language is indigenous have access to bilingual education; and for those living in rural zones (the majority), inter-cultural education does not go beyond the primary level (Vasquez, 2007 p. 78). For those who do not have access to bilingual schools, there are other barriers to receiving quality education in addition to linguistic and cultural obstacles. On average, indigenous students face far longer commutes to the nearest school (Vásquez 2007, p. 79). Another study (Hernandez-Zavala et al. 2006) revealed that, on average, the teaching staff serving indigenous communities had significantly lower levels of education and fewer years of instructional experience. The impact of these factors can be seen in the significant discrepancies between indigenous and non-indigenous skill levels in core subjects such as mathematics and Spanish.

Health

97. Peru has a rights-based legal framework for health promotion, although it emphasizes individual rather than state responsibility in fulfilling that right. The 1993 Constitution (Article 7) and the General Law on Health (Law 26842) of 1997 state that citizens have the right to participate individually or collectively in health-improving activities; but neither establishes the right of an individual to a healthy life (Vásquez 2007, p. 28). The current framework is actually a step backwards in terms of rights-based norms in Peru, since the 1979 Constitution had established the right of all citizens to health care (Vásquez 2007, p. 27). Yet, even though the Ministry of Health (MINSA) currently operates without rights-based underpinnings, it has institutionalized health pre-guarantees in its strategic policy, asserting "that health is an inalienable right for human beings," to be supported by all sectors of the government (Vásquez 2007, p. 28). In addition, the General Law on Health requires the state to disseminate relevant health information, stipulating that "every individual has the right to be adequately informed by health authorities on measures and best practices regarding hygiene, nutrition, mental health and a healthy lifestyle" (Vásquez 2007, p. 27). The state has implemented several health promotion programs based explicitly on a rights perspective, considering the "individual and not the disease" as the focus of attention.[35]

98. The General Law on Health guarantees all Peruvians "unhindered access to health." The public health sector comprises the Ministry of Health (MINSA), the national Social Security in Health Company (ESSALUD), and the health care units of the Armed Forces and the National Police. MINSA provides the majority of services utilized by the poor, particularly those living in

[34] http://www.educared.edu.pe/general/mundo2/243/conozca-la-nueva-ley-general-de-educacion-n-28044/.
[35] Statement on the Model for Integrated Attention to Health [MAIS] program; see Aliaga 2003, p. 207.

rural areas, although it manages less funding than ESSALUD (Perez et al. 2006, p. 112). As in education, Peru has achieved relatively high coverage levels for health services, most markedly in pediatric interventions such as immunization provision and care for respiratory infections (Cotlear 2006, p. 6). Particularly between 1996 and 2006, Peru implemented several new health programs of significant scale, including the construction of new hospitals and health centers. Yet even with improved coverage, **access** to care is still a significant concern, and is considered a key factor in the inequality in health outcomes, particularly between urban and historically isolated populations. The majority of health resources are concentrated in Lima and the Lima district, particularly specialized care (Perez 2007, p. 116). Even so, the 2003 Living Standards Measurement Survey (LSMS) found that geography is less of an obstacle to accessing health services than it once was. Rather than coverage, the main impediment to access has become cost. One in two Peruvians does not have insurance coverage (Guigale et al. 2007, p. 23); and of the 13.4 million people captured by LSMS as having suffered an illness in 2003, only 62 percent received medical treatment. Of those who did not access care, approximately two-thirds cited the inability to pay (Cotlear 2006, p. 8).

99. **Financial protection** for health does exist in Peru, although it is not based on a rights perspective. Peru's General Law on Health guarantees financial protection for those with minimal resources, asserting that state financing will be preferentially oriented to subsidize (partially or fully) health care for those without other public or private means to pay for service. In addition, MINSA's governing objectives ensure financial coverage for the poor, and the state-sponsored program of insurance for the poor (the Integrated Health System, SIS), along with other state-supported funds, ensure free or subsidized health services for the poor. SIS boasts 9 million affiliated constituents; however, even with the normative and institutional guarantees, the financial protection available is not reaching all who qualify (Vásquez 2007, p. 47). One reason could be widespread unawareness among the poorest communities of their health rights and available support services (Vásquez 2007, p. 47). It is not clear how the state disseminates information about what comprises this assistance or how to access it. Therefore, even with the promise of financial protection, the reality remains that the poor are 4.8 times more likely than the better-off ***not*** to receive health care, and citizens are put in the position where they must finance 39 percent of their health expenses, with most of this going for medication (Perez, et. al. 2006, p. 107).

100. Article 8 of Peru's Ministry of Health Law (Law 27657) guarantees that health provision will be of "good quality" according to medical and scientific criteria. Yet in practice, few guiding standards exist in Peru's health industry, from health care provision to research to regulation, by which to evaluate quality (Vásquez 2007, p. 34; Cotlear 2006, p. 37). In addition, the information systems that capture health statistics used to measure outcomes are weak, because of underdeveloped monitoring practices and other challenges in data collection gathering (Cotlear 2006, p. 37). Hospital operations offer only minimal transparency, which interferes with evaluation and accountability, whether the issue is the use of public money, comparing health outcomes across regions, or staff hiring and firing. Moreover, MINSA does not control its own budget, unlike other government ministries, which means it is less able to improve quality when it learns of weaknesses in its programming or to pursue other mechanisms for revision (Perez 2007, p. 130). Since the majority of health services for the poor are provided through MINSA, this lack of budgetary control directly affects their health programs. The public's lack of awareness

(among doctors and patients) about service quality entitlements, and the ability to pursue redress for poor service in some hospitals exacerbates these quality concerns.

101. Peru's normative framework does not include a guaranteed right to **mechanisms for redress**. While the General Law of Health states that "all people have the right to demand that health authorities disseminate pertinent health information (Vásquez 2007, p. 34), no norms have been instituted mandating that citizens have channels to claim their rights to health services. Yet because Article 7 of the 1993 Constitution establishes citizens' right to participate in health services, NGOs have been able to assist some individuals who have been denied care to pursue recourse through Peru's judicial system (see footnote 26 in Table 4). Citizens can also turn to the Ombudsman for assistance in accessing health services to which they believe they are entitled; though in reality, the public does not have a clear understanding of the system's decisionmaking processes or how to use the Ombudsman's administrative mechanisms for redress.

Food Policy

102. Nutritional support and food assistance programs comprise one component of Peru's overall health policies. They represent about 0.4 percent of GDP and reach approximately 9.5 million beneficiaries (Cotlear 2006, p.26). This aspect of health is not legally or normatively recognized as a fundamental right for citizens, but instead is included in the 1993 Constitution as a parent's responsibility on behalf of his/her child. Rights-based obligations, therefore, do not drive the state's nutritional initiatives; instead, food services to the public have been guided primarily by changing political priorities. Over the past 30 years, the government's strategy has evolved from functioning primarily as a coordinating body for externally supplied aid (1970s), to launching targeted direct assistance not necessarily coordinated with non-governmental service providers (1980s), to institutionalizing collaboration with civil society food providers under federal management to improve implementation (1990s). In the past decade, there has been an increase in initiatives that provide food support to vulnerable and disadvantaged groups as a means to guarantee the right to nutritional health. While not underpinned by law, this rights-based philosophy has shaped program design and implementation and justified decisions to protect budget allotments for certain programs.

103. State intervention to improve citizens' nutritional health began in 1972, with the establishment of the National Office for Food Support (ONAA) to coordinate international food assistance (reception, transport, and dissemination); followed in 1974 by the creation of the Ministry of Nourishment to improve nutrition by better harmonizing food production and consumption (World Bank 1993, p. 44).[36] In the 1980s, the government expanded its nutritional support, transitioning from functioning primarily as a coordinating agency to administering government-sponsored food programs. These programs included: the Direct Assistance Program (PAD) for employment-based food assistance; and the Glass of Milk Program to meet the nutritional needs of at-risk children under 6 years old. In the 1990s, as part of the overall social policy expansion in the face of structural adjustment, funding for nutritional support increased and existing programs were concentrated under the management of the Ministry of the President. This included merging PAD and ONAA into the National Program for Food Assistance

[36] These initial programs were weak and plagued with problems. The Ministry of Nourishment closed not long after its founding, and the ONAA managed to coordinate only a fraction of incoming food aid, while different networks of NGOs held the bulk of responsibility and distributed far larger volumes of food support and reached more beneficiaries.

(PRONAA) to create one central government initiative through which most other food programs would be managed (Glass of Milk is managed separately).

104. Peru's nutritional health programs have had two important achievements: establishing laws and norms that promote active citizen **participation** in implementation and decisionmaking; and protecting **programs' budgetary allocations**. Glass of Milk's legal framework, Law 27460, protects the program's resources from fluctuating economic cycles and changes in political decisionmaking. That Law also implemented decentralized administration, with mandated civil society representation. Since community groups, primarily made up of mothers of beneficiaries, handle the bulk of preparation and distribution for the government-funded program, their inclusion in management means that the people most aware of operational challenges and opportunities have a central role in decisionmaking. In forming PRONAA, the government also recognized the critical role of community-based food programs in nutritional assistance by passing Law 27732, which institutionalized civil society involvement in the design, implementation, budgetary decisionmaking, and revision of nutritional programs. The laws underpinning both Glass of Milk and PRONAA prioritize public "voice and vote" which establishes conditions in which beneficiaries can pursue redress when they believe their needs are not being adequately met. In addition, Law 27740 establishes basic quality standards, including a nutritional minimal (determined by the National Institute of Health and usually set at 207 kcal per ration[37]) to be provided 7 days a week and by which service quality is to be evaluated.

105. Yet even these programs, administered with increased resources, a rights-based philosophy, protected budget lines, participatory governance structures, and measurable quality standards, have had minimal impact on reducing malnutrition in Peru, which continues to afflict one in three children under five years old (UNICEF 2004). One factor has been low utilization rates among eligible Peruvians, which translates into minimal **access**. As a result, even with a coverage level of 68 percent in 2005, only 28 percent of those eligible actually benefited from the program (Vásquez 2007, p.68). For the citizen canteens managed under PRONAA, the results have been better, but still with a large gap between coverage and utilization – 97 percent and 36 percent, respectively (Vásquez 2007, p. 63). Another factor is inadequate funding, which minimizes the benefits of **financial protection.** Though government resources for nutritional health have steadily increased since the 1990s, Peru still allocates less than the regional average to its food programs. Even with institutionalized financial protection, for instance for the Glass of Milk program, the resources available remain inadequate because the funding allotment, while protected, remains at a level insufficient to effectively reach all those in need.

106. Another issue is that citizen participation in program decisionmaking has had some negative results. Law 27470's expansion of Glass of Milk to include 6-13 year olds and the elderly could be seen as an attempt to increase coverage in response to beneficiary input. On closer examination, however, one can see that many of those children in the upper age bracket were not new participants, but youth who had aged out of the initial program, most of them from families involved in program implementation who wanted their children to continue receiving services. In addition, this reallocation of services to older youth has meant that fewer children 6 and under receive nutritional support from Glass of Milk, the age group targeted because of how critical these formative years are for human development. This situation demonstrates that even

[37] Centro Peruano de Estudios Sociales. "El Sector Lacteo en Peru y en el Mundo," http://www.cepes.org.pe/cendoc/cultivos/ leche/20031100/20031100.htm. Website accessed on May 15, 2007.

mandated participation can become exclusionary, benefiting community members empowered in leadership roles at the expense of the rest of the community. The conclusion should not be that participation is problematic, but instead that management and monitoring mechanisms must accompany active community participation to ensure that objectives continue to be met and that those who participate cannot take advantage of the power gained through their direct involvement.

107. Even for those able to access the programs, it is unclear whether the interventions are significant enough to adequately nourish the undernourished. The programs have been criticized as “food and not nutrition programs” (Vásquez 2007, p. 64), since the **quality** standards for the food distributed are not necessarily sufficient to transform an individual’s overall nutritional level, and distribution is not connected to any other kinds of education or health interventions that could augment the effects (Cotlear 2006, p. 39).

108. The effectiveness of **mechanisms for redress** varies significantly. On the local level, where community participation is encouraged and promoted, members can address issues as they arise with the implementing civil society organizations in efficient, transparent processes. However, the mechanisms for addressing problems with local and federal government partners have proven to be inaccessible and ineffective. In principle, citizens are educated about available mechanisms for redress at higher levels by civil society groups, which receive training from the Ombudsman (Defensoría del Pueblo 2006). Yet, in reality, the ability of citizens to even learn of these mechanisms depends entirely on whether civil society groups are present and active in a given region and have the capacity to disseminate such information. Even if civil society activity is strong in a given area, there is no functional mechanism through which the Ombudsman, PRONAA, or Glass of Milk administrators and civil society can collaborate to resolve complaints. Further, since it appears that the Ombudsman does not track such complaints, it is unclear how many complaints are being filed and what are the areas of dissatisfaction (Vásquez 2007, p. 58).

Conclusion and Lessons

109. The three sectors reviewed in the Peru study all suggest limitations to the intention to implement a social policy that fulfills fundamental social and economic rights. In the education sector, the weakness of quality standards throughout the system undermines the effectiveness of a school system which delivers impressive levels of access. Peruvians’ capacity to intervene to claim improvements in quality is restricted by the lack of information on educational quality, and the lack of established scholastic standards by which student progress can be measured. In the health sector, the lack of information on rights, as well as inaccessible and ineffective redress mechanisms have resulted in substantial inequalities in access to health care. In relation to food policy, while key programs have been designed with strong participatory mechanisms at the local level, such mechanisms have proven inaccessible or ineffective at higher decisionmaking levels. The evidence suggests that this hampers the capacity of citizens to make claims for access, and to exert pressure for improved effectiveness and quality.

Uruguay: Revising an Established Social Contract

Context

110. Uruguay is the country with both the greatest political stability and the strongest welfare tradition in the region. It has been committed to the achievement of access to specific social services, while actively pursuing goals of economic growth. It also has the smallest gap between rich and poor, a very active society, and strong middle class. In the early 1900s, Uruguay made significant progress with regard to the labor rights of women and children (children under the age of 13 were not eligible to work, and those under 19 years of age would have shorter working hours); and limited the maximum number of working hours per week. By the 1930s, Uruguay was considered a modern country, with a well-established middle class and a high level of literacy.

111. Uruguay's political institutions have also enjoyed support and legitimacy from the citizenry, with the exception of a 12-year military regime (1973 to 1985) that was ended by the financial and economic crises of the 1980s.

112. With the election of President Tabaré Vázquez in 2005, there has been a renewed emphasis on social issues, driven mainly by the critical situation in employment, the drastic fall in real wages, and the increase numbers of people living in poverty. The newly created national Ministry for Social Development is responsible for the development and implementation of programs, policies, and strategies for youth, women and families, the elderly, and people with disabilities. It is also in charge of coordinating the Executive's actions aimed at guaranteeing the full exercise of social rights to nutrition, education, health, housing, work, social security, nondiscrimination, and the enjoyment of a healthy environment. The Ministry for Social Development also chairs the newly created Social Cabinet, which comprises the Ministers of Economy and Finance, Education and Culture, Labor and Social Security, Public Health, Housing, Territorial Mapping, and Environment. The Cabinet's main function is to develop integrated social policies, define priorities, and ensure their funding. An Emergency Plan has also been put in place to address the nutrition, health, and education needs of people living in extreme poverty.

113. Social policy in Uruguay reflects a system of entitlements based on an old corporatist welfare model. Since the 1930s,[38] the system has evolved to respond to the needs of an industrial society with a stable family structure, in which benefits associated with the salary of formally employed heads of family reached the majority of the population. With globalization, a move toward more flexible labor markets, and a less stable family structure, however, new social risks have emerged, having to do with income instability, polarized fertility trends, residential segmentation, as well as an increasing segmentation of the quality of services and opportunities for accessing them. This new reality calls for reforms in social policy in order to reestablish equity among various groups.

[38] The first child welfare code in Uruguay was approved in 1934 (see Pilotti 1999).

114. Three main socio-economic strata can be distinguished in Uruguay's current fragmented society: (a) an "old state" or corporatist stratum, comprising 32.4 percent of the population, mostly elderly and retired citizens relying on benefits; (b) a private sector stratum, 27.7 percent of the population with few or no children and higher than average income; and (c) a vulnerable stratum, 39.9 percent of the population, with few two-parent families, many minors, and few opportunities for formal employment with accompanying state benefits. A marked generational discrepancy in poverty has also emerged. The likelihood of children under 5 being poor is about ten times higher than that for seniors above the age of 65.

115. This "juvenilization of poverty" in Uruguay can be attributed in part to the obsolete system of social protection that, on the one hand, allows for organized participation and contains strict guarantees for pensioners; and the other, has a weaker structure and allows almost no participation in decision-making for vulnerable families with children. Civil agency and the capacity to organize and claim rights are generally high in Uruguay, but only for certain segments of the population. Middle class groups, mainly formal employees and the retired, are traditionally the most mobilized, and exert the most pressure on social policy decisions. Given the new social challenges in the country, however, it is necessary to redesign social policy guarantees and social programs to consider the interests of the more vulnerable and less organized groups.

116. Some elements of a rights-based reform in social policy can be addressed through technical means, e.g., by establishing legal and administrative guarantees with regard to access, quality, civic participation, etc. For the reforms to be successful, however, a new fiscal pact will have to be reached among all major political, social, and economic actors. There is no universal answer for how a fiscal pact should be redrawn – in Uruguay it could occur as a result of economic growth, increased tax revenue, and/or a redistribution of public spending allocations (as already proposed in a health sector reform pending Congressional approval). Increasing social spending is another option; yet Uruguay already has the highest social spending in Latin America, with the exception of Cuba. Uruguay's social spending could also achieve a greater impact through reformulated entitlement structures and resource distribution. While a fiscal pact is generally seen as a pre-requisite for rights-based policies, a focus on rights can, in itself, serve as an instrument to achieve a fiscal pact by (a) encouraging civil participation and a wider public discourse on prioritizing equity and universal needs through social policy; and by (b) creating channels through which all citizens can claim the fulfillment of entitlements.

117. Table 5 summarizes some elements of Uruguay's existing pre-guarantees in education, health, and social security programs. The analysis that follows highlights some discrepancies in pre-guarantee levels within each sector, and suggests directions in which social guarantees can be developed further in order to strengthen the accountability of social programs and their positive impact on social equity.

Table 5. Accessing Social Guarantees in Education, Health and Social Security in Uruguay			
	Education	**Health**	**Social Security (Pension System and Family Allowances)**
		Access	
Are the beneficiaries and services clearly defined?	Children between 4 and 17 years old.	All citizens but the type of benefits covered depends on income, type of employment (formal or informal) and, for individual subscribers to health insurance — on age and medical condition. A basic set of immunizations, pre and post-natal care for mothers and infants, and chronic disease treatment are universally guaranteed.	Pension – yes, through formal labor history. There are also need-based pensions that are given without contributions or pensions based on semi-contribution. Family allowances – families with children, and families below a certain income.
Are there institutional procedures for monitoring access?	Yes, through enrollment statistics in primary and secondary grades (by *Gerencia de Indicación y Evaluación*) – the results are compared to household surveys to determine how many children in a given age group have not enrolled. This system, however, only monitors enrollment not actual attendance. Social security allowances for families with children are received of the condition that the child attends school (school verification is required)	Yes, pre-natal check-ups and health care for mothers with infants is monitored through pediatric cards. The Ministry of Social Development performs close-up, house-by-house, monitoring for populations at risk (determined by territorial indicators.) Teenage pregnancies are especially monitored (receive care via the INFAMILIA program of the Ministry of Social Development); a system against omission exists, including a recent judicial case in which a teenage pregnant woman, not receiving service by INFAMILIA, was identified and enrolled in the program.	Labor history for the pension system. Strict monitoring system for family allowances has been introduced thorugh the National Program for Social Emergency, PANES. The government has reached out to households (house-by-house monitoring), and many families eligible to receive allowances have been identified. PANES was designed, however, as a temporary, two-year, program.

Are there legal or institutional mechanisms that ensure non-discrimination in the access to services?	It is a Constitutional norm. Special norms for children with behavioral problems exist, so that they are not excluded from the system.	Yes, for formal workers. Non-formal workers acceding to the mutual health funds can be refused coverage based on age or results of medical examinations.	Not relevant – generally there are no opportunities for discrimination.
Are services guaranteed for the amount of time needed?	There are no barriers to pass from one grade to another, and students above the age of 15 who are continually repeating primary grades are automatically transferred to secondary school. However, related costs such as books, lunches, and uniforms are only guaranteed in primary school.	Yes, treatment is provided as long as needed, including lifelong treatment of chronic diseases. Anti-retroviral drugs are provided for free for HIV patients (constitutional norm). However, it is conditional on citizens' affiliation with either the public or one of the private health care networks.	Yes, for the pension system. Family allowances, including through PANES, are provided as long as the family continues to meet eligibility criteria (have children under 18 enrolled in school, and income below a specified threshold). PANES is a two-year program scheduled to end in 2007 – continuous provision is contingent on its renewal.
Is there a maximum waiting period for receiving the service?	No.	Immediate attention for emergency services is explicitly guaranteed. For all other services, there is no specified waiting period and no integrated system to guarantee alternatives. Standards for HIV patients are being developed.	Social security is automatic.
If service is unavailable within this waiting period, what is a guaranteed alternative (in the same time period)?	N/A	N/A	N/A
Financial Protection			
Do beneficiaries need to contribute to the cost of service?	No, although for secondary education there are implicit costs (books, uniforms, food).	Yes, through contributions to the Social Insurance Bank (*Blanco de Prevision Social*) or through the public health system free of charge (a system with different stages of co-pay depending on income is being developed).	Through regular pension contributions. No, for family allowances.

Are services accessible to beneficiaries who cannot contribute to the cost?	Yes, for primary schools. No or not always for secondary schools.	Yes, through the no co-pay public system – only accessible to individuals below certain income.	Yes, for all programs, although benefits without contribution are not of adequate quality (e.g., minimum pension only covers the cost of the basic food basket).
Is this information effectively communicated to the public?	Yes.	Yes.	Yes.
Quality			
Are there clear quality standards?	The teacher/student ratio is defined. Primary school teachers need special certification, whereas this is not the case with secondary school teachers. Use of standardized tests to measure learning.	The Ministry of Public Health defines the criteria. Laws and decrees and *Cartilla de Derechos* (Book of Rights) also define quality standards.	Pensions are adjusted according to the Line of Indigence (*Linea de Indigencia*) that takes into consideration the basic food basket. In the 1970s, family allowances involved the estimated cost of children to the family. Now, it is 16 percent of the minimum wage/month, regardless of the number of children (1360 Uruguayan pesos; around US$ 60/month). The amount of allowances can also be adjusted 20 percent below or above this percentage (i.e., it is very dependent on political choices). A new index for calculating allowances is currently being developed.
Are programs being evaluated on a regular basis?	National Standardized Measurement of Learning (MECAEP); Program for International Student Assessment (PISA).	No. Only some programs (HIV, maternal health, vaccinations) are evaluated, but not on a regular basis.	Basic indicators exist in all programs but they are not evaluated on a regular basis. PANES has been evaluated, but it is only a two-year program (2005-2007).
Are the standards and evaluation results effectively communicated to the public?	No.	No.	No.
Mechanisms for Redress and Enforcement			
Are there mechanisms allowing citizens to claim adequate provision of the services guaranteed?	Yes, claimable administratively and judicially.	Users can claim for the quality, but claiming procedures are costly. Free lawyers are assigned only for defendants.	Yes, legally and administratively. The problem is that floors for benefits are neither set adequately nor with a focus on equity (for both pensions and family allowances, especially the latter). As a result, claiming the guaranteed entitlements does not solve the problem of insufficient social security.

Participation and Continual Revision			
Do civil, parent, or community organizations have a concrete role in the design, implementation, and monitoring of the program?	Pre-school: Marginal participation from parents. They are invited to participate in workshops/meetings before the beginning of the school year. Primary: Program for strengthening school-family-community links – no major impact. Parents are involved in discussions about primary education theoretically, but not in practice. There is no institutional procedure that regulates their involvement. Some NGOs are involved in enhancing the quality of learning (*Convenio con Fundación Logros, Convenios con Clubes de Niños).* Secondary: Marginal to zero parents' participation (through parents' commissions); some NGO involvement (e.g., Youth House aimed at reducing drop-out rate).	None	None for the general state program on family allowances. For PANES: a number of civil society organizations participate in local Social Councils. They were created as part of the mission of the Ministry of Social Development, Office for Citizen Development. Civil society was not involved in the design of PANES, but is involved in its implementation. Organized participation for pensioners, including guaranteed representation in decisionmaking bodies regarding the pension system.
Which law or institution guarantees citizens' involvement?	Every education center is responsible for facilitating community participation.	None.	Office of Citizen Development, Ministry of Social Development.
Are there mechanisms that allow for continual imporvement of services?	Board of Central Directors (CODICEN) is responsible for the revision. For secondary education, the Board of Secondary Education (CES) also works for the revision.	No explicit guarantee to employ the latest (best) treatment. The Ministry of Public Health is responsible for the continual revision of standards and services.	Not specified for the pension system. Transfers through PANES are adjusted every four months according to the Consumer Price Index.

Education

118. The Uruguayan state guarantees free and secular pre-school, primary, and secondary education. The mechanisms that ensure the fulfillment of this guarantee have been most effectively developed for primary education; while the norms and policies guiding the provision of secondary education have not evolved sufficiently to encourage universal coverage, despite the education reforms of 1995-2000. The difference in the level of this pre-guarantee is reflected in enrollment and completion rates. Primary school enrollment and completion in Uruguay is close to 100 percent, while secondary school enrollment is close to 75 percent, with a 30 percent drop-

out rate (2004), due in large part to the lack of certain normative and institutional guarantees regarding access, financial protection, quality, and evaluation. This section examines only the public education system in Uruguay, which covers about 90 percent of students, with the remaining 10 percent being served by a private system. Our focus is on primary and secondary education (6 years each), even though some guarantees for free tertiary education, and free and obligatory pre-school education (with 90 percent enrollment of 5-year olds), are also in place. The National Administration for Public Education (ANEP) is the institution in charge of all major educational decisions, and has primary responsibility for public education spending.

119. The reforms of 1995-2000, while they did not explicitly adopt a rights-based approach, focused on increasing equity – especially in pre-school and secondary school, where the largest inequalities existed – by targeting access and quality. However, the reforms did not address community/parent participation, continual revision, and some aspects of financial protection for secondary schools, thus leaving important gaps in opportunity for universal completion of secondary education.

120. In terms of **access**, free full-curriculum schools were established in selected deprived zones; they provide food and bilingual education, where necessary, and prioritize the primary grades. The program "Every Child Can Learn" was introduced to facilitate access and decrease drop-out in regions with high rates of primary grade repetition. The government also invested in school buses for primary and the first three years of secondary school, which yielded highly positive results in rural and poor zones. Special needs schools are also available.[39] The contribution of the latter to increasing equal opportunity and access is yet to be evaluated.

121. The opportunity to receive service in the time needed is guaranteed for all students, as there are no barriers for passing grades other than unsatisfactory test results; students aged 15 who are still repeating primary grades are automatically allowed enrollment in secondary school. Continuation of education during primary and secondary grades is also ensured through incentives in the social security system – families with children under 18 receive allowances conditional on proof that their children are attending school.

122. In terms of **quality**, the reforms diminished the gap between public and private education. A new paradigm, focusing on "learning how to learn," was introduced in the secondary school curriculum and reflected in teacher training.[40] Still, some of the main quality evaluation programs, such as MEMFOD (Secondary School and Teacher Training Modernization Program) and MECAEP (Project for Improving the Quality of Primary Education), which were funded by and are still financially dependent on external assistance from the Inter-American Development Bank, have never been fully incorporated into the state institutional apparatus.

123. While support for equitable access and quality advanced reasonably well under the reforms, the state has lagged in the development of participation and **financial protection** guarantees. Financial protection, including all implicit costs – for books, uniforms, transport, and lunches — is in place only for primary education, while secondary school students/parents are responsible for covering these costs, which for some can be prohibitive. The latter may account

[39] There was also a "rural expanded school" scheme, but it has been terminated.
[40] Teacher requirements are generally stricter for primary than for secondary school in Uruguay.

for the fact that only 5 of every 10 students who enroll in secondary education are able to complete it.[41]

124. **Redress and enforcement** mechanisms, both judicial and administrative, exist for education, but are rarely used, given the relatively high enrollment rate. In principle, issues regarding the right to education in Uruguay are claimable judicially, as this right is protected by the Constitution. For example, a recent court case was decided in favor of a student who had not been allowed to enroll for refusing a required vaccination. Claiming specific benefits, however, such as receipt of textbooks or transportation, are only associated with more concrete norms and guarantees outside of the Constitution. The absence of such norms makes services non-redressable even if they ultimately lead to a violation of the right to education.

125. The **continual improvement** of education services is ensured by the Board of Central Directors (CODICEN) and the Board of Secondary Education (CES). As mentioned above, some of the best practices in evaluation and teacher capacity-building are provided by donor-funded programs that are not a permanent part of the state's education policy. The guarantees of continual revision and quality evaluation can be strengthened by institutionalizing regular procedures for the monitoring of learning results and teacher performance; for teacher capacity-building; and for making the results of monitoring available for public debate.

126. Guarantees for **citizen participation** in the education sector are almost non-existent. As in Peru, a number of parents' organizations and donor-funded NGOs (e.g., *Convenio con Fundación Logros, Convenios con Clubes de Niños*) exist to strengthen school-community links and prevent discrimination, exclusion, and declines in quality. However, there are no explicit norms requiring participation, and no administrative mechanisms to facilitate it, so the efforts of these groups have only a marginal impact on education, except in a few cases where a school administration makes an explicit effort to work with such groups, whose importance has yet to be widely recognized. Some elements of student voice have been incorporated through the "Student Spaces" (*Espacios Adolescentes*) program, through which students can discuss their interests, but there is no information about how this program may have influenced curriculum decisions or other aspects of education.

127. The reforms have not had farther-reaching results in part because they did not come about as a result of social participation and social pressure (unlike pension reforms, for instance), and so did not achieve the status of permanent normative guarantees and were not reflected in national legislation. This lack of a normative basis threatens the sustainability of all programs and the success of future reforms as well.

Health

128. Strong universal mechanisms for health care have been developed in three areas in Uruguay: two concerning prevention - (i) immunizations for all and other preventive services, such as dental and vision check-ups for children under 18, and (ii) pre- and post-natal care for mothers and infants - and one related to the (iii) treatment of chronic diseases, including free antiretroviral drugs and other specialized medications, and hospital treatment for a list of medical conditions. Apart from these three areas, the pre-guarantees on health services, especially with

[41] Other factors may be the inability to access an education center, inefficiency of institutions for redress, or other causes.

regard to quality, financial protection, redress and enforcement, and participation, have not advanced substantially, which accounts for various breaches of health entitlements in the country, namely non-affordability of services, long waiting lists, and non-redressability of quality and access problems.

129. Health care is provided through three major insurance plans: the State Health Service Administration (ASSE); the Institutions for Collective Medical Attention (IAMC), contributions and funding for which are administered by the Uruguayan Social Insurance Bank (BPS); and the Institutions for Private Medical Attention (IAMPP). The first two, which cover about 90 percent of the population, will be the focus of this analysis. The public health system, ASSE, does not require contributions over time and generally serves the poorest segments of the population – non-formal workers, and dependents of formal employees whose parents/guardians are not financing their health care through IAMC. ASSE beneficiaries are provided with Assistance Cards (*Carné de Asistencia*) associated with different levels of co-pay, based on need. Formal workers and pensioners subscribe and pay contributions to the private IAMC health network, where co-payments are required along with a monthly contribution. Citizens can also subscribe to the IAMC individually.

130. **Access** to health care in this system is ensured universally for the three specified areas, yet different forms of inequity and discrimination occur in the rest of health services. The public health system, ASSE, relies on an old and inadequate infrastructure, and its users may not always receive service in a timely manner. Once assigned to the public health care system, one cannot use the private network services on an ad hoc basis. Discrimination in the private health sector, on the other hand, can occur for financial reasons (described below; and also against individual subscribers (non-formal workers and non-pensioners), who can be denied a subscription based on age or medical condition.

131. For ASSE beneficiaries, **financial protection** is structured around different levels of co-pay, based on income. The poorest beneficiaries, holders of *Carné Gratuito,* are not required to contribute a co-payment for any services or medications. Higher-income subscribers hold a *Carné Bonificado* and are required to contribute a minimum co-payment. In this sense, the system ensures against discrimination for financial reasons for part of the poorest population. However, formal workers registered in the IAMC-BPS system, and individual subscribers to that system, are obliged to pay a co-payment related to the type of service required. If they are unable to pay, they are not allowed to use the free public health centers, as they are already subscribers to the private system. This lack of flexibility of the health administration violates the norms of financial protection.

132. The guarantee of a maximum waiting period for receiving services with stipulated alternatives is not in place or is only normatively defined. Immediate assistance is required in cases of emergency, as per Article 32 of the Penal Code; however, there are no procedures stipulating an alternative (e.g., redirection to another health center) if the normative guarantee is not met. Procedures on assigning alternative providers can be developed in emergency care as well as other areas in health.

133. **Quality** is one of the weakest aspects of the health sector in terms of the development of institutional mechanisms for regular monitoring and control. Formally, the Book of Rights and

Obligations of the Beneficiaries of Health Services (*Cartilla de Derechos*)[42] sets the quality standards to be followed. Yet, with the exception of maternal care and immunization programs, no wide-scale monitoring has been performed (evaluations of HIV treatment are pending the approval of HIV health care standards). Even those health programs that have been evaluated do not use regular monitoring mechanisms. Limited resources are commonly cited as the reason for the lack of stricter quality control. Yet, even if resources became available, they would need to be accompanied by a set of instruments and procedures for regular quality control. Norms on the **continual revision** of services – a factor that affects quality – have been developed only for the immunization program and the Uruguayan National Resource Fund – a non-governmental public body that provides financial coverage for highly specialized medical procedures for the entire population, without discrimination. In all the other health services, there are no explicit mechanisms for quality update; the Ministry of Health is under no explicit obligation to make such revisions, and they are undertaken only on an irregular basis.

134. **Redress mechanisms** are present but costly, and therefore unlikely to help poorer people. In most cases, the use of courts is required, but lawyers are assigned by the state only to defendants, not to people making claims. Since 2002, citizens have been entitled to make claims regarding the quality and timing of medical services, as provided for in the Book of Rights. Nevertheless, the generic and declarative character of this document has not made it an effective tool for redress. A new set of articles was added to the Book of Rights in January 2006 that specifies redress and enforcement procedures in more detail (Decree 15/006); an evaluation of the effectiveness of this decree and methods of increasing public information about it, will give some important insights into further developing the guarantee on redress.

135. Redress opportunities are facilitated to a much greater extent for minors. For example, the case of a pregnant teenage drug-user who was eligible for but not enrolled in a program of health check-ups, INFAMILIA, was brought to court, which obliged the physician to take action under the Uruguayan Child and Adolescent Protection Code (*Código de la Niñez y la Adolescencia*, 2004) and ensure that the patient is enrolled and receives the proper benefits.

136. Finally, the Uruguayan health system does not promote or ensure any form of **civic engagement** in the design and monitoring of health services, which in effect eliminates any direct opportunity for citizens to exercise voice in the conduct of health policy. A health reform envisioned for 2008, pending approval before Congress, would introduce more mechanisms for civil participation, more explicit quality and monitoring guarantees, and a financial redistribution of health contributions that would relieve the burden of healthcare for families with children by shifting resources away from other groups, including pensioners, who currently enjoy higher social benefits.

Social Security – Pension System and Family Allowances

137. The Uruguayan social security system is one of the oldest in Latin America, and was also the most comprehensive during the 1960s. Both the pension system and the system of family allowances include implicit pre-guarantees, with the aim of reducing poverty and social inequality. However, there are important gaps between the way norms and guarantees are

[42] *Cartilla de Derechos y Deberes de los usuarios de los servicios de salud, Uruguay.* Approved by Decree 297/002 (2002). See Filgueira 2007.

structured in the two programs, and a comparison of the two from the perspective of social guarantees and sub-guarantees can bring out important lessons for addressing the problem of the "juvenilization of poverty" in the country. The paragraphs below outline some major differences in the design of the two programs, and also highlight experience the National Program for Social Emergency Assistance (PANES), initially launched in 2005 for a two-year period, which has taken a progressive approach to reforming the family allowance system from a rights perspective (see para. 200).

138. The pension and family allowance programs evolved with different types of **participation mechanisms,** and this has had a marked effect on the effectiveness of each program. In particular, strong representation and political pressure by pensioners' networks brought about important and permanent improvements in the structure of the pension system. In 1989 a campaign by the Organizations of Pensioners and Retired, ratified with 80 percent general electoral approval, realized a reform by which pensions would be calculated as a function of the Median Salary Index (*Índice Medio de Salarios*) and adjusted with every salary increase of the Central Administration employees (Law 15.900). This reform was later enshrined in the Constitution. By contrast, the amount of family allowances is adjusted based on both the national minimum wage and Consumer Price Index +/- 20 percent, which constitutes a much less strict guarantee on the adequacy of family allowances.

139. The discrepancy in participation and representation between these two social protection programs has a direct impact on their **quality;** i.e., on the impact they have on reducing poverty, as can be seen by the trend of high and growing youth poverty, as opposed to relatively lower poverty among seniors. Under the regular state family allowance program, families receive a set sum, subject to political discretion (generally between 8 percent and 16 percent of the minimum wage), which is not differentiated according to the number of children in the household. The result is assistance that does not meet even most basic needs of its beneficiaries, let alone promote social equity.[43] Under the pension program, on the other hand, the mechanism for calculating pensions, as described above, has evolved to ensure the adequacy of pensions.

140. The quality or the adequacy of social assistance has an impact on the effectiveness of **redress and enforcement** mechanisms i.e. pensioners entitled to certain benefits can claim those benefits more easily than poor families who have not been entitled to receiving adequate benefits by the state in the first place. There are both judicial and administrative channels through which citizens can claim access to the money transfers to which they are entitled; however, this does not amount to a redress of rights in the case of family allowances, since the entitlements granted by the state are not structured in an equitable manner.

141. PANES, the first program initiated by the newly created (2005) Ministry of Social Development, aims to complement and update the system on family allowances by incorporating many elements of a rights-based perspective, namely a commitment to monitoring access for all eligible families, the engagement of civil society, and a mixed basket of transfers and services to ensure more effective assistance than the traditional family allowance program.

142. In terms of **access**, PANES has been highly effective, reaching 80 to 90 percent of its target population. This success relates strongly to the mechanisms of ensuring access that the

[43] Prior to 1970, allowances were determined based on an estimate of the cost of children to the household.

program adopted (Filgueira 2007). The formal process of collecting application forms from eligible beneficiaries was accompanied by house-to-house visits in order to verify the information, and most importantly, to increase awareness about social security options and identify eligible families who had not applied. Many eligible families that had not registered in the regular family allowance system were identified as a result of PANES.

The **quality** of PANES, meaning its adequacy in terms of reducing poverty and increasing equity, is inherent in the way in which beneficiaries and the amount of cash transfers are determined. Beneficiaries of PANES were identified as those whose income fell below the Average Value of the Basic Food Basket as of March 1st, 2005, and families below the Minimum Value of the Poverty Line. This included all families in the poorest quintile of the population, which gave PANES a means of reaching poor children and youth, households in which the head of the family is unemployed, pregnant women, seniors, and disabled citizens living in poverty. Beneficiaries receive a monthly transfer of 1,360 Uruguayan pesos (approximately US$55) for the two years of the Program's duration, adjusted according to the Consumer Price Index every four months. Apart from a money transfer, PANES also offers:

- Food.
- Primary health care services: prevention and attention, including dental care and mental health in public hospitals in municipalities and communities, with a focus on vulnerable groups such as children and youth, pregnant women, and young mothers in a critical poverty situation.
- Temporary employment.
- Assistance to refugees in camps, coordinated with public and private organizations, especially NGOs: psychological, health, dental, and neurological assistance and citizenship promotion.
- Educational assistance in deprived areas: infrastructure, school supplies, food, cultural and sport extracurricular activities.

143. PANES has also been progressive in terms of **civil participation.** Various NGOs are assisting in its implementation, even though civil society was not involved in the initial design of the program. When the Ministry of Social Development was created, local Social Councils were also established, in recognition of the importance of local government and civil society involvement in the functioning of the new Ministry. The objective was to ensure that social programs such as PANES incorporate more feedback from citizens, and to establish a civil mechanism for monitoring them.

144. Through PANES, the Ministry of Social Development in Uruguay has begun to assert itself as a key player in defining new and more effective approaches to reducing poverty. The next challenge for reforming social assistance in the country will be sustain PANES' achievements through a consolidated and long-term system of allowances. The program has already contributed to strengthening the family allowance system in Uruguay by identifying and including many eligible families in the social security system. Nevertheless, the elements of its overall structure, and especially those that relate to a rights-based approach, have not been incorporated into the existing family allowance program. These include mechanisms for monitoring access and for civil participation, as well as mechanisms for determining the adequacy of services to effectively address poverty reduction and enhance equity between vulnerable

groups and the rest of the population. The upcoming Plan for Equity, which is being developed to replace PANES, may be one option for sustaining these mechanisms, provided that the program is successfully integrated with the traditional family allowances system.

Conclusion and Lessons

145. Overall, the social security system in Uruguay is fragmented between a solid pension system, whose beneficiaries are strongly represented in policy decisionmaking, and a system of family assistance that targets the most vulnerable groups but is not sufficient to substantially alter the impoverished circumstances in which they live. An analysis of both areas of social security, using a framework of social guarantees, points to concrete differences in the way mechanisms for civil participation, quality, and access are structured, which in turn are linked to differences in the impact of each program on maintaining equity. Even though citizens are able to claim their entitlements both judicially and administratively, the system of entitlements itself is not sufficiently pro-poor to effectively work for the rights of the poorest. This indicates that the process of continual revision of entitlements and service standards, in order to gear the allocation of resources to realizing rights on an equitable and universal basis, may periodically need to rebalance entitlements among different social groups. A theme that emerges in all sectors in Uruguay is the significance of political mobilization. This underlines the importance of operationalizing the sub-guarantee of participation at the national level, so that social groups which do not have strong representation in the formal political system can exert pressure for the more equitable allocation of public resources.

South Africa: The Role of the Courts in Realizing Rights to Health and Housing

Context

146. When Apartheid ended in South Africa in 1992, the new Constitution, adopted in 1996, included a comprehensive list of civil, political, social, cultural, and economic rights. The Constitution specifically recognizes the rights to housing and health care, including reproductive heath care, and imposes an obligation on the state to take reasonable legislative and other measures, within available resources, to progressively realize those rights.[44] It also recognizes the interdependence, indivisibly, and interrelatedness of rights, and protects a range of civil, political, social, economic, and cultural rights that are directly or indirectly related to housing and health rights. The comprehensive protection of housing rights is particularly important in the South African context, where the right to housing is so closely linked to the right of access to land, and dispossession of land was a key feature of the creation of the Apartheid state. More broadly, the Constitution also provides for public engagement in social and economic policies, and facilitates public involvement in the lawmaking process and in oversight of policy implementation

[44] Sections 26(1)(a) and 26(2) for housing; sections 27(1)(a) and 27(2) for health care. The Constitution also protects the right of every person not to be arbitrarily evicted (section 26(3)); the right of children to shelter (section 28(1)(c)); and the rights of detained and sentenced prisoners to adequate accommodation at state expense (section 35(2(e)). It also recognises other health-related rights, such as the right to bodily and psychological integrity; the right to an environment that is not harmful to health or well-being, and the right to emergency medical treatment (section 27(3)). It imposes duty on the state to respect, protect, promote, and fulfill the rights in the Bill of Rights (section 7(2)).

147. South Africa's rights-based approach to social policy had been expressed for the first time in 1994, with the adoption of the Reconstruction and Development Programme (RDP), which expressly acknowledged housing and health care as human rights, which committed the government to delivering those services in a manner consistent with human rights standards and the democratic principles of inclusiveness, participation, and transparency. The program paid special attention to the basic needs of the poor, women and children, and other vulnerable groups. It was complemented by a macroeconomic framework – the Growth, Employment and Reconstruction Programme – which shared the same principles, while aiming primarily to increase growth and stimulate job creation.

Housing – Policy, Legislation, and Results

148. The formulation of South Africa's housing policy commenced prior to the democratic elections of 1994, with the establishment of the National Housing Forum. This forum was a multi-party, non-governmental negotiating body comprising 19 members from business, community, government, development organizations, and political parties then outside of government, who developed a broad housing sector convention, known as the National Housing Accord (NHA). This was followed a year later by the White Paper on a New Housing Policy and Strategy in South Africa (the White Paper on Housing), which had four main objectives: (a) provide housing to the homeless and alleviate overcrowding; (b) improve the quality of housing through the provision of formal top structures (i.e., buildings); (c) increase the security of tenure and promote ownership; (d) develop "sustainable human settlements." The White Paper set out the framework to be followed in the development of the national housing laws, policies, and programs.[45]

149. The White Paper aimed, first, to address the housing crisis directly through the scale of delivery of subsidized housing for low-income households, both for ownership and for rental; and second, to create an environment in which the subsidized housing market can operate normally as part of the broader, non-subsidized housing market. The key policy aimed at implementing the right to adequate housing was the Housing Subsidy Scheme, adopted in 1995, which provided a one-off housing grant to people with dependents who earned less than R3500 per month and had never owned a home before. Over time, this ownership program was extended to households earning less than R1500 (households earning between R1500 to R3500 are required to contribute R2479 to access their subsidy), and there was an increased emphasis on e building core structures of houses. All subsidized housing delivery had to conform to the national minimum norms and standards – a $30m^2$ unit (usually one room with a toilet) on a $250m^2$ plot of land. With regard to rental housing, the delivery of well-constructed units has been limited by the fact that many people are unable to afford them (Rust 2006).

[45] The first piece of legislation promulgated under this framework was the Housing Act of 1997, which repealed the discriminatory Apartheid housing laws, dissolved all Apartheid housing structures, and created a new non-racial system for the implementation of housing policy. It also clarified the roles and responsibilities of the three national, provincial, and municipal levels of government. Other housing laws enacted between 1997 and 1999 included (a) the Extension of Security of Tenure Act, which provides security of tenure and protection from arbitrary eviction for people who occupy land belonging to someone else in rural and peri-urban areas; (b) the Prevention of Illegal Eviction from and Unlawful Occupation of Land Act (commonly known as PIE), which provides a framework for the protection against unlawful occupation and simultaneously ensures that unlawful occupiers are treated with dignity; (c) the Housing Consumers Protection Measures Act of 1998; the Rental Housing Act of 1999, which sets out the relationship between and the duties of landlords and tenants, and permits the Minister of Housing to establish Rental Housing Tribunals to deal with the disputes between landlords and tenants; and (d) the Home Loan and Mortgage Disclosure Act, which promotes fair lending practices, and seeks to ensure that financial institutions are serving the housing credit needs of the communities without discrimination.

150. Several years after the White Paper, the Government also began to focus on the development of sustainable human settlements. The Comprehensive Plan for Sustainable Human Settlements of 2004 (also known as Breaking New Ground) is the key policy in this regard. It prioritizes the upgrading of informal settlements and integrated planning for sustainable human settlements. The Plan collapses income bands used to identify who should receive state housing support, and proposes the increased use of a People's Housing Process as a mechanism for increased and improved housing delivery (National Department of Housing 2004). Among other things, this Plan introduces an expanded role for municipalities, which are closer to communities than national government. This means that municipalities will be the ones to determine the location and nature of housing as part of a plan to link supply and demand (Rust 2006).

151. Another important housing program, the Housing Assistance in Emergency Circumstances Programme, was also launched in 2004, as a consequence of the celebrated Constitutional Court decision in the *Government of South Africa and Others v. Grootboom and Others* (Box 6). This program aims at assisting people in urban and rural areas who have urgent housing needs as a result of natural disasters, eviction, demolition, imminent displacement, or immediate threat of life, health, and safety. Through this program, administered by municipalities, beneficiaries receive assistance in the form of alternative land, infrastructure, and basic services. Qualified beneficiaries can also apply for subsidies for permanent housing (Khoza 2007, p. 156).

Box 6. Government of South Africa and Others v. Grootboom and Others

This case, brought before the Constitutional Court in 2000, involved a group of adults and children who had moved onto private land to escape bad conditions in an informal settlement. The group was evicted and their building materials were destroyed, rendering them unable to construct shelters. They applied to the High Court to be provided with temporary housing until they got permanent accommodation, relying on the right of access to adequate housing in section 26(1) and the rights of children to shelter in section 28(1)(c) of the Constitution. The Cape High Court said that there was only a violation of the right of children to shelter and not the right to adequate housing. In reviewing the case, the Constitutional Court set out the standard of "reasonableness" as a guide to deciding whether the Government's housing program met constitutional requirements. According to this standard, the Government's measures to provide adequate housing must be comprehensive, coherent and coordinated (para. 40); capable of "facilitating the realisation of the right" (para. 41); balanced and flexible, and appropriately provide for short-, medium- and long-term needs (para. 43); clearly allocate responsibilities and tasks to the different spheres of government, and ensure that financial and human resources are available (para. 39); be reasonably formulated and implemented (para. 42); and provide for the urgent needs of those in desperate situations (para. 44).

These elements of reasonableness have become key factors in developing and implementing other social policies programs, and in ensuring that they are in line with the human rights norms and standards articulated in the Constitution.

152. As a result of the White Paper, the Comprehensive Plan for the Development of Sustainable Human Settlements, and the Grootboom case, dramatic changes have occurred in South Africa's housing landscape. About 1.4 million subsidized houses have been delivered since the introduction of the Housing Subsidy Scheme in 1994, at the cost of R20 billion (Public Service Commission 2003), and the government has added more than two million housing units

to the formal housing in the country, comprising 15 percent of all formal housing units in South Africa. The Housing Subsidy Scheme, however, cannot keep up with the ever-increasing housing backlog in the large metropolitan areas. For example, Cape Town's estimated housing backlog grew from 150,000 in 1995 to 240,000 in 2002, and Johannesburg and Durban have even larger backlogs (Public Service Commission, 2003). Corruption, incompetence, and skills shortages contribute to the poor implementation of well-intentioned policies and legislation.

153. The Plan for Sustainable Human Settlements may succeed in addressing the urgent needs of the country's 2.4 million informal settlers in the medium to longer term. However, it has taken more than two years to complete the famous N2 Gateway Housing Project,[46] which has been riddled with administrative and political problems, including alleged corruption in the issuing of tenders.

154. New directions in housing policy have focused on strengthening provisions for groups with special needs (National Department of Health 2004), for emergency housing, and for increasing access to housing finance in the light of rising property prices. The constitutional protection of rights and laws, in and of themselves, cannot solve all social problems. For example, farm evictions have been on an increase since 1994. It was estimated that about 940,000 black South Africans have been forcefully removed from farms during the period 1994-2004. Wegerif (2006) argues that this is a failure of rights and the law. There is therefore a need for political will and strong civil society activism to hold government accountable to its constitutional obligations and policy and legislative commitments, and to monitor compliance by the government with court decisions and orders.[47]

Health

155. Prior to the RDP, the African National Congress developed the National Health Plan (African National Congress 1994), which sets out policies and principles for radically reforming the health care system. This was followed by the White Paper on the Transformation of the Health System of South Africa (White Paper on Health), which articulated the direction, strategies, and pace of reforms (Department of Health 1997). The White Paper on Health aimed to (a) unify the fragmented health system; (b) give priority to primary health care and make it available and accessible to all people; (c) ensure the availability of safe and quality essential drugs; (d) give special attention to the health needs of vulnerable groups such the poor, the elderly, women and children; and (e) promote the participation of community structures in the delivery of health care.

156. The reforms began with the dismantling of the racially fragmented health care system. The 14 Apartheid departments of health were unified into one national department and decentralized into nine provincial departments. The National Health Act 61 of 2003, which came into force in 2005, was enacted to put this new structure on a statutory footing (Department of Health 2001). The Act gave women and children access to free health care services in the public

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[46] This major intergovernmental housing delivery project involves the national and provincial departments of housing as well as the City of Cape Town municipality. The project is aimed at delivering housing to more than 100 000 residents from poor backgrounds living in the city. It is a lead pilot project of the new Comprehensive Housing Plan for South Africa, which was adopted by the Cabinet on 1 September 2004. See Thamm (2006) and Pressly (2006).

[47] One of the problems facing South Africa today is the government's increasing disregard of court orders, particularly on social security cases, in the Eastern Cape and in KwaZulu Natal provinces.

sector. It also gave special protection to people needing emergency treatment by outlawing the refusal to provide such treatment.

157. A central tenet of public health care (PHC) is universal access to a package of essential health services. The government has developed a framework for implementing PHC over a ten-year timeframe. This involves, among other things, creating a decentralized District Health System (DHS), consisting of 50 health regions and 170 districts (Rensburg 2004); and bringing communities into the planning and organization of health care services. Both the PHC and the DHS call for a fundamental shift in the allocation of health care resources, through the dismantling of racial and urban biases. The health budget is being diverted from academic and tertiary hospitals to fund PHC and DHS. From 1996 to 1998, there was a shift of 8 percent from hospital services and 10,7 percent towards district health services (Van den Heever and Brijlal 1997). In addition, a massive Clinic Building and Upgrading Programme constructed about 500 new clinics in rural areas between 1994 to 1999 (Abbot 1997).

158. The Government's first step toward improving access to health care services was a 1994 decree granting free care at public health facilities to pregnant women and children under the age of six (Department of Health 1994). Access to free health care in primary health care facilities has since been extended to the entire population (Rensburg 2004). Another legislative measure, the Choice on Termination of Pregnancy Act 92 of 1996, has radically transformed access to abortion services. This Act allows free termination of pregnancy upon request during the first 12 weeks.[48] Although rural women still experience problems in accessing abortion services, access generally has vastly increased.[49]

159. The Government has also taken steps to ensure that health care services are affordable. The Medical Schemes Act 131 of 1998, which outlaws discrimination in access to medical schemes on the basis of disability and state of health, also requires that these schemes offer a prescribed minimum of benefits to all members. The Pharmacy Amendment Act 88 of 1997 includes measures to encourage the setting up of pharmacies in rural and other underserved areas. The Medicines and Related Substances Control Act 90 of 1997 was passed with the aim of making medicines affordable through price controls, parallel importation, promotion of generic substitution, and the prohibition of incentives by drug companies. However, this measure has yet to be implemented, in part because of opposition from drug companies. The Government has developed and implemented the National Patients Rights Charter, which aims at improving the quality of health care. However, the Charter is not legally binding, and therefore does not offer any recourse.

160. Despite numerous initiatives to transform the South African health system, the reality is that – in terms of the World Health Organization's (WHO's) criteria of good health, equity, and responsiveness – the system is as problematic as it was 12 years ago. In a league table of health system performance, South Africa was ranked 175th out of 191 member states (Schneider et al. 2007, p. 290). Though post-Apartheid health sector transformation has been characterized by far-reaching policy statements that recognize the structural weaknesses of the health system, the cumulative effect of all of the policies and interventions described above has been disappointing.

[48] Section 2(1)(a) of the Choice of Termination of Pregnancy Act 92 of 1996.

[49] The Act took effect on February 1, 1997. From February to July 1997, 12,887 abortions were performed. By December 1997, the number had risen to 26,406. Under the earlier law, the Abortion and Sterilisation Act of 1975, an average of 800 to 1,200 abortions per year were performed (South African Institute of Race Relations 1997).

The amalgamation of numerous fragmented authorities into one national and nine provincial authorities, and changes to the gender, racial, and profession profile of health administration, stand as the most significant achievements of the post-Apartheid era. Beyond this, many of the structural problems of the health system remain. The distribution of resources (financial and human) between public and private sectors, and within the public sector, is as unequal as it ever was,[50] and the performance of the public health system is highly uneven, both within and across provinces. This is reflective of enduring social inequities.

161. There have, nonetheless, been some significant areas of progress. Many interventions aimed at women have had positive outcomes. In particular, the abortion legislation and the resultant health services development have resulted in improvements in abortion-related morbidity and mortality (Jewkes and Rees 2005), although implementation remains far from satisfactory (Blanchard, Fonn, and Xaba 2003). The abortion legislation came into effect on 1 February 1997. By July 1997, 12,887 abortions had been performed, and by December 1997, the number had risen to 26,406 (South African Institute of Race Relations 1997). By comparison, under the previous legislation, the Abortion and Sterilization Act of 1975, which restricted access to abortion services, there was a high incidence of death from illegal abortions. Another success has been in the control of malaria. While malaria has a localized epidemiology in the northeast of South Africa and is not a major cause of ill-health nationally, it exceeds HIV as the foremost health problem in much of Africa. South Africa has been part of a regional collaboration on malaria control with Swaziland and Mozambique, which involves active praying of households (with DDT), implementation of new malaria treatment regiments, and surveillance activities. The impact has been dramatic. In South Africa alone, the number of new malaria cases dropped from 64,622 in 2000 to 12,098 in 2006.[51] And the withdrawal of user fees has led to significant expansions in access to and utilization of healthcare facilities, particularly among women and children (McCoy 1996).

Seeing Health and Housing Through the Framework of Social Guarantees

162. Table 6 summarizes some of the key developments and features of South Africa's health and housing regimes, in terms of the sub-guarantees framework discussed above.

[50] In 2000, South Africa was ranked by the World Health Organisation as number 175th out of 191 member states (Schneider et al. 2007, p. 290).
[51] National Department of Health, *Malaria statistics (1999-2007).* Available at http://www.doh.gov.za/issues/malaria/annualdata.pdf.

Table 6. Accessing Social Guarantees in Health and Housing in South Africa		
	Health	**Housing**
	Access	
Are the beneficiaries and services clearly defined?	The Constitution guarantees that: • Everyone has the right to have access to health care services, including reproductive health care (s27(1)). • No one may be refused emergency medical treatment (s27(3). • Children have a right to basic health care (s28(c)). • Prisoners and detained persons have a right to adequate medical care (s35(e)). Some policies provide for: • Free primary health care for all citizens. • Free health care for children under 6 and pregnant and lactating women, as well as citizens with moderate to severe disabilities (all levels of care) (RDP and White Paper on Health).	The Constitution guarantees that: • Everyone has the right to have access to adequate housing (s26(1)) • No one may be evicted from their home, or have their home demolished, without an order of court made after considering all the relevant circumstances (s26(3)) • Children have a right to shelter (s28(c)) Some policies provide for: • Subsidized housing for certain eligible beneficiaries e.g. households earning less than R1500 are eligible to a non-contributory housing subsidy and those earning between R1500 and R3500 must contribute some money to get the subsidy (National Housing Subsidy Scheme)
Are there institutional procedures for monitoring access?	• Monitoring and evaluation falls under the program Health Information Evaluation Epidemiology and Research, managed by the Deputy Director General of Health Service Delivery. • Additionally, there is an Office of Standards Compliance and under this office is a Directorate of Quality Assurance. The Directorate is responsible for the development of systems and methods for quality assurance. • The South African Human Rights Commission (SAHRC) collects information using questionnaires (or protocols) from government departments and compiles a report on progress made in realizing the right to health care, among others.	• A Directorate of Policy and Programme monitoring in the Department of Housing exists to monitor the implementation of housing policy and program. • Provinces are required to submit conditional grant reports and provide the information in terms of the approved guidelines, and make additional information available as necessary. The National Department submits expenditure reports and non-financial information on a quarterly basis to heads of departments, ministers, and members of Executive Council meetings, where the content is discussed in detail. • The SAHRC also monitors progress in realizing housing rights in general.

Table 6. Accessing Social Guarantees in Health and Housing in South Africa		
	Health	**Housing**
Are there legal or institutional mechanisms that ensure non-discrimination in the access to services?	• The Promotion of Equality and Prevention of Unfair Discrimination Act (2000) provides legislative protection against discrimination. • The National Health Act and the Medical Schemes Act of 1998 specifically outlaws discrimination against people on the basis of their disabilities and health conditions. • Numerous policies also prohibit discrimination in the provision and access to health care services (RDP, White Paper on Health, etc.) • People who have been discriminated against can lodge complaints with the SAHRC or approach the courts, including the Equality Courts.	• The Promotion of Equality and Prevention of Unfair Discrimination Act (2000) gives legislative protection against discrimination. • The Home Loan and Mortgage Disclosure Act. • The Draft National Action Plan to Combat Racism in the Housing Sector notes that, over and above existing patterns of inequity, racism and other forms of discrimination (e.g., discrimination against foreigners and people living with HIV/AIDS) also sometimes occur in the allocation of housing resources. • Numerous policies also prohibit discrimination in the provision and access to housing (RDP, White Paper on Housing, etc.). • People who have been discriminated against can lodge complaints with the SAHRC or approach the courts, including the Equality Courts. If it is a dispute between the landlord and the tenant, a complaint can be lodged with the Rental Housing Tribunal.
Are services guaranteed for the amount of time needed?	Free primary health care for all citizens; free health care for children under 6 and pregnant and lactating women; as well as citizens with moderate to severe disabilities (all levels of health care).	N/A.
Is there a maximum waiting period for receiving the service?	No.	No.
If the service is unavailable within this waiting period, what is a guaranteed alternative (in the same time period)?	N/A.	N/A. However, in the case evictions, people are often provide alternative accommodation where they can stay temporarily until their long-term housing needs are addressed.
Financial Protection		
Do beneficiaries need to contribute to the cost of service?	Not as far as primary health care is concerned.	Households earning less than R1500 are eligible for a non-contributory housing subsidy, and those earning between R1500 and R3500 must contribute some money to get the subsidy (National Housing Subsidy Scheme).
Are services accessible to beneficiaries who cannot contribute to the cost?	Yes, they are accessible.	According to the Minister, the contribution requirement will formally be discontinued.

Table 6. Accessing Social Guarantees in Health and Housing in South Africa		
	Health	**Housing**
Is this information effectively communicated to the public?	Information is available on government and civil society organizations' websites. It is also accessible in user-friendly manner and local languages at clinics and hospitals, as well as community-based organizations and district offices of health. But information is not always effectively communicated by the departments.	Information is available on government and civil society organizations'' websites. It is also accessible in user-friendly manner and local languages at local offices of the housing department, through civic society organizations who also run information sharing workshops at community levels. But information is not always effective communicated by the government departments.
	Quality	
Are there clear quality standards?	Quality assurance programs in all provinces include: Clinical audits and monitoring of mortality and morbidity. They provide health teams with important information that enables them to address weaknesses in the provision of medical care.	The National Home Builders Registration Council regulates the quality of housing and provides a warranty for houses built under the subsidy scheme.
Are programs being evaluated on a regular basis?	• Yes, mechanisms exist both inside and outside the department to evaluate programs. • The Health Systems Trust conducts regular evaluation of specific programs; e.g., they often evaluate and monitor the prevention of mother-to-child-transmission of HIV/AIDS. • Through the monitoring mandate of the SAHRC, health care policies are also regularly evaluated for compliance with the rights-based approach to social service provision.	• Yes, mechanisms exist both inside and outside the department to evaluate programs. • Through the monitoring mandate of the SAHRC, health care policies are also regularly evaluated for compliance with the rights-based approach to social service provision.
Are the standards and evaluation results effectively communicated to the public?	The standards are available, but people need to be empowered through training and education to access information about them.	The standards are available, but people need to be empowered to access information about them.
	Redress and Enforcement	
Are there mechanisms allowing citizens to claim adequate provision of the services guaranteed?	• The National Health Act requires every province to have a formal complaints system covering all levels of care. • Provinces report that increasing numbers of patients have the confidence to make formal complaints. The existence of telephone hotlines has also made the process easier. • Provinces monitor the pattern of complaints and performance in responding to complaints. • Complaints can be lodged with the SAHRC. • A complainant can also approach the courts.	• Yes, claimable administratively (if a person is on a housing waiting list). • Complaints can be lodged with the SAHRC. • A complainant can also approach the courts and Rental Housing Tribunal, if the matter involves rent.

Table 6. Accessing Social Guarantees in Health and Housing in South Africa		
	Health	**Housing**
Participation and Continual Revision		
Do civil, parent, community organizations have a concrete role in the design, implementation, and monitoring of the program?	• Government can call on civil society organizations when designing policy although this is discretionary. There is also the parliamentary process in the case of legislation, where civil society organizations are asked to comment on policy at parliamentary hearings. • Civil society organizations involved in monitoring the programs through the South African Human Rights Commission (SAHRC)	• Often government calls on civil society organizations when designing policy. There is also the parliamentary process in the case of legislation, where civil society organizations are asked to comment on policy at parliamentary hearings. • Civil society organizations involved in monitoring the programs through the South African Human Rights Commission (SAHRC)
Which law or institution guarantees citizen's involvement?	The Constitution is founded on the values of openness, accountability, and transparency. Parliament is constitutionally obliged to facilitate public involvement in lawmaking processes (s72).	The Constitution is founded on the values of openness, accountability, and transparency. Parliament is constitutionally obliged to facilitate public involvement in lawmaking processes (s72). The Constitutional Court has enforced this provision in the Doctors for Life international case (2006).
Are there mechanisms that allow for continual improvement of services?	The Department of Health is responsible for policy documents and strategic plans that aim for improvement of services.	The Housing Department, through engagement with other interested parties, is responsible for drawing up policy proposals, which can form part of new and improved programs (e.g., the Comprehensive Plan for the Development of Sustainable Settlements, which recommits the department to delivery more and sustainable housing).

163. The following section examines the key institution dimensions of South Africa's transformation toward a rights-based approach to social policy since 1994.

The Institutional and Legal Framework

164. The Constitution established a number of institutions through which socioeconomic rights are implemented, monitored, and enforced. Such institutions also provide avenues for individuals and groups to meaningfully engage with the development and implementation of policy and laws, as well as to claim and defend their rights through judicial, administrative and other means. Key institutions include parliament, the courts and public bodies (institutions supporting constitutional democracy), and others statutory bodies.

165. **Parliament** is charged with the power to make laws and to play an oversight role over the executive. Through these roles, it has been involved in the design of legislation that gives expression to social guarantees, and in the implementation and enhancement of social service delivery. In line with its constitutional obligation to facilitate public involvement in the formulation of legislation, Parliament also holds public hearings to solicit the views of civil society actors on pending legislation and critical policy issues. In addition, Parliament has undertaken provincial consultation visits on issues such as the implementation of abortion

services, the rollout of anti-retrovirals, prevention of mother-to-child-transmission (PMTCT) programs, primary health care, hospital management, budgetary issues, and the recruitment and retention of human resources for health (Parliamentary Research Unit 2007). Through these visits, Parliament monitors the impact of policies and programs created at the national level, and determines whether they are delivering benefits and rights as anticipated.

166. The **courts** are another key institutional arena in terms of engaging with issues of rights, shaping social policies, the allocation of budgets, and the development of laws. In enforcing rights, particularly socioeconomic rights, the courts have been instrumental in setting and enforcing the human rights standards on which social policies must be based.

167. The Constitutional Court, the highest court in all constitutional matters, has been particularly important in enforcing rights. The first judges appointed to the Constitutional Court were human rights activists and legal practitioners who had played a critical role in the liberation and human rights struggle. Some of them had also drafted the interim Constitution and have assisted with the drafting of the constitutions of other countries.[52] They came with the political credentials, legal knowledge, expertise, and commitment to apply the vision of the Constitution. Early in its existence, the Constitutional Court determined that the enforcement of socioeconomic rights is not fundamentally different from that of civil and political rights. At the very least, the court said, socioeconomic rights can be protected from minimum invasion[53] – meaning that the duty to respect them can be enforced. Subsequently, the court expanded its mandate from negative to positive enforcement – i.e., the duty to take steps to enforce social rights – as illustrated by the *Grootboom* case (Box 6). In recent years, the courts have been making decisions with wide-ranging implications for social policy and budgets.

168. Technical legal provisions within the Constitution have greatly facilitated the legal system's scope of action with regard to social and economic rights claims. The most important of these is the broad *locus standing* provision, through which (section 38) a broad range of individuals and groups can approach the court alleging that a right in the Bill of Rights is threatened or has been violated.[54] This provision helps to mitigate the three main barriers to poor people accessing the courts: cost, length of litigation, and lack of direct access (particularly to the Constitutional Court, which does not accept cases without legal representation). Various civil society organizations and public interest litigation groups have used the expansive locus standing provision to challenge social policies that do not adhere to human rights standards and constitutional requirements. One of the most successful groups to use this provision has been the Treatment Action Campaign (TAC), which, along with its affiliate, the AIDS Law Project, has advocated for treatment for people living with HIV/AIDS (Box 7).

[52] For example, the former Chief Justice and first President of the Constitutional Court, Arthur Chaskalson, served as a consultant on the Namibian Constituent Assembly for the drafting of the Namibian Constitution.

[53] South Africa Constitutional Court (1996), p. 78.

[54] Section 38 states that "anyone listed in this section has the right to approach a competent court, alleging that a right in the Bill of Rights has been infringed or threatened, and the court may grant appropriate relief, including a declaration of rights. The persons who may approach a court are: (a) anyone acting in their own interest; (b) anyone acting on behalf of another person who cannot act in their own name; (c) anyone acting as a member of, or in the interest of, a group or class of persons; (d) anyone acting in the public interest, and (e) an association acting in the interest of its members.

Box 7. Minister of Health and Others v. Treatment Action Campaign and Others

In 2002, the Treatment Action Campaign (TAC) challenged the limited nature of government measures to prevent mother-to-child transmission (MTCT) of HIV, on two grounds: (i) unreasonable prohibition against administering the antiretroviral drug, nevirapine, at public hospitals and clinics, except for a limited number of pilot sites; and (ii) failure to produce and implement a comprehensive national program for the prevention of MTCT of HIV/AIDS.

The High Court and the Constitutional Court, applying the reasonableness test developed in the *Grootboom* case, decided that the government program was unreasonable in restricting access to a potentially life-saving drug to only a few sites. Both courts also found that the state's program to prevent MTCT of HIV/AIDS did not comply with its obligations in terms of sections 27(1) and (2) of the Constitution, in that, by restricting the program to a few sites, it excluded a significant number of people who are desperately in need of the drug. The Constitutional Court ordered the Government to remove these restrictions and roll the program out nationwide.

169. Also significant for the enforcement of rights has been the constitutional rules on *amicus intervention* (Box 8). These rules allow an organization to intervene as *amicus curiae* (friend of the court) in a case that is before the courts. Numerous specialist organizations have intervened in cases involving the right of access to health care and housing.[55] These interventions have provided the courts with expert information on a range of human rights issues, and have contributed significantly to the development of laws and policies that are responsive to the needs of the poor.

Box 8. Amicus Intervention: Do Socioeconomic Rights Impose Minimum Core Obligations?

The Community Law Centre (CLC) at the University of the Western Cape has intervened as amicus curiae on major socioeconomic rights cases, such as Grootboom (together with the South African Human Rights Commission) and TAC (together with the Institute for Democracy in South Africa (IDASA). In both cases, the CLC and its partners sought to persuade the Constitutional Court to interpret socio-economic rights as imposing minimum core obligations on the state. The concept of minimum core obligations was developed by the United Nations Committee on Economic, Social and Cultural Rights, in its interpretation of the nature of the state's obligation under the International Covenant on Economic, Social and Cultural Rights.* According to this concept, the state has a core obligation to ensure access to the essential minimum levels of the rights (for example, basic foodstuff, primary health care, basic shelter and housing).

The essence of the amicus argument in both cases was that the socio-economic rights provisions in the Constitution entitle individuals to a basic (minimum) core service directly and immediately. While in Grootboom such a service would be basic shelter, including shelter for children, in TAC it would mean immediate access to nevirapine for pregnant women living with HIV/AIDS and their newborn babies. The Constitutional Court rejected this argument in both cases, asserting that (i) it would be difficult to

[55] For example, owing to its socioeconomic rights focus and expertise and interest in the case, the Community Law Centre at the University of the Western Cape intervened in the Constitutional Court cases of the *TAC* (health rights), *Grootboom, Modderklip,* and more recently, in the Supreme Court of Appeal case of *City of Johannesburg v Rand Properties* (evictions).

determine in the abstract what the minimum threshold should be for the realization of the right, as the opportunities for fulfilling these rights varied considerably and the needs were diverse; (ii) determining the minimum core for a particular right requires a great deal of information to which the courts often do not have access; and (iii) courts are not institutionally equipped to make the wide-ranging factual and political inquiries necessary for determining what the minimum core standard should be.

In addition, the Court asserted that the language of the socioeconomic rights provisions in the Bill of Rights does not support the notion of imposing minimum core obligations on the state. Further, it found that it is impossible to give everyone access to a core service immediately, and that all that can be expected from the state is that is acts reasonably to provide socioeconomic rights on a progressive basis. Significantly, however, the Court contended that the concept of minimum core obligations might be relevant in assessing the reasonableness of the measures taken by the state. This finding has had far-reaching effects.

* General Comment No 3 (5th session), 1990, UN Doc. E/1991/23, The nature of State Parties' obligations (art.2(1) of the International Covenant on Economic, Social and Cultural Rights.

170. The final significant factor in setting the climate for active judicial intervention has been the power and willingness of the courts to intervene to ensure that the situation of rights claimants actually improves. In TAC, for example, the Constitutional Court not only declared that there was a breach of the state's obligation, based on the reasonableness standard, but also instructed the Government to remove all barriers to access, and to design a comprehensive program for the rollout of nevirapine nationwide.

171. However, some in South Africa believe that the Court could have done more to improve the lives of the poor and vulnerable by accepting that constitutionally mandated socioeconomic rights impose minimum core obligations on the state. By rejecting the minimum core standard, they argue, the Court simply protected their right to "inclusion" in policy development and implementation, but failed to define their needs as priorities (Bilchitz 2003). Others contend that the minimum core obligation represents the standard of rights provision necessary to meet the basic needs of vulnerable groups. Through this standard, they argue, vulnerable groups experiencing severe socioeconomic deprivation would have a directly enforceable right to a basic level of material assistance from the state; and the state would have to realize a certain minimum level first, without delay, and improve the level of provision beyond the minimum level over time (progressive realization). This standard would place the burden on the state to demonstrate that it marshaled all resources at its disposal to satisfy, as a matter of priority, its minimum core obligation.

172. According to some commentators, the practical implication of the Court's rejection of the minimum core argument is that the poor will not receive direct individual relief, although they may indirectly benefit from the positive order of the court (Liebenberg 2003). The fact that Grootboom did not get immediate direct relief (a house) from the positive judgment is an example in point. The *Grootboom* relief entitles a successful litigant to a reasonable policy which would only pass constitutional muster if it included people in desperate need of a service (house or health care service). However, individuals bear a heavy evidentiary burden to prove that the challenged government policy is in fact unreasonable.

173. Since the Court is unlikely to move beyond assessing the reasonableness of government measures, human rights practitioners, including supporters of the minimum core obligation, are now focusing their energies on developing a more robust standard of reasonableness as a way to

respond to the basic needs of the poor. Initial supporters of the minimum core argument have also found solace in the fact that the Court has acknowledged the potential role of the minimum core standard in the reasonableness review process (Liebenberg 2004).[56] The Court said that for a program to be reasonable, it must include short-term measures for vulnerable groups in desperate need and living in intolerable conditions. This element of the reasonableness review is generally regarded as an element of minimum core. However, some argue that it must be strengthened by employing a higher standard of justification where vulnerable groups are deprived of essential services (Liebenberg 2003).

174. In addition to the courts, a range of **quasi-judicial and administrative mechanisms of redress** exist in South Africa, including the South African Human Rights Commission (SAHRC), the Commission on Gender Equality (CGE), the Office of the Public Protector (Ombudsman), statutory institutions such as Rent Housing Tribunals, and various tribunals and boards that have a legislative mandate to resolve rights disputes. SAHRC is the most important of these quasi-judicial mechanisms. In addition its monitoring mandate, SAHRC has the power to receive and investigate complaints, report on human rights violations, and assist people in getting a speedy remedy when their rights have been violated. If it cannot resolve the complaint through negotiation or mediation, it can litigate (at no charge) on behalf of the complainant. The CGE uses the same procedures for gender-related issues. The Public Protector's scope of action is restricted by a prohibition on investigating complaints against individuals, and a policy of encouraging people to exhaust all other remedies before approaching the Protector's office.

175. Some legislation also prescribes non-judicial forms of resolving disputes. For instance, the Prevention of Illegal Evictions From and Unlawful Occupation of Land Act of 1998 requires that parties make an effort to settle their dispute through mediation before approaching the courts (section 7). Similarly, the National Health Act 61 of 2003 requires health care users to make claims in accordance with procedures posted near the entrances to clinics and hospitals. Complaints about doctors and nurses can be lodged with the relevant training and licensing institution (the Health Professionals Council of South Africa for doctors; the South African Nursing Council for nurses). In addition, the National Health Act provides for the establishment of a National Office of Standards Compliance and an Ombudsperson (not yet operational), who is responsible for receiving complaints about health care services.

176. In sum, few recourse mechanisms – whether administrative or legal – are found in the social policy framework. Rather, the mechanisms for claiming rights are derived from the governing legislation and the Constitution. Various institutions that people can use to claim their rights are established by statute or the Constitution. The strong constitutional framework; a stronger, pro-poor judiciary; and the inefficiencies and the lack of awareness of some non-judicial structures have created an over-reliance on the courts to resolve rights disputes. A greater use of non-judicial structures could go along way toward ensuring efficient and cost-effective negotiating space for the resolution of rights disputes.

177. Another significant institutional feature behind the culture of rights in South Africa is a range of active **civil society organizations** that take up issues on behalf of the poor and

[56] Liebenberg, the initial supporter of the minimum core argument, regards the reasonableness test as giving the courts a flexible, context-sensitive tool to adjudicate positive socioeconomic rights claims. She sees it as allowing the Court to respect the role and competencies of the other branches of government, while abdicating its responsibilities to enforce the positive duties imposed by socioeconomic rights.

marginalized. These include the Treatment Action Campaign, organized in 1998 to advocate for treatment for people living with HIV/AIDS; the Anti-Eviction Campaign; the Landless Movement, which lobbies for fair land redistribution and restitution; the Homeless People's Alliance, which mobilizes the poor against homelessness; and the People's Housing Process, which encourages self-help in building houses.

178. It is important to note that these post-Apartheid struggles are located within the country's constitutional and human rights frameworks. Civic organizations have demonstrated the power of using the rights-based approach to fight for access to adequate housing and health care, and to influence government policy on treatment and prevention of HIV/AIDS. TAC, for example, has been skilled in using a combination of political negotiations, mass mobilization, and adversarial strategies such as litigation to achieve its goals. TAC's well-documented success[57] demonstrates how the rights-based approach can be invoked to legitimize specific social claims.

Conclusion and Lessons

179. The South Africa case illustrates the potential complementarity of judicial (courts), quasi-judicial (e.g., SAHRC), and administrative (tribunals, facility-based complaints mechanisms) approaches to providing citizens with mechanisms of recourse and redress. Clearly, the shock of the political transformational created unusual conditions, but there are, nonetheless, lessons to be drawn. What is striking about South Africa in terms of economic and social rights is the extent to which rights specified in the Constitution have become a major feature of the social policy landscape. While written constitutions are increasingly including references to social and economic rights,[58] there is great variability in the extent to which constitutional guarantees actually have an impact on policy, legislation, and resource allocation. The South African case illustrates a successful structure for taking the rights approach forward. In particular, the Constitutional Court, and the provisions of locus standing and amicus curiae, which allow for pro-poor public interest litigation, have enabled the court system to promote systems of redress and accountability more broadly, leading to a strengthening of non-judicial mechanisms.

180. At the same time, the slow progress made in some areas of social policy, particularly health care, suggests the need for a more rigorous social guarantees approach to specifying entitlements, as well as the chain of responsibilities for providing them. A useful starting point could be an examination of why inequities in resource allocations persist despite the profound political, policy, and institutional changes of the last 13 years. While the politics of redistribution in service provision are always complex, the Chilean experience suggests that a process of wide public debate about what levels of service should be guaranteed to all citizens can provide a way of forcing the hard choices to be made.

[57] See, for example, Mbali (2005) and Friedman and Mottiar (2006).
[58] A review conducted of 187 countries found that 165 had written constitutions, of which 116 made reference to a right to education, and 73 made reference to a right to health care (Brinks and Gauri 2006, p. 3).

IV CONCLUSIONS AND RECOMMENDATIONS

Overview of the Social Guarantee Approach

181. This section brings us back to the initial hypothesis of this study: that social inclusion and the reduction of poverty can be strengthened and accelerated by means of a specific rights-based approach, namely a framework of social guarantees. Rights-based approaches to policy have mostly been developed in the conceptual arena. The value of the social guarantee framework has been in presenting a concrete and technical framework for the operationalization of social and economic rights. The social guarantee policy approach has been researched extensively by the Chilean Foundation for Overcoming Poverty and, in the case of Chile, translated into a concrete health program, the Regime of Explicit Health Guarantees.

182. Apart from presenting Chile's experience, this paper has looked for insights into ways in which a social guarantee framework, as a conceptual approach to social policy, can be used to improve service delivery in various country contexts. In particular, it can be used as a starting point for monitoring and evaluation of social programs through which one can identify concrete breaches in access, quality, participation, etc. that impede programs form advancing citizen's rights.

183. The analysis of the country cases demonstrates that the emergence and evolution of pre-guarantees follows a distinct pattern in every state. With a few exceptions, in particular in South Africa (where strong human rights principles were enshrined in the constitution), most social policies have not been designed from a rights perspective, or in the best scenario, have adopted rights-based principles without translating them into explicit policy provisions.

184. The two most developed sub-guarantees across the case studies were found to be access and financial protection. Quality, participation, and continual provision, and especially the mechanisms for redress and enforcement (particularly in the Latin American cases), have evolved the least. In other words, people generally have access to services at low or no cost, yet services do not respond to quality standards, are not provided in due time, and in case of deficient provision or poor quality, there are few redress mechanisms that would allow the affected individuals or groups to claim their rights. For all analyzed policies, the structure and level of services provided are still at a stage of pre-guarantee.

185. The study highlights a number of factors that potentially obstruct the development of rights-based social policies. Some have to do with unequal evolution of the legal, institutional, programmatic and financial frameworks that support certain programs and services. In many cases, there is a gap between policy formulation and policy implementation, related to the lack of a solid conceptual and methodological framework to guide the political and technical translation of social rights into corresponding poverty reduction programs:

186. *First, the discourse on rights in the four Latin American cases has been general and descriptive.* In many cases, it has been impossible to distinguish the concrete values or legal

norms that protect given rights, and to draw the boundaries that can steer social policy towards promoting and protecting the realization of the guaranteed rights.[59]

187. *Second, the lack of mechanisms for the redress of entitlements associated with social and economic rights has been shown to limit their realization,* implying that they cannot be claimed in practice.[60] Redress for economic, social, and cultural rights can take place through a range of channels which, ideally, should work in a complementary fashion. Administrative forms of redress include complaint and mediation processes internal to ministries and service delivery institutions (e.g., hospital-based systems); and committee structures established around service facilities (e.g., schools, clinics). Quasi-judicial channels include institutions established to oversee legal provisions but stand outside of the court system (e.g., Human Rights Commissions, Ombudsmen). Judicial mechanisms comprise the formal legal system, including, where relevant, constitutional courts.

188. In South Africa, the Constitution established a number of institutions through which socio-economic rights are implemented, monitored, and enforced. Such institutions also provide avenues for individuals and groups to meaningfully engage with the development and implementation of policy and laws. Key institutions include parliament, courts, and the South African Human Rights Commission. The courts have played a significant and influential role in shaping social policies, allocating budgets, and developing laws. In enforcing rights, particularly socio-economic rights, the courts have been instrumental in setting and enforcing the human rights standards that need to be followed in developing and implementing policies.

189. The productive role of the courts in South Africa has been driven by a number of factors, including the establishment of a Constitutional Court staffed with judges with human rights expertise and a commitment to the goals of the constitution; rules that enabled civil society organizations to act on behalf of those who otherwise could not access the legal system; an active and engaged civil society prepared to take up cases on behalf of excluded groups; the willingness of the courts to provide remedies by directing public policy and service delivery. At the same time, non-judicial mechanisms of redress have also played a significant role in advancing social and economic rights in South Africa. The creation of institutional "engineering," which allows for the judicial mechanisms supporting the enforcement of social and economic rights to have such a strong impact in South Africa, was clearly facilitated by the nature of that country's political transition. As the rewriting of constitutions to promote social transformation is no longer a rare event (Gauri and Brinks 2007), the specific features of the operationalization of constitutional rights in South Africa can provide lessons for other contexts. A unique feature of the South Africa experience of relevance for the cases reviewed here is that judicial mechanisms have given guidance to policymaking in the form of judgments about a "reasonable" interpretation of public responsibilities to support constitutional provisions on social and economic rights.

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[59] For example, in the cases of Chile and Peru: are early childhood development and initial education part of citizens' rights, and should they be guaranteed by the state?

[60] For example, in the case of Chile, the right to housing is not guaranteed. State action is limited to providing subsidies to eligible families to enter the subsidized housing market. To function, this approach would require private developers interested in providing housing for the socially disadvantaged. Second, there is an issue of quality, as the developers have no clear standards to follow and regulatory mechanisms are weak – which has, in fact, resulted in poor quality housing. Further, there are no clear redress mechanisms, as existing laws do not provide an adequate legal framework for addressing issues of housing quality. This should be contrasted with the experience of South Africa, where the New Housing Policy and Strategy, adopted in 1995, instituted mechanisms for the provision of quality housing (i.e., formal structures) to the homeless.

190. The case studies reviewed here suggest that the establishment of robust mechanisms of redress is a crucial element of making a rights approach work. The appropriate nature of these mechanisms is dependent on context. Where policy frameworks are clearly specified and judicial mechanisms are costly and inaccessible, it may be appropriate to focus on developing administrative mechanisms of redress. In the case we reviewed where these are most effective (the AUGE case in Chile), it is worth noting that the office through which such claims are pursued (the Superintendency of Health) has its existence, independence, and mandate specified clearly in law. That institution could, therefore, be seen as a quasi-judicial mechanism under some frameworks.[61]

191. A key factor that is necessary under most conditions to make judicial mechanisms accessible to poor people is the existence of civil society organizations which are prepared to support pro-poor public interest litigation. The level of legal mobilization will also depend on the direct access of ordinary people to a legal profession that is qualified and oriented to fighting for social and economic rights (Gauri and Brinks 2007). However, as the South Africa case shows, the social benefits of litigation are not necessarily limited to those individuals who are able to successfully pursue claims. Individual cases may bring benefits to non-litigants who are in a similar situation, by making, for example, landlords less likely to evict squatters using illegal methods. Public interest litigation can lead to the direct extension of benefits to classes of people none of whom individually brought a case (as in the roll-out of anti-retroviral drugs to prevent mother to child transmission of HIV in South Africa). High-profile cases, such as the Grootboom case in South Africa, may also produce general political effects by changing the interpretation of the rules of policymaking. In this case, there was also concrete policy follow-up in the form of the Housing Assistance Emergency Circumstances Programme. Furthermore, most observers of South Africa would agree that key rulings in the Constitutional Court have created new awareness and norms with respect for constitutional provisions that support the realization of social and economic rights.

192. It is clear that judicial, quasi-judicial, and administrative channels are all potentially important for promoting the realization of economic and social rights. It remains the case that courts are often inaccessible and unaffordable to the poor and vulnerable, and thus have little effect in compensating for social rights violations for the most disadvantaged. Various experiences, such as the Chile health sector, suggest that non-judicial mechanisms can be created through institutions capable of accepting claims and producing solutions. Such administrative channels can be employed to protect guarantees relating to social services before claims need to reach a judicial court. Thus, the creation of mechanisms within social institutions for resolving social claims is crucial.[62]

193. *A third factor impeding the full realization of economic, social, and cultural rights, is the lack of clearly defined state or non-state obligations to protect and facilitate the exercise of rights.* The development of precise definitions of obligations can generate resistance from groups that associate economic, social, and cultural rights with a growing state apparatus and/or

[61] See, for example, World Health Organization/Office of the High Commissioner for Human Rights (2007).

[62] Over the last decade, courts in Latin America have taken a more active role in dealing with human rights and social and economic policy. While this has, in some cases, enabled people to assert their rights and hold politicians accountable, it has also raised concerns about the appropriate balance of powers and responsibilities between representative and elected bodies, and appointed members of the courts. It has also had some unintended consequences arising from unequal access of different groups to the courts and from the effects of contradictory rulings on policy. For a detailed discussion of this issue, see *The Judicialization of Politics in Latin America* by Sieder et al. (2005).

excessive public investment, regulation, and economic intervention of the state. This tension is evident in all of the studied cases. Nevertheless, incorporating a rights perspective in social policy by means of guarantees encourages a change in the paradigm through which social policies are conceived, implemented, and evaluated. On the one hand, it generates the imperative of closer and more active collaboration among the state, the market and civil society for the betterment of social services. On the other hand, it requires placing poverty reduction and social inclusion at the center of state activities, with the objective of changing the nature of the relationship between states and their most excluded citizens.[63]

194. As Ferrajoli suggests, *"Guarantees are nothing else but techniques, foreseen or supported by legislation, that reduce the structural distance between norms and results, and as such make possible the maximum efficacy of [defined] fundamental rights…."* (Ferrajoli 2004, p. 25). Social rights, which by nature generate expectations for provision of certain services, require the establishment of more complex techniques in order to be guaranteed, than those required by civil rights. This does not suggest in any way a "statist" or "interventionist" solution that inevitably brings about "fiscal disequilibrium." Rather, the discussion of guarantees revolves around the specific technical developments that allow for the exercise of rights and amplify the range of options available for their realization.

195. Regardless of the techniques put in place for the realization of rights and guarantees, each guarantee requires the elaboration of **explicit and precise normative (or legal), institutional, operational-programmatic, and financial frameworks:**

196. *Legal Framework.* The experience reviewed here suggests that an effective legal framework of social guarantees should clearly define and develop the obligations of state and non-state actors for the realization of the right, including defining the scope of the right. This involves a clear and explicit definition of the right-holder, who can utilize the instruments and institutions – which should also be clearly stated – for redress, control, and/or enforcement. In other words, the legal framework refers both to the general norms and regulations regarding rights that are normally found in every state's constitution, and to the more detailed stipulation of those rights.

197. The cases examined in this study demonstrate distinct stages of development of the legal framework. In states where the judicial dimensions of social guarantees are more advanced, such as South Africa Uruguay and Chile, the positive and negative obligations of the responsible actors (state and non-state) are highlighted more clearly, as are the procedures through which the fulfillment of rights is expected to occur.[64] In these cases, the space for political manipulation (bureaucratic, administrative) has been effectively diminished, which is of great importance for a region where clientelist policies and corporatist interests have had a large impact on social policy, to the detriment of excluded and less powerful groups. In this sense, well-elaborated social guarantees in the legal realm are an empowering factor, as they give citizens the ability to claim non-compliance with explicit guarantees to which they are entitled.

[63] For a concrete example in the Chilean case, see Government of Chile (2001), p. 58.

[64] However, within each country, the development of these norms is not uniform across sectors. For example, while Chile has a well-advanced guarantee system in place for the health sector, with corresponding constitutional rights, institutions, programs, and budget allocations, the country's education sector has not reached the same level of development.

198. *Institutional Framework***.** In the countries reviewed here, there are institutions responsible for the design and implementation of social programs, but their responsibilities are defined in a vague or generic manner. One can note that guarantees are best integrated in those policies and programs that have one clearly defined responsible institution (or committee/council) in charge of design, implementation, and monitoring. In some cases, the responsible bodies are mixed, that is, of a state and non-state character, involving non-governmental actors to ensure higher technical expertise, more objectivity, or simply to engage civil actors in the policy process. This involvement is welcome and does not signify an expansion of the public apparatus, but rather an articulation of responsibilities among public, private, and civil society actors. This study has also shown that public-private alliances in social programs can help to control for other risks such as focusing on short-term delivery (for political payback), opposition to the programs from highly powerful political stakeholders, or ineffective state delivery.[65]

199. In South Africa, the expanded provision of social services to a larger segment of the population was made possible by the presence of a strong and independent institutional framework for implementing, monitoring, and enforcing policies. For example, the fact that the departments and non-state actors have a good track record of working together to formulate, implement and monitor policies was useful in achieving greater impact in policy provision. That working relationship, in turn, was made possible by the fact that the benefits were not only constitutionally guaranteed, but also operationalized through institutions that allowed monitoring and enforcement. Such institutions also provided avenues for individuals and groups to meaningfully engage with the development and implementation of policy and laws.

200. Consequently, in order to further advance the development of a social guarantee, it is important to define the institutional dimensions of responsibility with respect to the design, implementation, and evaluation of each sub-guarantee: access, quality, redress and enforcement, etc., regardless of whether they are assigned to state or non-state actors. Considering the experience of the cases analyzed, three relevant aspects of the institutional dimension can be distinguished:[66]

- It is desirable to have public-private-civil society partnerships. It is also essential, within state institutions, to have inter-ministerial coordination across the responsible government bodies.
- It is crucial to define the institutions responsible for the auditing, monitoring, and evaluation of the programs.
- It is essential to ensure that monitoring institutions are independent from the government and political authorities.

201. *Instrumental Framework.* The instrumental framework refers to the policy and programmatic instruments that are intended to support the realization of a particular right or guarantee. Across the cases analyzed here, the articulation between different programs with respect to achieving the outcomes in question tends to be weak. There are different programs that

[65] The South African case shows how civil society organizations involved in monitoring AIDS and housing programs have focused on monitoring access to health and housing benefits, enabling interested parties to determine whether the Government is making progress in meeting people's social needs, and social benefits are reaching the intended beneficiaries.
[66] These aspects do not refer to an expansion of state institutions, but rather to more precise definition of their responsibilities and regulatory functions.

deliver goods and services in a poorly coordinated manner, decreasing the efficiency of all the programs and increasing the risk of these programs being used in a discretionary manner.

202. In the development of the social guarantee, the instrumental framework is a fundamental technique for reducing the gap between norms and operational results. Among other things, it constitutes the direct and everyday link between rights-holders and services. However, having a programmatic framework (clear programs with well defined services) is not enough to build a social guarantee. The instrumental framework also needs legal and institutional instruments that specify obligations, requirements to receive the service, expected results, and mechanisms of redress.

203. *Financial Framework.* This framework refers to all economic resources allocated to and invested in the realization of the guarantee and its sub-dimensions. Ideally, it represents the social and fiscal pact that a society has reached in order to guarantee a social right.

204. In all the cases analyzed, some form of financial framework was developed for the support of selected plans and programs. However, only in the AUGE example in Chile does this financial framework reflects a kind of social-fiscal pact agreed upon by diverse stakeholders.[67] The budget security of most social programs (ensuring that they will be sustained regardless of political change and economic fluctuations) is also weak. In all of the cases, there is a still a risk that changes in government will lead to changes in rules of the game or a discontinuation of programs. Furthermore, social accountability mechanisms are also poorly developed.[68] There are no adequate channels of information to inform citizens of the amount of, and results from, public investment related to the fulfillment of certain rights and entitlements.

205. Another important issue highlighted by the cases relates to the role of the state in the provision of guarantees. The universal principle of the entitlement does not imply equal support across different socio-economic groups, but rather the need to ensure that existing benefits and resources reach those unable to fulfill or satisfy their rights (due to poverty and/or exclusion) without positive state intervention. The health benefit guarantee program (AUGE) in Chile shows the progress made in providing financial protection for those unable to afford services, which has allowed a maximization in the use of the existing financial resources along with the inclusion of all rights holders. The cases also suggest that there is much to do with regard to defining and communicating the principles and criteria used for targeting and providing differential levels of support.[69] An effective social guarantee program requires a clear definition of how the protected value is expressed in the normative, institutional, programmatic, and financial domains of policy, as it is in these domains that one can determine the extent of socio-political and fiscal consensus,

[67] The example of housing from South Africa is relevant here. The severe and progressive deficit in housing, created by the gap between the rate of population growth in the slums and the rate of new housing delivery, is aggravated by the insufficient subsidy to cover the cost of new housing. The lack of a social and fiscal pact deprives the program of an adequate level of funding and renders the redress mechanisms ineffective.

[68] In the case of South Africa, most notably, many civil society organizations ensure that the Government lives up to the principles of openness, transparency, and accountability embedded in the Constitution. The Uruguay (PANES) and Peru (education ombudsman) cases also have some forms of social accountability. Similarly, the AUGE program in Chile has completed a participatory monitoring exercise addressing issues of perception about service provision.

[69] In South Africa, the courts have been ruling on issues that have policy and budgetary implications. For example, they have scrutinized policies pertaining to (a) the criteria used by a hospital to determine who is eligible for dialysis treatment; (b) the accessibility and availability of nevirapine to pregnant mothers and their new babies to prevent mother-to-child transmission of HIV/AIDS; and (c) the accessibility of anti-retroviral drugs to prisoners living with HIV/AIDS. These examples illustrate the need to have clear rules for defining beneficiaries and the level of support to which they are entitled, so that such issues can be settled administratively before reaching the courts.

regardless of whether the institutional framework is public, private, or mixed; whether the financial framework is restricted or ample; or whether the programs are flexible in their operation. The Chile AUGE case illustrates that a social guarantee system is a social contract, which protects a minimum value and provides institutional mechanisms for revisions that will be translated into financial support.

206. A social guarantee approach constitutes a mechanism that allows for a flexible consignment of rights. As mentioned above, this point is extremely relevant because one of the main critiques of rights-based policy is that it introduces rigidity to public policy. The cases examined suggest that it is possible to articulate a universal consignment of rights with a guarantee system that secures a social minimum to all and that is subject to periodic revision to account for changes in country context. In this context, the realization of a system of guarantees requires the clear and precise definition of the values to be protected. When there is wide public discussion and consensus building within a society, it is much easier to achieve what Ordoñez calls the "threshold or frontiers of the value of each one of the rights which is intended to realize" (Ordoñez 2000).[70]

Impacts of a Social Guarantee Approach

207. A social guarantees approach offers a number of promising avenues for strengthening the delivery of social policy and for operationalizing a rights-based approach. The main areas we can highlight at this point are as follows:

- The framework of sub-guarantees outlined above provides a useful representational schema of inter-locking dimensions of policy implementation and service delivery. By focusing explicit attention on these dimensions, the sub-guarantees framework identify blockages to the realization of economic and social rights, and suggest strategic measures to correct them.

- In giving concrete meaning to social and economic rights, the framework of social guarantees makes space for a process of social dialogue. The participation of the poor and voiceless in this process is critical, and an area where more experience and effort are needed.

- The guarantees approach allows for a practical process to determine (as an element of the social fiscal contract) the space available for progressive improvement after the realization of a minimum. What levels of entitlements are affordable under different conditions is a question that needs to be answered by society as a whole, and the approach outlined here makes space for a process of this kind.

- The framework of sub-guarantees allows for a process of monitoring the progress that countries are making toward the realization of economic and social rights, independent of outcome or input dimensions. This is important because those dimensions of social policy cannot be determined fairly on a cross-country basis due

[70] For example, a definition of the "right to education" should specify whether the right includes pre-school, primary, secondary, university education, education for adults, etc. It should also specify the rights and obligations of providers and beneficiaries at each level of education.

to the varying fiscal and economic capabilities of different countries. The material reviewed here suggests that the sub-guarantees approach outlined above can provide a framework for monitoring the strength of the social, legal, and policy arrangements underpinning the realization of economic and social rights. A social guarantees monitoring framework will simultaneously guide policy in a direction that underpins a strengthened social contract and framework for citizenship; and will also provide a means of measuring the process of integrating a rights approach into social policy.

208. The adoption of a rights-based approach through the lens of social guarantees (even if partial and consisting of pre-guarantees) in the analyzed cases has had positive impacts in at least three domains:

- *Increased access to social service provision*. The Chile case shows that AUGE, in spite of its short period of implementation (from 2005), has been beneficial to all socio-economic groups, particularly middle-income groups and the poor, which have increased access to services previously unavailable such as treatment for depression and diabetes. Two out of three people consider that the program has improved the provision of health care in the country, and the most valued guarantee across social sectors is access. Similarly, the South African example demonstrates that courts have enforced the right of access to health care services and housing. As a result of such enforcement, children up to the age of six now receive free medical care, and access has increased for pregnant women and people living with disabilities.

- *Increased efficiency in delivery*. In the Uruguay education case, the reforms have diminished the gap between public and private education and increased the overall efficiency of the system, with per capita investment now producing better academic results. In South Africa, the decentralization of health services has brought health care closer to the poor, and the participation of local communities in planning has resulted in the dismantling of the curative and urban biases of the past while cutting the costs of health service provision

- *Increased voice and participation in social policy provision*. In Peru, the laws mandating and regulating the participation of parents' associations in educational institutions, as well as the improvement of health care, have contributed to raising the consciousness and participation of social groups with less power. Citizens can turn to NGOs or to the Ombudsman in Health and Transparency for assistance if they cannot access health services to which they believe they are entitled. In South Africa, the rights-based framework has ensured that citizens are not passive actors or mere recipients of goods and services. Individuals and groups are able to influence and/or challenge policies through various institutional mechanisms.

Recommendations for Moving Forward with a Social Guarantees Approach

209. One tool that can be used to support the design of rights-based social policies, monitor the progress of their implementation, and inform overall policymaking is a social guarantee index. It is a simplified attempt to measure social guarantees, and so does not represent the concept of social guarantee in its entirety. Its major advantage is its capacity to synthesize in a single index

a large set of variables that constitute a social guarantee. This index has been proposed by the Chile's Foundation for Overcoming Poverty and the University Alberto Hurtado (FUNASUPO/ UAH), based on the analysis of the Chilean case reported in this study.[71]

210. The index combines a number of criteria related to the sub-guarantees and assigns specific values to each sub-guarantee, allowing a comparative analysis of a number of guarantees. Specifically, such an index would allow for comparison of the level of development of sub-guarantees within each program. For example, through the index, it would be possible to assess implementation progress across different dimensions within a program (quality, continuous provision, participation, etc.); the evolution of sub-guarantees across programs; and the level of development of a social program relative to a social guarantee framework. Though the specification of such index still needs to be further developed, the innovative approach taken by FUNASUPO/UAH represents a workable proposal for monitoring the progress toward – or the approximation of social policies to the notion of – rights-based social policy. This proposal merits further analysis and development based on new cases and its use by various stakeholders (multilateral agencies, governments, and civil society organizations) to monitor program outcomes and inform policy design.

Independent Monitoring

211. To maintain systematic monitoring and evaluation of social policies and their impact on the realization of guarantees/entitlements, it is advisable that some institutional responsibility be assigned for this task. Such an institution (such as a Ministry of Social Development) should be financed through the government budget, but be free from political interference and represent a wide spectrum of stakeholders. Its monitoring function should result in the regular provision of technical recommendations to the government, parliament, and the public. The institutions should be organized and governed by a mixed council that includes mostly authorities with technical expertise in social policy, representing different opinions across the country. This would contribute to ensuring a transparent evaluation of policy, and would motivate honest and comprehensive public discussion of the collected data.

Building a Social and Fiscal Pact

212. The main challenge in implementing a rights-based approach to social policy through the establishment of guarantees is the development of social and fiscal contracts that reflect the content and financing of the specified guarantees. Social contracts are expressions of power relationships and of resource allocations that are materialized in fiscal and budgetary decisions.[72] The analysis of the cases presented here indicates that the development of social-fiscal contracts follows diverse paths, reflecting each country's socio-political, institutional, and economic environment. There is no single prescription for how to develop a social-fiscal contract. However, four elements are essential:

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[71] For a full discussion, see the background report prepared by FUNASUPO and Universidad Alberto Hurtado, "Garantias Sociales para la Superación de la Pobreza en Chile" (2007), in particular the section on the methodological framework *(marco programatico)* dealing with the development of the *Índice de Garantías Sociales*.

[72] See Shultz (2002) and Birdsall (2002), which – with different assumptions and objectives – discuss how new social contracts need to address the deep structural inequalities that inhibit poverty reduction and have an obligation to do this by appropriating the public funds necessary for their provision but also by taking the appropriate legal steps toward the fulfillment of the rights not only of the poor but also vulnerable groups who are under constant risk of becoming poor.

- *First, timing is important;* there needs to be a window of opportunity for revising the existing contract and advancing a rights-based agenda. Both South Africa and Chile highlight the opportunities presented by political transformation.
- *Second, there needs to be open information and clear indicators of the current situation* that would allow the different stakeholders to articulate their interests, in line with a long-term perspective.[73] An open public dialogue on the extent of basic entitlements, and/or the launch of a social guarantee index, as described above, would be useful tools.
- *Third, it is important to have in place a normative framework that would allow for the implementation of the new social contract.* Alternatively, as the South African case clearly highlights, the agents of reform (governments, civil society, or judicial actors) should have wide political support and a clear mandate for making the changes necessary to allow the enactment of the required constitutional reforms or laws protecting the agreed-upon civil, political, social, cultural, and economic rights.
- *Finally, the process requires the existence of a system (and clear criteria) for assessing the budget trade-offs that will be involved in defining a new social policy contract.* To be effective, as the Chilean case of AUGE demonstrates, this system needs to be open and participatory, and not only based on technical and financial criteria. Budget decisions reflect political priorities and power relations, and this needs to be acknowledged in the decisionmaking process in order to build the necessary consensus for the reallocation of budget envelopes across different policy priorities.

Coordination among Social Development and Social Sector Ministries

213. Moving forward, the social guarantee focus requires strong political and institutional leadership. Young democracies across the developing world, including in the Latin American region, are facing the challenge of redesigning their institutions to respond to constantly changing political and economic realities. The social policies and programs to which they are increasingly allocating resources have, in many cases, not been fully coordinated with one another or among different government ministries. In addition, institutional responsibilities regarding regular monitoring of programs, redress and enforcement mechanisms, and continual revision are often stipulated in a vague manner, and overcoming this problem requires an institutional design that enhances policy coordination, permits regular and effective evaluations, in order to help social programs to achieve their full potential. The Ministries of Social Development are in a unique position to advance institutional collaboration among all social sectors by promoting and overseeing comprehensive and cross-cutting social policies.

Public-Private-Civil Society Partnerships

214. Apart from advancing inter-sectoral collaboration, it is important that social sector ministries also engage in active dialogue with civil society and the business sector, since adequate

[73] See Pierson's (2004) analysis of policy decisionmaking and how short-term interests threaten the advancement of reform agendas. Similarly, Grindlee and Thomas (1991) discuss how policy choices are shaped by class interests, historical context, and the areas of conflict. In particular, it is important to consider the stakes in the short term, when decisions will be dominated by concerns about micropolitical and immediate rewards.

realization of social and economic rights depends on shared responsibility for social issues. Public-private-civil society alliances for social service provision can mitigate certain risks, such as the focus on short-term delivery for political payback, opposition from powerful stakeholders, or ineffective state delivery. The AUGE case in Chile illustrates how the public and private health sectors can be coordinated and made to adhere to common quality standards and redress procedures, in order to provide a basic set of services to all citizens. And the South African case shows how monitoring by civil society organizations can help determine whether health and housing benefits are reaching all eligible individuals. Civil society groups in South Africa have also played a significant role in advocating for the poor with judicial institutions and supporting the ability of vulnerable groups to claim their entitlements.

Robust Mechanisms for Redress

215. The availability of redress mechanisms is at the core of the rights-based approach, and should be an essential element of a social guarantee framework. In terms of an agenda for future research and knowledge generation, the case studies have pointed to the importance of understanding the functioning of a range of different institutions of recourse and redress in different contexts. As outlined in the Overview, the mechanisms for redress can be administrative (internal to the service delivery institutions and ministries), judicial (the formal legal system) or quasi-judicial (established to oversee legal provisions but standing outside the court system (ombudsmen, human rights commissions). While a solid body of literature is emerging on the role of judicial mechanisms (notably Gauri and Binks 2007, forthcoming), there are significant gaps in understanding in relation to how non-judicial mechanisms work, how they can best be constructed to have a positive impact on the poor, and how they articulate with formal legal mechanisms in different contexts.

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Annex 1: Legal, Institutional, Instrumental and Fiscal Domains Matrix

Chile

<table>
<tr><th colspan="4">Table A1. Right to Education in Chile</th></tr>
<tr><th>Legal Framework</th><th>Institutional Framework (1)</th><th>Instrumental Framework (Policies and Programs)(1) (2)</th><th>Financial Framework(3)</th></tr>
<tr><td rowspan="10">Constitution, Art. 19 (secs. 10 and 11) – declares the right to education and freedom of education.

Law Nº 18.956 – restructures the Ministry of Public Education (D.O. 08.03.1990).

Law Nº 18.962 – creates the Constitutional Organic Law on Education (D.O. 10.03.1990)

-Law Nº 19.494 — establishes norms for full-day schooling (D.O. 25.01.1997)

-Law Nº 19.532 — creates norms on the regime and application of full-day schooling (D.O. 17.11.1997)

-D.F.L. Nº 2/1998 — re-formulates and clarifies the text of -D.F.L. Nº2/1996, on state subsidies in education (D.O. 28.11.1998)

-D.F.L. Nº 1/2005 — reformulates and clarifies the text of the Organic Constitutional Law on Education Nº 18.962 (D.O. 21.02.2006)</td><th colspan="2">Pre-school Education</th><td rowspan="10"><u>Education Spending</u>
According to the Classification of Government Functions for 2005:

US$ 3,599,243,000 (4)

<u>Social Spending on Rights-based Policies:</u>

2002: US$ 2,277,358
2003: US $13,522,642
2004: US $69,688,679
2005: US$115,413,208
2006: US$140,730,189</td></tr>
<tr><td>Foundation INTEGRA, Socio - Cultural Section of the Presidency</td><td>Nurseries and kindergartens INTEGRA (national). For children of women in extreme poverty and/or social risk: workers, unemployed, heads of households, and youth with disabilities. Children of underage parents or beneficiaries of the SENAME system and Chile Solidarity System.</td></tr>
<tr><td>Foundation INTEGRA, Socio - Cultural Section of the Presidency</td><td>State kindergartens for children of temporary agriculture or tourism workers.</td></tr>
<tr><td>Foundation INTEGRA, Socio - Cultural Section of the Presidency</td><td>Intercultural Mapuche Nurseries (Regional). For children of Mapuche origin who live within communities of their ethnicity.</td></tr>
<tr><td>Foundation INTEGRA, Socio - Cultural Section of the Presidency</td><td>Kindergartens (regional) for children between 2 years and 4 years and 11 months of age, who live isolated areas with less population density.</td></tr>
<tr><td>National Association of Kindergartens (JUNJI)</td><td>Integrated Pre-school Education: nurseries and kindergartens, JUNJI: Classic Kindergarten. (National) for children Ander 6 from vulnerable areas.</td></tr>
<tr><td>National Association of Kindergartens (JUNJI)</td><td>Integrated Pre-school Education: nurseries and kindergartens, JUNJI: Classic Kindergarten. (National) for children under 6 from vulnerable areas.</td></tr>
<tr><td>National Association of Kindergartens (JUNJI)</td><td>Integrated Pre-school Education: nurseries and kindergartens, JUNJI: program for the families of children attending these centers.</td></tr>
<tr><td>Ministry of Education</td><td>Free Textbooks program. (National). For children from municipal and particular subsidized schools.</td></tr>
<tr><td>National Association of Kindergartens</td><td>Agreements with municipalities and other institutions (pre-school</td></tr>
</table>

Table A1. Right to Education in Chile			
Legal Framework	**Institutional Framework (1)**	**Instrumental Framework (Policies and Programs)(1) (2)**	**Financial Framework(3)**
	(JUNJI)	education, national). For children under 85 days, who live in poverty or are in a vulnerable position, and their subsequent integration in the General Basic Education system.	
	Subsecretariat of the Education Unit on Pre-School Education	Program for Childhood Improvement (PMI). Focuses on poor and extremely poor groups (concentrated rural and urban). For children under 6.	
	Ministry of Education	Regular Education Transition Subsidy program (preschool, national). For children under 6.	
	Basic and Middle Education		
	Ministry of Education	School subsidies for free or partially paid regular education of children and youth.	
	Subsecretariat of Education/ Ministry of Education	Law on 12 Years Obligatory Education. Pro-Retention subsidy program (national). For children pre-kindergarten to 4th grade of secondary education.	
	Subsecretariat of Education/ Ministry of Education	Law on 12 Years Obligatory Education. Intersectoral program for reintegrating youth in the school system (national). For children and youth who have dropped out of the school system (middle and secondary levels).	
	Subsecretariat of Education/ Ministry of Education	Intercultural Bilingual Education. Regions I, II, III, V, IX, X, XII and RM. Middle and secondary education for indigenous students. Municipal centers in various parts of the country where more indigenous population is concentrated.	
	Subsecretariat of Education/ Ministry of Education	Law on 12 Years Obligatory Education. Support to the Rural School Transport System. Focus on regions (*comunas*) where rural population exceeds 30%, and on the 20 *comunas* considered to be in situation of critical isolation by the Ministry of Education. Students form education centers governed by D.F.L Nº 2 of 1998 on Educación or by D.L. Nº 3.166 of 1980 on rural zones.	

Table A1. Right to Education in Chile			
Legal Framework	**Institutional Framework (1)**	**Instrumental Framework (Policies and Programs)(1)(2)**	**Financial Framework(3)**
	Ministry of Education	Increase of state subsidies (national) for students of municipal and certain subsidized schools.	
	Ministry of Education	Program for School Tools (national). For all children receiving PAE. Includes pre-school, basic and middle school students.	
	Ministry of Education (realized in coordination with the National Youth Institute)	Program for study tours for municipal schools. Region V and metropolitan region. For students in 2nd middle grade and 700 teachers in these regions.	
	National Association for Educational Support and Scholarships (JUNAEB)/ Ministry of Education	Presidential Scholarship (middle education, national). For low-income students, based on educational merit and conditions of vulnerability that put at risk their further education.	
	Subsecretariat for Education/Ministry of Education	Law on 12 Years Obligatory Education. Program School for All (national) for youth in middle education with at high social risk. Students in a vulnerable social position are often at higher risk of dropping out.	
	Subsecretariat for Education/Ministry of Education	Practice allowances for graduates from middle technical-professional schools (national). For graduates from these schools who have already begun their practice, or have finished it and are in the process of completing their degree.	
	Ministry of Education (realized in coordination with the National Youth Council)	Program for study tours for municipal schools. Region V and Metropolitan region. For students in 2nd middle grade and 700 teachers in these regions.	
	National Disability Fund (FONADIS)/Ministry of Planning	Scholarships for technical support: Program to Support Students with Disabilities (national). For children, youth and adults with low incomes and mental or physical disability.	
	National Association for Educational Support and Scholarships (JUNAEB)/ Ministry of	Indigenous Scholarship (national). For indigenous children and youth at a vulnerable socioeconomic position, and	

Table A1. Right to Education in Chile			
Legal Framework	**Institutional Framework (1)**	**Instrumental Framework (Policies and Programs)(1)(2)**	**Financial Framework(3)**
	Education	showing good academic performance in basic, middle, or higher education.	
	National Association for Educational Support and Scholarships (JUNAEB)/ Ministry of Education	Scholarships for Extreme Zones (middle and higher education). (Regional. Pascua and Juan Fernández Islands in Region V of Valparaíso and the Palena Province in Region X, as well as any location in Region XI, Aysén and Region XII, Magallanes). For students of these regions who show good academic performance and wish to continue their middle or higher education but lack such schools in their areas of residence.	
	National Association for Educational Support and Scholarships (JUNAEB)/ Ministry of Education	Housing Scholarships: Residential Student Family Scholarship (national). For low-income students in municipal and subsidized schools, preferably from 7th and basic grades (in special cases, can be given to students of lower grades) and from middle grades in rural areas.	
	National Association for Educational Support and Scholarships (JUNAEB)/ Ministry of Education	Housing Scholarships: Student housing (12 such houses exist in the country). For students of both genders in 7th, 8th or middle grades, mostly from rural or highly vulnerable social backgrounds.	
	National Association for Educational Support and Scholarships (JUNAEB)/ Ministry of Education	Housing Scholarships: Boarding School Scholarships (Regions: IV, V, R. M., VI, VII, VIII and X). For children in 7th, 8th or middle-school grades from isolated areas who wish to continue studying in technical or agricultural high schools, which are not available in their areas of residence.	
	Ministry of Education	School Transport Pass for public transport (national). For secondary and higher education students.	
	National Association for Educational Support and Scholarships (JUNAEB)/ Ministry of	School Food Program (also mentioned in the matrix on health).	

Table A1. Right to Education in Chile			
Legal Framework	**Institutional Framework (1)**	**Instrumental Framework (Policies and Programs)(1) (2)**	**Financial Framework(3)**
	Education		

(1) The institutional and instrumental frameworks are larger than the presented legal framework. The laws highlighted here are the general laws that regulate the education sector. Not every program is necessarily supported by a law in order to function.

(2) The programs and services described in this column have reached varying degrees of coverage and success. That is why they should be reviewed with caution – most do not incorporate educational guarantees for the entire population, not even for those segments of the population who are able to pay. At the same time, due to the existence of numerous programs and instruments in the country, it has been impossible to present a complete list in this matrix. Only the most significant national and some regional programs are included here.

(3) Budget data were obtained from the Budget Office of the Treasury of Chile. Information is available only up to 2005.

(4) Includes spending on higher education.

<table>
<tr><th colspan="4">Table A2. Right to Health in Chile</th></tr>
<tr><th>Legal Framework</th><th>Institutional Framework(1)</th><th>Instrumental Framework (1)(2)</th><th>Financial Framework(3)</th></tr>
<tr><td rowspan="12">Constitution Art. 19 Nº9: guarantees the right to health protection.

DFL 1/2005 Establishes the public and private health systems

DFL 725/67 Sanitary Code (regulates health promotion, protection and recovery)

Law 19.966 Establishes the General Regime of Health Guarantees (AUGE)

DTO 228/05 Determines the guarantees covered by the Law on AUGE.

DTO 68/06 Determines the minimum financial coverage of the Explicit Health Guarantees.

D.S. 136/05 Rules that establish the norms effectiveness and additional financial coverage of the explicit health guarantees.

D.S. 369/85 Rules on the Public Health System.

Ex. Resolution 1052 Regulates the Preventative Health Examinations</td><td colspan="2">Promotional/preventive (4)</td><td rowspan="12"><u>Spending on Health</u> According to the Classification on Government Functions for 2005:

US$ 3,599,243,000

<u>Spending on Rights-Based Policy (Plan AUGE):</u>

2002:
US$ 2,277,358
2003:
US$ 13,522,642
2004:
US$ 69,688,679
2005:
US$ 115,413,208
2006:
US$ 140,730,189</td></tr>
<tr><td>Ministry of Health (MINSAL)</td><td>National Plan for Health Promotion (national). For the entire population.</td></tr>
<tr><td>National Institute for Provisional Normalization (INP)/Ministry of Labor</td><td>Campaign for Integrated Care for Seniors. For pensioners in the INP.</td></tr>
<tr><td>National Association for Support and School Scholarships (JUNAEB)/ Ministry of Education</td><td>Life Capabilities Program. (Regions I, II, III, IV, V, VI, VII, VIII, IX, X, XII and Metropolitan). For children in 1st and 2nd grade in the Transition to Education; For pre-school and 1st -3rd primary grades of municipal and special subsidized schools, in areas with high socio-economic, psychosocial risk and bad state of education services.</td></tr>
<tr><td>National Association for Support and School Scholarships (JUNAEB)/ Ministry of Education</td><td>Healthy Schools Program. For communities and schools with at least 200 students.</td></tr>
<tr><td>Ministry of Health (MINSAL)</td><td>Early childhood development and evaluation of psychomotor development (national). For children under 6 who use the public health services (including health posts and clinics).</td></tr>
<tr><td>National Health Fund/ Ministry of Health (MINSAL)</td><td>Preventive Health Examination Program (national). For the entire population.</td></tr>
<tr><td>National Council for Drug Control; Ministry of the Interior</td><td>National Fund for the Prevention of Drug Consumption. For social organizations.</td></tr>
<tr><td>Ministry of Health (MINSAL)</td><td>Extended Immunization Program (national). For all children.</td></tr>
<tr><td>National Council for Drug Control; Ministry of the Interior</td><td>Family Program for the Prevention of Drug Consumption. Program PREVIENE) focused on 93 communities in the country. For individuals, organizations and institutions.</td></tr>
<tr><td>National Council for Drug Control; Ministry of the Interior</td><td>Preventative Program for Street Children and Youth. For children who spend most of their lives in the streets, are in situation of extreme poverty, malnourished, and/or consume drugs, do not attend school or have dropped out, as well as for children from dysfunctional families.</td></tr>
</table>

Table A2. Right to Health in Chile			
Legal Framework	**Institutional Framework(1)**	**Instrumental Framework (1)(2)**	**Financial Framework(3)**
DTO 594/99 Establishes sanitary conditions and basic sanitary rules for workplace environments.	National Council for Drug Control; Ministry of the Interior	School Prevention Program. For teachers, technicians, students, parents and guardians.	
	Ministry of Health (MINSAL)	National Complementary Food Program (PNAC). For children under 6 and pregnant women.	
	Ministry of Health (MINSAL)	Sanitary campaigns (national). For the entire population.	
	National Association for Support and School Scholarships (JUNAEB)/ Ministry of Education	Regular and special School Food Programs (PAE, national). For low-income students in pre-school, basic, and middle grades.	
	Ministry of Health (MINSAL)	Complementary Food Program for Seniors (national). For beneficiaries of the primary care centers of the national public health system (SNSS FONASA), who are older than 70, and for those who are older than 65 and are undergoing tuberculosis treatment in the center for primary health care.	
	National Institute for Provisional Normalization (INP)/Ministry of Labor	INP Active Sector Program (national). For micro, middle, and small enterprises.	
	Ministry of Health (MINSAL)	Youth Health Program (national). For children and youth between 15 and 19, throughout the country, who are registered in the public health system.	
	Ministry of Health (MINSAL)	Community Prevention Program (national). For formal and informal youth organizations formed around a project/ideas for health prevention.	
	Ministry of Health (MINSAL)	Children Health Program (national). For all children younger than 10, beneficiaries of the Public Health System.	
	Curative		
	Ministry of Health (MINSAL)	Plan for Universal Access to Explicit Health Guarantees (AUGE, national). For the entire population for treatment of 40 diseases.	
	Ministry of Health (MINSAL))	Odontological Care for Low-Income Citizens (national) For low-income women who are heads of household and for low-income families.	
	Ministry of Health (MINSAL)	Community Health Centers (national). For the entire population.	
	Ministry of Health (MINSAL)/	Family Health Plan (national). For	

Table A2. Right to Health in Chile			
Legal Framework	**Institutional Framework(1)**	**Instrumental Framework (1)(2)**	**Financial Framework(3)**
	National Health Fund (FONASA)	all affiliates of FONASA.	
	Ministry of Health (MINSAL)	Mental Health Program (national). Various beneficiaries according to the components of the program.	
	Ministry of Health (MINSAL)	Emergency Basic Care (SAPU, national). For beneficiaries of the public health system.	
	National Health Fund / Ministry of Health	Temporary benefits. For women who are seasonal workers.	
	Ministry of Health (MINSAL)	Health Program for Women (national) For all women between 25 and 64, affiliated with the public health system.	
	Ministry of Health (MINSAL)	Program for Adult Health.	
	Ministry of Health (MINSAL)	Program for Senior Adult Health (national) For all citizens older than 65.	
	National Association for Support and School Scholarships (JUNAEB)/ Ministry of Education	Medical Services for Students (opthalmology, otorhinolaryngology, and spinal – national). For students in pre-basic, basic and middle grades in municipal or special subsidized schools.	
	Ministry of Health (MINSAL)	Health and Indigenous People. Concentrated in 22 of the 28 health services: in the 44 communities of highest indigenous concentration. For all members of indigenous groups, who are beneficiaries of the public sector (FONASA A, B, C, D) of all ages.	
	Ministry of Health (MINSAL)/Ministry of Planning (MIDEPLAN)	United MIDEPLAN/ FONASA Chile Solidarity Program (national). For all beneficiaries of the Chile Solidarity System.	
	Ministry of Health (MINSAL)/Ministry of Planning (MIDEPLAN)	Accident Insurance Program (national). For beneficiaries of any income level (A, B, C, D) and of FONASA, regardless of income (A, B, C, D) and that receive services through the institutional window.	
	National Association for Support and School Scholarships (JUNAEB)/ Ministry of Education	Student Health Program (odontological services – regional). Applied in regions V, VI, VII, IX, X, XI, XII and Metropolitan). For students of age from 6 to 14 (1st to 8th grades of basic education). Dental services for students from 1st to 7th grades in vulnerable socio-economic situation, attending municipal and special subsidized	

Table A2. Right to Health in Chile			
Legal Framework	**Institutional Framework(1)**	**Instrumental Framework (1)(2)**	**Financial Framework(3)**
		schools. PAE – flour for students from 1st to 8th grade in rural communities with no fluorized water.	
	National Association for Support and School Scholarships (JUNAEB)/ Ministry of Education	Student Health Program (medical services – national). For students in pre-school, basic, and middle grades (ages 4-18) from municipal and special subsidized schools.	
	Rehabilitation		
	National Council for Drug Control; Ministry of the Interior	Program for Support of Plans for Treatment and Rehabilitation. For beneficiaries of FONASA with drug problems.	
	National Fund on Disability (FONADIS)/ Ministry of Planning	Funding for Technical Help (national) for low-income persons with disabilities or non-profit organizations that provide care for them.	
	National Fund on Disability (FONADIS)/ Ministry of Planning	National Project Competition: Prevention and Rehabilitation (national) for persons with disabilities (physical/mental/ sensory).	
	Ministry of Health (MINSAL)	National Program for Relief and Palliative Care for cancer patients (national) for all patients diagnosed with terminal/advanced cancer, confirmed by a specialist.	

(1) The institutional and instrumental frameworks are larger than the presented legal framework. The laws presented here are the general laws that regulate the health sector. Not every program is necessarily supported by a legal provision in order to function.

(2) The programs and services described in this column have reached varying degrees of coverage and success. That is why they should be reviewed with caution – most do not incorporate health guarantees for the entire population, not even for the segments of the population who are able to pay for services. At the same time, due to the existence of numerous programs and instruments in the country, it has been impossible to present a complete list in this matrix. Some regional and local programs have been omitted.

(3) Budget data have been obtained from the Budget Office of the Treasury of Chile. Information is available only up to 2005.

Table A3. Right to Housing in Chile			
Legal Framework	**Institutional Framework**	**Instrumental Framework (Policies and Programs)**	**Financial Framework (3)**
- Constitution: Art. 5.2º - International: Art. 11.1 of the International Covenant on Economic, Social and Cultural Rights (19.12.1966) - Legal: (a) Law N° 16.391 (D.O. 16/12/1965) created the Ministry of Housing and Urban affaire (V. and U.); (b) Decree Law N° 1.305 of 1975 (D.O. 19.02.1976); (c) General Law on Urban Affairs and Constructions (D.F.L. Nº458, D.O. 13.04.76); (d) D.L. Nº2.552/1979; Law Nº 19.537/1997 (co-ownership of real state). - Regulations: (a) General order on Urban Affairs and Constructions; (b) D.S. Nº 174, V. and U. (D.O. 09.02.2006) – approves the Rules on the Housing Solidarity Fund; (c) D.S. N° 40, V. and U. (D.O. 19.03.2004) – approves the Rules on the System for Housing Subsidies; (d) D.S. Nº62, V. y U. (D.O. 20.06.1984); (e) D.S. Nº 149.V y U. – sets the rules of the Program for Improving Family Housing and its Surroundings (D.O. 20.07.2005); (f) D.S. Nº 255/2006 (V. y U.) – sets the rules of the Program for Family Protection (D.O. 25.01.2007); (g) D.S. Nº127, V. y U. – sets the rues of the Participatory Program for Financial Assistance in Social Housing Condominiums (D.O. 08.10.1998); (h) D.S. Nº117/ 2002, V. y U. – approves Rural Subsidy Program.	- Ministry of Housing and Urban Affairs (MINVU); - Regional Ministerial Secretariats (SEREMI) of housing and urban affairs; - Housing and urbanization services (SERVIU); - Other organs with housing competency (e.g., municipalities – especially their sections of public works; regional governments (GORES) and regional environmental commissions (COREMAS); MIDEPLAN in the case of the beneficiaries of the Chile Solidarity Program.	- Solidarity Housing Fund I and II; - System for Housing Subsidies; - Rural Subsidies; - Progressive Housing Program; - Housing without Debt; - Housing for Senior Adults; - Program for Family Protection. - Program for Improving Family Housing and its Surroundings; - Participatory Program for Financial Assistance in Social Housing Condominiums; - System for Housing Mobility (National) for subsidized beneficiaries and/or debtors of SER VIU; - Chile Housing Solidarity Program (National). For family beneficiaries of the Puente program.	**Spending in the Housing Sector and Community services** According to Classifications of Government functions for 2005: **US$ 264,574,000**
(3) Budget data has been obtained from the Budget Office of the Treasury in Chile. Information is available only up to 2005.			

Guatemala

Table A4. Right to Education in Guatemala

Legal Framework	Institutional Framework (Formal and Informal)	Instrumental Framework (Policies and Programs)	Financial Framework (USD, 2006)
Constitution, Art. 71 and 74 – obligation of the state to provide education without discrimination. Parents have the right to choose regarding the education of their dependent children.	Ministry of Education	Initial Education	1,368,079
National Law on Education, Congress Decree 12-91 – guarantees the right to access to education and the obligation of the state to provide it, responding to social demand and to the multicultural/multilingual demographic. Establishes the functions of the Ministry of Education. Internal Organic Rules of the Ministry of Education, Government Agreement 20-2004 – defines the internal structure and organization of the Ministry of Education. Law on Social Development, Congress Decree 42-2001 – every person has the right to education and to equal benefit from the educational services provided by the state (Art. 27). Law on the Dignity and Promotion of the Rights of Women, Congress Decree 7-99 – the state guarantees that education in all stages for women will be provided in conditions of equity, and non-discrimination. Recognizes the right of indigenous women to attend school in indigenous clothing. Law on the Protection of Children and Youth, Congress Decree 27-2003 – establishes the right to education, and participation in cultural and sports activities. States the obligations of the public education system, of the state, parents and educators.		Pre-primary Education	33,384,962
		Bilingual Pre-primary Ed.	9,698,554
		Primary Education	301,128,695
		Bilingual Primary Education	23,706,374
		National Program for Self-managed Primary Education (PRONADE)	71,521,931
		Primary Education for Adults	3,519,269
		Middle-School Education	47,223,192
		Program for Universal Secondary Education	18,138,240
		Diversified Middle Education	25,244,758
		Out-of-school Education – includes alternative modes of schooling	3,705,751
		AIDS and Drug Prevention	649,351
		Literacy Campaign	9,901,393
	After Education Reform	Program for the Development of School Administration (PROESCOLAR)	
		Curriculum Reform	
	Population and Social Development Policy	Program for Education and Human Development	
		Program for Increasing Coverage and Quality of Education	
		Program for Integral Attention to Children 0-6 (PAIN)	1,368,079
		Community Pre-school Learning Centers (CENACEP)	505,657
		National Program for Self-managed Primary Education (PRONADE)	71,521,931
		De la Mano Edúcame	
		Telesecundaria	6,404,651

Table A4. Right to Education in Guatemala			
Legal Framework	**Institutional Framework (Formal and Informal)**	**Instrumental Framework (Policies and Programs)**	**Financial Framework (USD, 2006)**
Individuals with disabilities have equal educational rights as far as their physical or mental limitations permit. From Peace Accords: Accord on Socioeconomic and Agrarian Issues; Accord on the Resettlement of Persons Displaced by Armed Conflict; and Accord on the Identity and Rights of Indigenous People – commitment of the state to implement an education reform that includes decentralization and adaptation of education to the cultural and linguistic necessities of indigenous people. In addition, the state commits to guarantee citizen participation, including that if indigenous people, in the creation of their respective curricula. Municipal Code, Congress Decree 12-2002 – municipalities are responsible for the provision of Pre-school and Primary education programs as well as of literacy and bilingual programs. Law Against Discrimination in Education, Congress Decree 81-2002 – the Ministry of Education is responsible for including a focus on eliminating discrimination in the education reform.		Institutes	9,077,543
		Physical Education Program	3,061,071
		Boarding School Program	
		School Food Program	28,709,382
		School Utilities Program	4,882,931
		School Textbook Program	6,568,647
		Scholarship Programs (sub-programs for: girls, peace, food assistance, academic excellence, eradication of child labor.	2,026,637
		School Subsidies Program (for transport; schools in Maya communities; non-profit educational organizations).	
	Education Reform 'In the Classroom	"Save First Grade"	
		Program for Multi-grade Schools	
		Support to the Education Sector	
		A la excelencia academica, soy uno	
		Libros por Amor	
		Inclusive Education	
		Educators' Committee for HIV/AIDS Prevention	
	Policy: "The Schools Belong to the Community"	School Boards (*Juntas Escolares*)	5,337,749
		Education Committees	
		Opposition Juries (*Jurados de Oposición.*	
		Institutions for Educational Services	
	Policy: "Education in a Competitive World"	Accelerated Primary Education	
		Family Educational Centers for Development	
		Municipal Centers for Capacity-building and Human Development	
		Pedagogical Centers	
		Educational Radios	
		Mobile Youth Program	
		Juvenile Community Workers *(Promotores Juveniles Comunitarios)*	

Table A4. Right to Education in Guatemala

Legal Framework	Institutional Framework (Formal and Informal)	Instrumental Framework (Policies and Programs)	Financial Framework (USD, 2006)
	Policy for Inclusive Education of Children with Special Needs or Disabilities	Inclusive Education	741,291
		Schools for Parents and Special Education Schools	

Table A5. Right to Health in Guatemala

Legal Framework	Institutional Framework	Instrumental Framework		Financial Framework (USD, 2006)
		Policies	Programs	
Constitution: Health is a fundamental human right and the state has the duty to ensure it is provided to all. All citizens have the duty to ensure health is protected (Art. 91, 94, 100).	Ministry of Public Health and Social Assistance (MSPAS)	Strengthening of the governing role of the Ministry		
Health Code, Congress Decree 90-97 – right of all citizens to health promotion, prevention and recovery; obligation of the state to guarantee the exercise of this right. Creates and defines the functions of the major health sector institutions under MSPAS. Creates the National Health Council as an evaluation body. Notes that MSPAS must develop a health care model considering the multiethnic composition of the state.		Satisfying the basic health needs of the population through the provision of quality and equitable services, considering the multicultural nature of the state in all levels of health care.	Health Service Program	236,515,806
			Integrated Health Care System	5,228,376
			Program for Individual Health Attention	
			Program on Vector-Borne Diseases	
			National program on chronic Non-Transmittable Diseases	
			National program on Oral and Dental Health	
Law on the Executive, Congress Decree 114-97 – obligation of MSPAS for all health activities.		Strengthening the de-concentration and decentralization of competence, responsibility, resources, and authority of national hospitals.	National Mental Health Program	
			National Program on Tuberculosis	
			National Program on Migrant Population	
Law on Social Development, Congress Decree 42-2001 – recognizes the right of all to responsible parenthood and reproductive health. Creates the Program on Reproductive Health. Establishes special measures to promote access to social programs for children in more vulnerable state.		Acquisition and provision of inputs in an optimal manner for the development of activities of health promotion, prevention, recovery and rehabilitation.	National AIDS Prevention Program	2,597,403
			National Program on Reproductive Health	4,230,245
			National program on Popular, Traditional and Alternative Medicine	
			Program for Access to Medications	3,203,420

Table A5. Right to Health in Guatemala				
Legal Framework	**Institutional Framework**	**Instrumental Framework**		**Financial Framework (USD, 2006)**
		Policies	**Programs**	
Law on the Universal and Equitable Access to Family Planning and Reproductive Health Services, Congress Decree 87-2005.		Modernization of administrative and financial management on the Ministry of Health and Social Assistance as an element of support to the delivery of health services.	Program on Extending Coverage of Health Services	29,163,068
Law on the Protection of Children and Youth – right to life and duty of the state to guarantee healthy life for children and youth.		Strengthening the development and administration of human resources in the health sector.		
General Law on Combating HIV/AIDS, Congress Decree 27-2000 – establishes mechanisms for education, prevention, research and epidemiologic vigilance. Guarantees respect and protection of the human rights to those affected by the virus/syndrome.		Promotion of activities that improve the healthy environment and quality of life of the population.	Program on Environmental Health Services	612,212
			Program for Environmental Control	
Law on Blood Transfusion Services – guarantees that blood tests for syphilis, HIV/AIDS, Hepatitis B and C will be performed.		Protection of the Population from Risks Related to Food and Medication Consumption.	Surveillance and control of related activates program; Program for Food Control	
Government Accord 342-86 – all persons affected with an STD must receive treatment in the institutions of MSPAS.				
Agreement on Socioeconomic Issues and the Agrarian Situation – MSPAS must implement health reform to ensure universal access to				

Table A5. Right to Health in Guatemala				
Legal Framework	**Institutional Framework**	**Instrumental Framework**		**Financial Framework (USD, 2006)**
		Policies	**Programs**	
health services, and increase health budget by at least 50% in 2000. Municipal Code, Congress Decree 12-2002 – duty of municipalities to monitor for compliance with sanitary standards.				
Organic Law on the Guatemalan Institute for Social Security (IGSS), Decree Law 295.	Guatemalan Institute for Social Security (IGSS)		Program on Accidents Maternity and Disease Program Disability, Seniority and Survival Program (IVS)	

Peru

Table A6. Right to Education in Peru (basic, ages 4-5; primary ages 6-11; secondary ages 12-16)			
Legal Framework	**Institutional Framework (Formal and Informal)**	**Instrumental Framework (Policies and Programs)**	**Financial Framework (USD, 2006)**
Constitution of the Republic of Peru — Art. 17 guarantees access for all. General Law on Education Nº 28044 — Recognizes that education is a right of all people; Recognizes the multicultural nature of the state; state's responsibility to guarantee free access to and quality of basic education (Art. 21). Decree Law Nº 25762: Organic Law of the Ministry of Education, modified by Law Nº 26510.	Ombudsman (*Defensoría del Pueblo*) Ministry of Women and Social Development (MIMDES)	 - Initial Education - Primary Education - Secondary Education - Special Education - Program for Education in Rural Areas - Program for National Mobilization for Literacy - National Program for Educational Infrastructure National Education Project 2006-2021	11,031,906.76 50,615,140.40 171,276,620.63 201,269,617.14 9,276,830.69 13,880,704.50 4,292,678.37 12,846,701.69
	Ministry of Women and Social Development (MIMDES)	FONCODES: Program for Education in Rural Areas	2,350,006.41
General Law on Persons with Disabilities Nº 27050.	Ministry of Women and Social Development (MIMDES)	National Council for Integration of Persons with Disabilities (CONADIS)	1,159,336.49
Supreme Decree N° 067-2001-ED.	MINEDU	Project *Huascarán*	2,600,673.76
Law Nº 28530 on Internet access for education purposes.	Ministry of Transport and Communication	National Institute for Investigation and Training in Telecommunications (INICTEL)	3,666,009.99
Law Nº 28628 — creates Parents' Associations (APAFAs) – responsible for monitoring access to and quality of education. Participate in decision-making regarding budget spending and hiring of teachers.		Parents' Associations (APAFAs)	No information
Law Nº 27427 on protected social programs (including initial, primary and secondary education).	Ministry of the Economy and Finances		1,350.2
Law Nº 28086 on the Democratization of the Book and the Development of Reading; Article 3.4 guarantees funding for school libraries in primary and secondary schools.	National Library	PROMOLIBRO/ FONDOLIBRO	15,666.71
Supreme Decree N° 062-2005-Program on transfers to the poorest.	Presidency of the Council of Ministers	National Program for Direct Support of the Poorest –	54,300,814.69

Table A6. Right to Education in Peru (basic, ages 4-5; primary ages 6-11; secondary ages 12-16)			
Legal Framework	**Institutional Framework (Formal and Informal)**	**Instrumental Framework (Policies and Programs)**	**Financial Framework (USD, 2006)**
(Draft) Law 28740 of the National System for Evaluation, Accreditation and Certification of the Quality of Education (SINEACE) – does not explicitly refer to the right to educational quality.	MINEDU	JUNTOS SINEACE via the Peruvian Institute for Evaluation, Accreditation and Certification of the Quality of Education.	At the level of draft bill, not functioning; has not been allocated a budget.
Supreme Decree N° 002-96-ED.	MINEDU	Unit for Measuring the Quality of Education (UMD).[74]	No information
Law N° 19326 on the establishment of bilingual education; (Law N° 21156: declares Quechua an official language along with Spanish).	MINEDU	Project of Bilingual Education (PBE).	No information
Law 28332 on the National Fund for Educational Development (FONDEP) – for all public schools, giving priority to deprived areas (Art. 4.4).		National Fund for Educational Development (FONDEP).	No information

[74] *Unidad de Medición de la Calidad Educativa* www.minedu.gob.pe/umc/.

Table A7. Right to Health in Peru			
Legal Framework	**Institutional Framework**	**Instrumental Framework (Policies and Programs)**	**Financial Framework (USD, 2006)**
Constitution of Peru Art. 7 – everyone has the right to the protection of his/her health Art. 11 – the government guarantees free access of health care through public, private or joint agencies and oversees their efficient operation.			
General Law on Health Nº 26842 Law of the Ministry of Health Nº 27657 /Regulation on the Law Nº 27657	General Office of Health Promotion of the Ministry of Health (MINSA)	Program on Health Promotion (*Modelo de Abordaje de Promoción de Salud)* Program for Healthy Family and Healthy Living Program for Health in Educational Institutions Program for Health in Municipalities and Communities Program for Health in the Workplace Information System of the Program for Health Promotion in educational institutions System of Information on Mental Health System of Community Health Monitoring (*SÍVICOS*) Technical Unit on Human Rights, Gender Equity, and Multiculturalism in Health — *MINSA* Model for Integral Attention on Health (*MAIS*)	Total expenditure on health promotion (including administrative expenses) was 2,099,823.16.
	National Institute of Health and Specialized Institutes		138,434,155.11
	Health offices in the respective districts	Hospitals/ public health establishments	Total or partial subsidies for medical attention for the low-income population. The spending of health offices was 58,826,389.19; the aggregate hospitals' spending was 289,242,805.45. In 2006 117,496,075.16 was spent on individual health care, and 173,940,575.39 on specialized health care.

	Office of Community Participation of the Ministry of Health		
	General Office of Human Health at the Ministry of Health	National Sanitary Strategies	15,325,575.02 were spent on epidemic control through the National Sanitary Strategy for prevention and control of metaxenic and other vector-transmitted diseases.
		Project 2000	
		Project on Basic Health and Nutrition	
		Program on Strengthening of the Basic Health Services	532,790.95
		Project '*Vigía*' — A project to confront the threats from emerging and reemerging infectious diseases	
		Program on Basic Health for All	
		Project 'Coverage with Quality' (*Cobertura con Calidad)*	19,525,221.35
	Ministry of Health	Integrated Health System (SIS)	93,990,592 /full-cost subsidy was extended for individual health care of persons living in extreme poverty
		Local Committee/s for Health Administration	19,525,221.35
	Office of Supervision of Health Providers		2,350,548.32
	Ombudsman Office for Health and Transparency at the Ministry of Health	INFOSALUD	No information
	Judiciary Power	Constitutional processes of protection and compliance	More than 185,850,020.19 were spent in 2006 on legal cases in the Supreme Court and High Courts of Justice
Organic Law on the Ombudsman Nº 26520	Ombudsman	Facilitates the access to quality health services of excluded population	6,048,744.33 were spent on defense of legal and constitutional health rights
Ministerial Resolution Nº 234-2005	Ministry of Health	Projects on support for the Modernization of the Health Services and their application in regions of Peru (AMARES)	908,878.68
Law Nº 27656 on the creation of the Intangible Solidarity Fund for Health – its purpose is to facilitating access to quality health services for the population that has been excluded from such access.	Ministry of Health; Ombudsman; Ministry of Foreign Affairs	Intangible Solidarity Fund for Health (FISSAL) /Integrated Health System (SIS)	Amount not available. The fund will be used for the building and equipment of SIS, just when the program has achieved the goal of total coverage.

Table A8. Right to Food in Peru			
Legal Framework	**Institutional Framework**	**Instrumental Framework (Policies and Programs)**	**Financial Framework (USD, 2006)**
Law Nº 27470 Art. 4 contains norms on determining nutritional quality	District Municipalities	Program "Glass of milk" (*Vaso de Leche)* – distributed through local Glass of Milk committees. National Institute of Health – determines minimum nutritional requirements for the distributed food rations.	115,703,150.55
Supreme Decree Nº 020-92-PCM	Ministry of Women and Social Development/ National Program for Food Assistance	Food and Nutrition Program for High-Risk Families (PANFAR)	3,944,441.34
		Complementary Food Program for Groups at High Risk (PACFO).	15,267,363.57
		Program for Children Canteens, outside of school (Infant Feeding Kitchens).	7,125,393.73
Decree Law Nº 22816	Ministry of Health, Ministry of Education, Ministry of Women and Social Development	School Breakfasts Program	56,939,462.36
		School Lunches Program	8,206,481.32
		Food Assistance Program at the Pre-school level (*Centros de Educacion Inicial* – CEIS; *Programas No Escolarizado de Educacion Inicial* – PRONOEIS)	11,673,561.53
Law Nº 28128	Ministry of the Economy and Finances (MEF)	Programs under the Protection of MEF.	Approximately 100 mln are allocated to the Glass of Milk program every year
Supreme Decree Nº 014-2002-SA		National Center for Food and Nutrition.	1,157,789.44
Law Nº 27731	Grassroots organizations – a group of grassroots organizations forms a Glass of Milk Committee		
Law Nº 25307			
Law Nº 28540 – creates the Unified Regional Registry of Social Program Beneficiaries	Ministry of Women and Social Development	Unified Regional Registry of Social Program Beneficiaries.	No information
Law Nº 27751 – eliminates discrimination against persons with disability in health and food programs			

Uruguay

Table A9. Right to Education in Uruguay			
Legal Framework	**Institutional Framework**	**Instrumental Framework (Policies and Programs)**	**Financial Framework**
Constitution Art. 70 and 71, Law 15739 Art. 6: free obligatory education Laws 14101 and 17015: obligatory education from preschool until the third year of secondary school. Constitution Art. 68 and Law 15739: secular nature of education.	Ministry of Education and Culture, National Administration for Public Education (ANEP), Council for Primary Education (CEP), Council for Secondary Education (CES) and Council for Technical-Professional Education (CETP).	**Primary Education** Public part-time schools, full-time schools, special schools and rural schools. **Secondary Education** Public high schools, Centers UTU with Basic Technical education and 2-year technical degree.	ANEP is the responsible institution, with funds based on a five-year public budget and a special Tax on Primary Education collected from all households. Programs MECAEP y MEMFOD financed by IADB. No information on the modification of budgets according to changes in demand.

Table A10. Right to Health in Uruguay			
Legal Framework	**Institutional Framework**	**Instrumental Framework**	**Financial Framework**
Constitution Art. 44: free health care for those who lack resources. Law 16426, Decree - Law 15181 and Decree 495/989: private and mixed public-private services. Penal Code Art. 32: the right to medical assistance to children, those who are unable to support themselves, and those who have been hurt or fainted.	State Administration for Health Services (ASSE). Social Prevention Bank (*Banco de Previsión Social, BPS*) for health insurance. National Insurance Company (*Banco de Seguros del Estado*) for insurance against work accidents of employees in the formal economy.	Public polyclinics and hospitals and their general services for low-income population. The only institution that acts to ensure equity in the distribution of health services is the National Resource Fund, which guarantees equal attention regardless of the type of service (public, private, or mixed) to which the user accedes.	-Ministry of Public Health, based on a five-year budget - Salary or other income support (Office for Social Security in Case of Illness, DISSE); Family Allowances). No information on the modification of budgets according to the changes in demand.

Table A11. Right to Income in Uruguay			
Legal Framework	**Institutional Framework**	**Instrumental Framework (Policies and Programs)**	**Financial Framework**
Emergency Social Assistance			
Law 17866: Creation of the Ministry of Social Development (MIDES) Law 17869: Establishment of the National Plan for Social Emergency (PANES). Law 17869 Art. 10: Cases in which the beneficiary may lose the allowance from the Citizen Income Program, such as unjustified failure to complete the conditions specified above or the determined set of eligibility requirements.	The Ministry of Social Development (MIDES). The Social Insurance Bank (BPS).	Direct contact with eligible population who are not aware of the benefit.	Law 17869 determines the resources. No information on the modification of budgets according to the changes in demand.