INTERNATIONAL FEDERATION OF HEALTH AND HUMAN RIGHTS ORGANISATIONS

REPORT

The UN Special Rapporteur on the Right to the Highest Attainable Standard of Health: Looking Back and Moving Forward

International Symposium

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Introduction

In 2002, for the first time a Special Rapporteur on the "right to of everyone to the enjoyment of the highest attainable standard of physical and mental health" was appointed by the United Nations Human Rights Council. After serving two terms, Prof. Paul Hunt of the Human Rights Centre of Essex University handed over the mandate to his successor recently. To look back at his work over the years and reflect on the way to move forward, the International Federation of Health and Human Rights Organisations (IFHHRO) together with the Human Rights Centre organised a symposium in London from 25 to 27 September. This symposium was a unique meeting as both the leaving and incoming Special Rapporteurs attended. Some 100 people participated from all over the world, ranging from UN staff, researchers, human rights educators, lawyers, to health rights advocates and health workers. This wide variety of backgrounds, experiences and perspectives gave the new Rapporteur, lawyer Anand Grover from India, an excellent opportunity to listen to the voices of a diverse group of promoters of the right to health in a relatively short period of time. In June, Grover was appointed Special Rapporteur by the UN Human Rights Council for a period of three years. He started work in August 2008.

In his six years of office, Paul Hunt and his team of the Human Rights Centre have left an impressive body of reports offering detailed analyses on elements of the right to health.[1] Among others, Hunt developed a framework for analysis of health-related issues that had so far not been studied from a human rights perspective. At the symposium most of the themes studied and strategies explored by the Special Rapporteur were discussed in plenaries and workshops, and suggestions for further research and implementation were offered. All participants were requested to give suggestions and recommendations to 1) the new Special Rapporteur, 2) health workers, and/or 3) the health and human rights community.

This report presents a summary of the presentations and group discussions, as well as the suggestions offered. It should be made clear in advance that these suggestions may not represent the opinions of all the participants. They should be regarded as a combined wish-list of a group of experts from different countries, backgrounds and professions rather than a rigorously debated set of recommendations. As such, the new Special Rapporteur, health professionals and their organisations, as well as health and human rights organisations may pick and choose from them as they wish.

[1] A full list of all the Special Rapporteur's reports including online access can be found on the websites of IFHHRO (www.ifhhro.org) and the Human Rights Centre (www2.essex.ac.uk/human_rights_centre/rth).

Plenary 1: The Right to the Highest Attainable Standard of Health, the Special Rapporteur and Health Workers

The first plenary on Thursday 25 September 2008 focused on the UN Right-to-Health mandate generally and the issue of health workers' involvement in human rights work. **Paul Hunt**, the former Special Rapporteur on the Right to the Highest Attainable Standard of Health, gave a brief overview of the six years of his mandate. Then, **Daniel Tarantola** of the Harvard School of Public Health raised several issues that could be taken up by the new Special Rapporteur. Finally, **Kgosi Letlape** from the African Medical Association highlighted the difficulties encountered by the health and human rights community to mobilise medical associations to fight for greater access to health care.

Paul Hunt, Human Rights Centre

Paul Hunt first emphasised that the production of reports – the core of his legacy – was a collaborative effort, based on extensive consultations with various actors and the hard work of his team at the Human Rights Centre and others. He also expressed the wish that the analyses in the reports will help the new Special Rapporteur in his endeavours.

The objectives of the mandate were and still are:
1. to raise the profile of the right to health as a fundamental human right
2. to clarify what it means
3. and to make it more operational by providing guidance on how to implement it.

General Comment 14, Hunt said, offers a common framework for unpacking the right to health.[2] However, it only gives limited guidance as it is a general text. Therefore, Hunt applied the framework to specific issues, which he studied using a human rights lens. Examples are neglected diseases, mental health and maternal mortality. Moreover, he elaborated elements of General Comment 14 and produced reports on issues such as indicators, benchmarks, the progressive realisation of the right to health, and accountability.
Hunt said that health workers in general do not like the language of General Comment 14. The document uses concepts as duty bearers, accountability, 'respect, protect and fulfil rights', etc., which are unfamiliar to most health workers. Health workers can play a vital role in promoting the right to health and besides, the right to health could assist them to deliver their professional duties. So, it is very important to involve them, but how? Of course it is important to always apply a right to health lens, but there is not always a need to be explicit about that. It could be more pragmatic to use other, more effective language, e.g., the concepts of equity and participation, to enlist health workers.

Another issue raised by Paul Hunt is that we should not overstate the role of the right to health. The right to health is central to health and human rights. It is more precise, more specific and more focused than the broader concept of health and human rights. However, the right to health concept does not give all the answers. Sometimes there is a double standard: more precision is expected from the right to health than from other human rights concepts.

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[2] General Comment 14 is a further explanation of Article 12 (the right to the highest attainable standard of health) of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which provides guidance on what the right to health means in practice.
http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En

In 2006, after four years of office, Hunt entered a new stage, he said. He realised by then that a more systemic approach was necessary. Thus, his attention turned from isolated themes to the issue of health systems and related topics, such as mainstreaming the right to health in the health sector, and the skills drain in developing countries. Another thing he started to realise was that, in order to be able to fully address the whole subject, it is also necessary to bring non-state actors into the arena. Thus, in his last year of office, Hunt and his team drafted rights-based guidelines for pharmaceutical companies, which were recently finalised.[3]

Daniel Tarantola, University of New South Wales Initiative for Health and Human Rights

Daniel Tarantola, who was involved in the drafting of General Comment 14 some years ago, said that he realised at the time that it had some flaws and inadequacies. A General Comment '14B', that is, a new document, could build on the old General Comment and include what we have learned in the last eight years since its conception.
During his lecture, Tarantola raised several issues that could be taken up by the new Special Rapporteur:

- Do not look at health workers just as promoters of the right to health, but instead as pivotal resources for change. Massive investments need to made in the health workforce. The Special Rapporteur should continue the work on health workers' migration, retention, education and payment.
- The global schemes such as GAVI (advancing child immunisation) and the Global Fund (fighting AIDS, malaria and tuberculosis) can be held accountable on health outcomes, but so far there is no provision to hold them accountable on human rights. This is also an issue the Special Rapporteur could look into.
- The problem with the recently released report of the WHO Commission on Social Determinants is that it is not linked to a human rights framework, which is a missed opportunity. The social determinants of health, such as access to safe drinking water and sanitation should be rephrased as state obligations and not only be regarded as social justice issues. A companion report to the official WHO report could recast the conclusions in a health and human rights framework. This new report might help civil society organisations to advocate for greater access to the social determinants of health.
- There is a relationship between health and development. People who are vulnerable to ill health also may be more vulnerable to food crises, the consequences of climate change, economic crises, etc. We need to overcome the barriers between health and these other issues and health workers should be educated on these links.

In response to a comment from the audience, Tarantola said that we should engage more with politics, as health is a highly political issue. This should not be limited to informing politicians, but include trying to shape policies.

3 Report to the UN General Assembly, 2008 (A/63/263) (see Annex)

Kgosi Letlape, South African Medical Association

Kgosi Letlape, who is the past president of the World Medical Association and current chairperson of the South African Medical Association, started his presentation by stressing that medical associations may not be the most perfect allies of the health and human rights movement. They are voluntary associations, which doctors basically join out of self-interest. They are also conservative by nature. Some issues raised by Letlape are:

- A huge challenge for medical associations is how to achieve access to the health system for all in countries where discrimination is common and where there are parallel systems of care, i.e. one well-resourced private system for the rich and a crumbling public system for the poor. State policies may not always promote the right to the highest attainable state of health. How can states be the guardian of this right when they are the perpetrators of violations?
- Another challenge to the right to health is the 'brain drain' of doctors to western countries and to the private sector. Prohibiting doctors to leave the country is not a good solution, as they have the right to move. One reason why doctors become doctors is that they like the lifestyle associated with it and we should keep that in mind.
- We need to start a debate on the role of western countries in this regard. They should compensate developing countries for the brain drain. Another issue which needs to be addressed is conflicting priorities of western countries. They may want to collaborate with developing countries on military issues such as the arms trade, but refuse to collaborate on access to medicines and health care.

In reply to a comment from the audience, Letlape stated that health and human rights organisations have become separated from medical associations. They should make it their business to change the mandate of medical associations and make sure these start to focus on access to health care.

Plenary 2: Health Systems and the Right to the Highest Attainable Standard of Health

(Friday, 26 September 2008)

In January 2008, the Special Rapporteur published a report on health systems and their links with realising the right to health.[4] In the second plenary session, issues related to health systems were addressed. First, **Gunilla Backman** of the Human Rights Centre briefly described the development, contents and impact of the report. Then, **Adriaan van Es**, coordinator of IFHHRO, gave his views on the issue. Finally, **Amar Jesani**, who is affiliated to CEHAT (an NGO in India) and the Indian Journal of Medical Ethics, spoke about the private sector and user fees as barriers to realising the right to health. After the plenary, four workshops related to health systems took place, on accountability; indicators and impact assessment; the social determinants of health; and international assistance and collaboration.

Gunilla Backman, Human Rights Centre[5]

Over the years, the Special Rapporteur has stressed the important role of health systems: "At the heart of the right to the highest attainable standard of health lies an integrated health system, encompassing health care and the underlying determinants of health, which is

[4] Report to the Human Rights Council, 2008 (A/HRC/7/11)
[5] PowerPoint presentation available on the IFHHRO website

responsive to national and local priorities, and accessible to all. Without such a health system, the right to the highest attainable standard of health can never be realised." Given its importance, the Human Rights Council asked Paul Hunt to try and identify key features of such a system.

After an extensive literature review and consultations and meetings with academics, UN agencies, health workers, local and national NGOs and representatives of indigenous populations, the team drafted a list of conditions for an integrated health system, which was presented by **Gunilla Backman**, Senior Research Officer at the Right to Health Unit of the Human Rights Centre.[6] It was decided that the added value of such an exercise would be that there is a legal obligation for governments to make sure that a good-quality, accessible system is in place. Some of the fundamental right-to-health features and principles that must underpin any health system are:

- At the centre should be the well-being of individuals, communities and populations.
- The right to health should be explicitly recognised and principles of transparency, participation, equity, equality, non-discrimination, cultural acceptability and quality should be uphold.
- The underlying determinants (including social determinants) should be dealt with, for instance, safe water and sanitation, food, housing, safe environment, education, gender, poverty and social exclusion.
- It should be underpinned by a comprehensive national health plan, including a situational analysis, prioritisation, impact assessment, time frames, monitoring & evaluation, accountability and an appropriate budget.

Backman said that the report can be used as an operational resource for governments and other actors. For example, Guatemala wants to use it to revise its health system and also USAID in Guatemala expressed an interest in utilising it.

Adriaan van Es, IFHHRO

Adriaan van Es, coordinator of IFHHRO, spoke from his own perspective as a health professional in the Netherlands. That country made a major shift in the last few years from public to private health care, culminating in 2006 in the full privatisation of health insurance. Dr. Brigit Toebes did a case study on this in 2007 and concluded that once there is privatisation, the question comes up how to regulate the private sector and protect the public from malpractice. In this regard, mechanisms for legal recourse are necessary.[7]
The issue of financing health care – especially primary health care – is another key question. Should this be entirely financed from the national budget or could insurance systems play a role? In the first case, how can we ensure that health does not have to compete with other sectors, such as defence? In the Netherlands, as well as in other Western countries, the majority of the population is insured. In the developing world, examples of wide-reaching insurance schemes are rare and evidence on existing projects is inconclusive.

From the perspective of health professionals, what can they contribute to the right to health (care)? Van Es suggested to develop a clearly visible protocol on health-care entitlements. With

[6] An explanatory figure can be found in the PowerPoint presentation.
[7] Brigit Toebes, The right to health and the privatization of health care services: a case study of the Netherlands, *Health and Human Rights (Quarterly Journal of the Harvard School of Public Health)*, 9, pp.102-128, 2006

regards to torture, the Istanbul Protocol gives clear guidance on how to deal with this, but in relation to inequality or inaccessibility of care, there is no similar protocol in place. Unfortunately, there are few practical resources for teaching students and guiding health workers on what the right to health means in practice.

Amar Jesani, Indian Journal of Medical Ethics & CEHAT, India[8]

Amar Jesani, affiliated to the Indian Journal of Medical Ethics and the Indian NGO CEHAT started his presentation by explaining that one of the reasons why he did not want to practise as a doctor was that he felt it was unethical to ask the poor to pay in cash for their consultations and treatment. Instead, he chose to work on the issue of health systems.

Some issues Jesani addressed are:

- As it is difficult for doctors to understand human rights language, we need to translate rights language into medical ethics language for health professionals.
- Given the fact that states are not neutral bodies, human rights cannot be either. Can a human rights approach afford to stay neutral? The answer is no. Pharmaceutical corporations and private health insurance companies play a big role in delivering health care. International human rights law should be developed to give some guidelines for social engineering, otherwise it will not provide aid to those working at the national level. The health and human rights sector should incorporate a political economy approach and try to change the health system.
- Evidence shows that no country has achieved universal access without controlling the market and the private sector. Some state measures will be necessary to achieve universal access to health care. Human rights must incorporate evidence and provide a better framework for dealing with the private sector.
- There is a friction between the ideal of universal access and the practice of user fees in health care. If people have to pay for health services at the time they urgently need them, this may be a barrier to access. There is compelling evidence that poor people with medical needs become even poorer because of the costs of health care. We need to address the worldwide increase in fee-for-service, user charges, co-payments and decide whether they are violations of human rights or not.

Alicia Aly Yamin, Harvard School of Public Health

Alicia Yamin, facilitator of this plenary, recapped some of the themes discussed and then offered her own insights on the Special Rapporteur's work and mandate. She shared that Paul Hunt has achieved much by setting out an alternative vision of a health system, contrast to the notion of health care as a charity or commodity. Health systems should be regarded as core social institutions, that can either increase equality or worsen inequality and exclusion. Thus, describing the specific features of a rights-based approach to health systems is extremely important. However, Yamin questioned the usefulness of Hunt's report for practical advocacy and activism: are the features identified by Hunt sufficiently tied to human rights? What does human rights really add in this area? Is the legal value-added of the concept of duty enough? And if so, should we be more specific? Shouldn't we adopt specific, measurable goals tied to rights, e.g., the minimum number of doctors per 1000 population? Further, Yamin thinks that we should operationalise words as disadvantage, equality and non-discrimination.

[8] PowerPoint presentation available on the IFHHRO website.

She also raised the question of whether we do not need more comparative and contextual reports. These enquiries should start from the bottom up, from injustices, defined by the people most affected by them. She praised Hunt for being enormously consultative, but expressed the hope that in the new Special Rapporteur's era there will be more social mobilisation, and that he will manage to bring his reports to the level of the population.

Discussion

During the discussion following the presentation, several issues came up. First, the new World Health Report will focus on WHO's new approach to health systems. It will address issues like universal access, system delivery, health policies, new leadership and good governance. According to **Hans Hogerzeil** of WHO, the UN agency is moving towards recognition of the role of governments. It is clear now that if you leave the system on its own, it will not progress in the direction of Primary Health Care and human rights. Hogerzeil also said that PHC is expensive. Given the fact that in many countries health budgets will grow in the coming years, we need to try and redirect this growth towards PHC.
Should health care be considered a public good or a legal obligation? Does the concept of public good imply that the state should provide all the services or does it also allow for private practice? According to **Alicia Yamin** the strength of the human rights approach is that it does not have a particular political stance and does not favour a particular type of health system. A state does not necessarily have to be the provider of health services – there might be a role for the private sector. However, each state has a primary social responsibility to deliver health care to all. It would be helpful if a Ministry of Health would adopt the idea that health care is a legal obligation. This would not only increase the accountability of the health sector, but will also help the ministry in its dealings with other ministries whose policies may negatively impact on health.
A final issue that came up was the definition of a health system. In the Special Rapporteur's report to the Human Rights Council, the health system was deliberately not defined. Do we consider everything that actually improves health as part of the health system, e.g., the underlying determinants? Paul Hunt explained that he had struggled with the definition, but in the end decided that although definitional questions are important, certain elements (referral systems, access, etc.) are required "however you define the concept".

Working Groups

Working Group 1: Accountability

The workshop on accountability started with a short presentation by **Helen Potts** Senior Research Officer in the Right to Health Unit of Essex University Human Rights Centre, on her recent report on this issue,[9] which was commissioned by the Special Rapporteur. After giving a summary of the contents, Potts discussed future work to be done on the topic, i.e. what has not been achieved yet. One of these issues is that the report focuses only on government obligations and not on the other actors involved (e.g., civil society).

Some issues that came up during the discussion are:

[9] *Accountability and the Right to the Highest Attainable Standard of Health*, Helen Potts, Human Rights Centre/University of Essex, 2008

- How can courts navigate this complex and politically sensitive terrain of economic, social and cultural rights? What roles can courts actually play in creating equity?
- Health workers need to be educated on accountability as part of the right to health. Both as actors that can be held accountable as well as guardians of a system of accountability.
- When access to health systems is very poor such as in conflict situations, how can accountability mechanisms function in such a situation? What can mainstreaming the right to health mean in this case?

Some suggestions for the new Special Rapporteur

1. Continue to work on the topic of accountability:
- exploring the link between freedom of information and accountability;
- addressing the relationship between corruption and accountability;
- analysing what are the gaps in health systems in terms of accountability;
- promoting the reproductive health indicators which Paul Hunt formulated;
- addressing the issue of decentralization and privatization as two major issues that have diminished accountability in health systems.

2. Establish more collaboration with the health community on this issue – they can serve as a valuable resource in accountability.

Some suggestions for health workers

1. Health workers need to be educated on human rights and the right to health including the element of accountability. It should be clarified to them that accountability does not mean individual blame for malpractice (so they do not feel personally attacked), and that instead they understand that:
- accountability has the potential to improve the position of health workers;
- health workers should/can apply their expertise in accountability mechanisms.

2. Accountability implies participation. Health workers who see themselves as health advocates, are in an excellent position to collaborate with communities to establish accountability mechanisms.

Working Group 2: New Tools and Techniques with a focus on Indicators and Impact Assessment

This working group started with a presentation by Gillian MacNaughton on the Special Rapporteur's work on indicators[10] and by Marije Nederveen on human rights impact assessment. **Gillian MacNaughton** from the University of Oxford (UK) worked with Hunt on these issues. She explained that indicators can be a powerful tool, not only for monitoring the progressive realisation of the right to health, but also for making better policies by holding the state accountable. They can be used before, during and after the drafting of a bill, or writing of a policy. Some existing health indicators can be used as right-to-health indicators, however they need to be disaggregated to sex, age and socio-economic status in order to be useful. A recent concept related to indicators is that of Human Rights Impact Assessment (HRIA). With HRIA we can predict the (potential) impact of policy changes, either before or during the implementation. At the request of UNESCO, the Special Rapporteur drafted a methodology for HRIA in relation

[10] Paper available on the IFHHRO website.

to the right to health.[11] **Marije Nederveen** from Aim for Human Rights in the Netherlands explained the six steps of the HeRWAI, Health Rights of Women Assessment Instrument, which can be used by NGOs to analyse the gap between what governments promise and what happens on the ground. This HRIA tool has been used to study various women-related issues, including maternal mortality, sex work and education on sexual and reproductive rights.[12]

Some challenges put forward by the participants are:
- The capacity of local NGOs to use these tools effectively. Applying tools like the HeRWAI requires some scientific skills related to collecting and analyzing data and deriving to objective conclusions.
- The fact that health indicators are often not sufficiently disaggregated. How do we know what are the vulnerable groups if we do not have disaggregated data?
- How data are collected matters to human rights. We should be very cautious about data on vulnerable groups such as sex workers and injecting drug users. Often these are collected against their will, e.g., through mandatory testing for HIV or tuberculosis.
- In most countries legal, medical and human rights professionals do not really work together. They may have different definitions, which makes it difficult to find common denominators for indicators.
- On many topics, we do not even have basic information available. Before we can start developing more indicators, we need to know what information needs there are. What needs to be collected that is not yet being collected?

Some suggestions for the new Special Rapporteur

1. Continue to explain why health rights impact assessment is important.

2. Continue to work on indicators; and especially on the following issues:
- promote that data are collected in a way that respects human rights (e.g., no forced testing for HIV/registration of HIV status);
- promote that data are analysed in a way that is respectful to human rights;
- promote that available (systems of collecting) data and indicators are being used and that information will be collected that is needed but not yet being collected.

3. Take advantage of the Round of Census that will take place in 2010:
- lobby for inclusion of human rights indicators (in cooperation with UN agencies, other Special Rapporteurs and treaty bodies).

Some suggestions for the health and human rights community

1. Make existing tools better known (rather than concentrating on developing new ones).

2. Involve health sector managers and policy makers in the development/use of indicators and health rights impact assessments.

3. Build capacity about health rights impact assessment at all levels – from grassroots to government.

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[11] *Impact Assessment, Poverty and Human Rights: A Case Study Using the Right to the Highest Attainable Standard of Health*, Paul Hunt & Gillian MacNaughton, Human Rights Centre/University of Essex, 2006, http://www2.sx.ac.uk/human_rights_centre/rth/projects.shtm

[12] http://www.aimforhumanrights.org/themes/women-s-human-rights/health-rights-of-women

Working Group 3: Determinants of Health

This working group started with a presentation by **Pascale Allotey** of the Centre for Public Health Research, Brunel University, who had the opportunity to review the draft report of the WHO Commission on Social Determinants (2008) before it was published. She defined the key determinants of health as those factors that lie outside the direct influence of what is traditionally regarded as the health sector. Examples are education, employment, housing and the environment. The Special Rapporteur has highlighted two of these issues, water and sanitation, in his 2007 report to the General Assembly.[13] He also paid attention to other underlying determinants in various country and thematic reports.
Allotey explained the reasons why she was disappointed with the report. One of these was that the Commission did not take into account Paul Hunt's work of the past few years and that consequently, there is a lack of rights language in the report.

The working group then set out to take stock of the last six years and formulate suggestions for the future. The participants agreed that Paul Hunt and his team have managed to bring rights language into public health and to move beyond the boundaries of health care. In his work, Hunt prioritised conceptual development, followed by advocacy and creating synergies. It is time now to reverse that order.

Some suggestions for the new Special Rapporteur

1. Prioritise as follows: 1) synergising, 2) advocacy, and 3) conceptual development.

2. Address the issue of individual accountability.

3. Analyse whether the working conditions of health workers can be regarded as a social determinant.

4. Continue to focus on education/training of health workers.

Some suggestions for health professionals

1. Promote synergies.

2. Mobilise professional bodies (e.g., medical associations) to take up the issue of social determinants of health.

3. Develop a toolkit for health professionals on addressing the determinants of health.

Working Group 4: International Assistance and Cooperation

Stephen Marks, Professor of Health and Human Rights at the Harvard School of Public Health, Boston, USA, spoke extensively about the issue of international assistance and cooperation

[13] Report to the UN General Assembly, 2007 (A/62/214)

(IAC). In 2006, the Human Rights Centre published a report on this topic.[14] Paul Hunt also reviewed the work of SIDA (the Swedish governmental development agency) to evaluate how Swedish development assistance has supported the realisation of the right to health abroad.[15] In his reports, Hunt stressed that IAC is a legal obligation. Stephen Marks underlined the importance of strengthening accountability for Millennium Development Goal 8 (a global partnership for development). He said that an appropriate accountability mechanism should be established in relation to MDG 8: how to hold states, both of developed and developing countries, and other actors accountable?

Some suggestions for the new Special Rapporteur

1. Address the imbalance of accountability between developed and developing countries. Developed countries continue to escape accountability when failing to fulfil their international commitments. Continuity and sustainability of international aid should be one component of legal obligations in relation to IAC.

2. Bring the health and development agenda into the health sector, so that health workers can assist civil society by contributing to the advancement of development.

3. Develop guidance on how international aid and resources should be distributed. The concept of equality plays an important role here, as well as private sector investments.

4. Continue to work on access to essential medicines, for instance by collaborating with WHO and the Human Rights Council's High-level task force on the implementation of the right to development.

Plenary 3: Mainstreaming a Human Rights-Based Approach to Health

In the second plenary, on mainstreaming a human rights-based approach to health, several aspects of integrating human rights were discussed. First, **Helena Nygren-Krug** of the Health and Human Rights Team of WHO explained the common understanding of a rights-based approach in the UN. Then **Ariel Frisancho** presented the example of his country, Peru, where the government became more susceptible to the right to health following a mission by Paul Hunt in 2004.
The plenary was followed by four workshops on respectively sexual and reproductive health; neglected tropical diseases; the brain drain; and human rights education.

Helena Nygren-Krug, Health and Human Rights Team, WHO[16]

Helena Nygren-Krug stressed that there was no official recognition of a rights-based approach in the UN system until a few years ago. The current common understanding of such an

[14] *The Right to Health and the Millennium Development Goals in developing countries: A Right to International Assistance and Cooperation?,* Octavio Ferraz & Judith Mesquita, 2006, http://www2.sx.ac.uk/human_rights_centre/rth/projects.shtm
[15] Report to the Human Rights Council, 2008 (A/HRC/7/11/Add.2)
[16] PowerPoint presentation available on the IFHHRO website.

approach in UN agencies is that all development cooperation should contribute to the development of the capacities of 'duty-bearers' to meet their obligations and/or of 'rights-holders' to claim their rights. Based on an analysis of capacity gaps, e.g., lack of resources, authority or leadership, capacities can be developed, both capacities for empowerment (to claim rights) and accountability (to fulfil obligations).
Universal access will remain an important issue, and there should be a spotlight on the most vulnerable, marginalised and excluded, Nygren-Krug said. Any work on this issue should start from the rights holder – the individual. Rights, responsibilities and obligations of health workers, non-state actors, governments, and the international community should be derived from there.
In the precious relation between WHO's mandate and the right to health, it helped to have Paul Hunt as a figure of authority, Nygren-Krug said.

Ariel Frisancho, CARE Peru[17]

Ariel Frisancho, National Coordinator of the Health Rights Program at CARE Peru, started his presentation by emphasising the critical role the Special Rapporteur has played in establishing the links between health and development rights. According to Frisancho, Paul Hunt contributed greatly to an integral understanding of the need of integrating the right to health into poverty reduction and development policies. He also stressed the impact that Hunt's visit to Peru in 2004 had for the national health and human rights debate. Among others, the visit led to a better dialogue between Ministry of Health officials and civil society. However, there remain some key challenges, including the problem of high turn-over of government officials, the lack of sufficient funds to implement rights-based policies, and the need for follow-up on country visits. The reports produced by Paul Hunt are a good basis to build on, Frisancho said.

Some suggestions for the new Special Rapporteur

1. Strengthen the construction of strategic alliances, both international and national (key partners, linkages with civil society networks for follow-up and raising awareness).

2. During country visits, work more with the media, congress, academies, even political parties – promote the report as a tool for advocacy and follow-up.

3. Always combine advocacy with operationalisation and technical assistance (benchmarks, standards, 'common language').

Some suggestions for health workers

1. Improve accountability mechanisms as an opportunity for improving performance.

2. Find a 'common language' to persuade other health workers to become advocates for universal insurance or universal access to good quality health care.

3. Promote collaboration where it does not yet exist with regards to the social determinants.

Discussion

[17] PowerPoint presentation available on the IFHHRO website.

Following the presentations, some discussion arose around the fact that WHO, like other UN agencies, does not have a corporate statement on health and human rights. There may even be pressures from within these organisations to tone down human rights language. This may be out of fear that the concept of legal obligation may lead to thousands of court cases filed by rights-holders, which may lead to distortion of the health budget. Someone from WHO replied that the concept of progressive realisation also applies to UN agencies: even though progress is slow, it is still visible. Frameworks and constitutions now include references to the right to health, which is a first step. **Daniel Tarantola** added that though WHO does not have a corporate statement on human rights, it does a lot on mainstreaming the right to health. He also suggested that the new Rapporteur should invite newly appointed high-level UN officials to issue a statement on health and human rights. This may challenge them to think about it and make public statements.

Another issue that came up during the discussion was finding a common language. Some participants feared that 'losing the language' would mean that we lose the power that is attached to it; claiming one's rights makes a better case than stressing one's needs. However, others argued that it is important to move from the legal sphere to the health sphere if we want to mainstream human rights. **Hans Hogerzeil** stressed that mainstreaming will inevitably lead to some compromise. By mainstreaming we may lose the precision of the language, but we have to allow that to make sure "it becomes their idea too", he said.

A third issue discussed is that there is still a lot of work to do in operationalising the right to health. More work needs to be done, **Paul Hunt** said, on the core obligations; what constitutes a minimum package of services, goods and facilities; and the meaning of 'maximum available resources' as laid down in Article 12 of the ICESCR. He also said that more guidance should be given on prioritisation and on permissible trade-offs in the policy-making process; and to health workers, e.g., by developing accessible protocols and guidelines.

Working Groups

Working Group 5: Sexual and Reproductive Health Rights, including Maternal Mortality

In a 2004 report, the Special Rapporteur paid particular attention to the issue of sexual and reproductive health and rights.[18] His 2006 report to the UN General Assembly focused on the reduction of maternal mortality, which is intrinsically related to sexual and reproductive health rights. In this working group, **Ariel Frisancho** (CARE Peru) and **Luz Melo** (UNFPA) presented their recommendations for donors with regards to sexual and reproductive health and rights. **Claudia Trautvetter** of the German development agency GTZ highlighted the work of her organisation on the topic.[19]

One of Paul Hunt's achievements is that the issue of maternal mortality is now framed as a grave violation of human rights and also of the right to health. There are many international organisations that support work on these issues and civil society groups have been effective in targeting and lobbying for sexual and reproductive rights. However, it is not clear yet if the interventions are making a difference. Another challenge is that talking about sexual and

[18] Report to the Commission on Human Rights, 2004 (E/CN.4/2004/49)
[19] PowerPoint presentations available on the IFHHRO website.

reproductive health rights is still difficult in many countries, as it is a sensitive issue. Cultural sensitivity is thus very important.

Some suggestions for the new Special Rapporteur

1. Coordinate with other mandates, UNAIDS, civil society and international organisations that work on sexual and reproductive health rights and women's rights.

2. Finding a balance between addressing new issues and building upon the existing work of Paul Hunt in the area of sexual and reproductive health. For instance: going beyond the establishment of maternal mortality as a human rights violation, and trying to provide guidance in how to implement policies and programs in the area of maternal health from a rights based approach.

3. Operationalise standards to prevent maternal mortality; work with governments on how to address this issue.

4. Look at transnational forces in regards to donor states providing financial assistance. An example is the Global Gag Rule (USA).[20]

5. Examine issues relating to particular vulnerable groups, including transgender and intersex people, and women living with HIV.

6. Addressing trends and challenges such as: sexuality education, unsafe abortion, the need of women to have access to safe, legal abortion, access to contraceptives, and pregnancy as a consequence of war-based rape.

Working Group 6: Neglected populations with a focus on Neglected Diseases

A focus on non-discrimination and poverty invariably draws attention to neglected tropical diseases (NTDs). This was one of the topics of Paul Hunt's first report to the UN General Assembly (2003).[21] Examples of NTDs are dengue, leprosy, trypanosomiasis and leishmaniasis. These diseases are closely linked to poverty and underlying determinants of health such as water, sanitation and access to information. Social stigma and discrimination are key characteristics of NTDs. In his presentation, **Francesco Rio** of WHO described the main features of NTDs and in what way they can be seen as a right-to-health issue:[22]

- NTDs almost exclusively affect poor and marginalised people in low-income countries, in rural areas and settings where poverty is widespread.
- Discrimination is both cause and consequence of NTDs.
- Health interventions and research and development have long been inadequate and under funded and the picture has changed only in recent years.
- Some of the essential drugs against NTDs are now accessible but other are still inadequate or unavailable.

[20] The Global Gag Rule mandates that no US family planning assistance can be given to foreign NGOs that perform abortion, provide abortion counselling and referral to women, or advocate for the decriminalisation of abortion.
[21] Report to the UN General Assembly, 2003 (A/58/427)
[22] PowerPoint presentation available on the IFHHRO website.

Some suggestions for the health and human rights community

1. Develop indicators with regards to neglected diseases and development.

2. Educate medical students and health workers on NTDs in relation to human rights.

3. Reach out to advocacy groups and policy makers with evidence that we have on the magnitude of NTDs.

4. Link technical experts with civil society organisations, national human rights commissions and other groups for advocacy.

5. Put NTDs and diseases affecting neglected populations on the human rights agenda of a number of actors, including national human rights commissions and civil society organisations.

6. Work towards the incorporation of NTDs in health sector strategic plans and national and sub-national budgets.

Working Group 7: Skills Drain

The issue of migration of health workers ('skills drain') was addressed in Paul Hunt's 2005 report to the UN General Assembly.[23] The report considers three possible policy responses: 1) strengthening health systems in the countries of origin, 2) ethical recruitment by destination countries and 3) compensation or restitution. The Working Group on this issue started with a presentation by **Mariska Meurs** of Wemos, the Netherlands. She observed that over the last six years, the issue of human resources for health has become much more central in the debate. Several organisations and countries have drafted codes of conduct to slow down the migration of health workers. However, there is no interest by any government of destination countries to consider compensation of countries of origin. Also, even though there has been increased funding for human resources, very little has changed in the working conditions of health workers at the ground level. Another problem that is not helping is the international aid architecture: the way in which the health sector is being supported is in many cases issue-based; AIDS being a well-known example.

Some suggestions for the new Special Rapporteur

1. Continue to pay attention to the issue of the skills drain, e.g., in a separate report.

2. Advocate for more resources for health workforce development.

3. Continue to stress in reports the importance of mainstreaming human rights through the professional associations of health workers – health workers need to know that individuals have the right to health.

[23] Report to the UN General Assembly, 2005 (A/60/348)

Some suggestions for the health and human rights community

1. Address push factors, mainly related to issues of remuneration and working conditions.

2. Work towards strengthening the health system – either we need more injection of resources into the country or better allocation within the country.

Working Group 8: Human Rights and Health Education

Sofia Gruskin, Director of the Program on International Health and Human Rights at the Harvard School of Public Health, introduced the topic of human rights education by giving the example of a database of syllabi and other health and human rights teaching materials. This database was published by her own organisation and the Initiative for Health and Human Rights at the University of New South Wales, Australia a couple of years ago.[24] The database lists course outlines and teaching materials used by a wide variety of teaching institutes, including medical schools, nursing schools and public health institutes. Any organisation that wishes to share its information can send it to the database managers. Gruskin expressed the wish that in the future there will be a general understanding of the core content of health and human rights education, which would be of great assistance to educators worldwide. The Special Rapporteur paid attention to the issue of human rights education for health workers in his 2005 report to the UN General Assembly.[25]

Challenges identified during the group discussion following Gruskin's introduction include the lack of time devoted to human rights education in most curricula; the lack of role models for students; misconceptions and scepticisms about the right to health; lack of resources (materials) and support/teaching opportunities for educators; political resistance; and more pressing education needs in less developed countries.

Some suggestions for human rights educators and others

1. Define the core content of health and human rights education for various student groups.

2. Share resources such as syllabi and curricula, and share ideas, questions and projects through for example databases and internet fora.[26]

3. Use case-based, experiential learning to teach students. Include human rights training not only in the curriculum but also in clinical education and outside the classroom, e.g., through onsite visits.

4. Raise interest of practitioners in continuing education on human rights by accrediting relevant courses.

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[24] http://www.hsph.harvard.edu/pihhr/resources_hhrdatabaseintro.html
[25] Report to the UN General Assembly, 2005 (A/60/348)
[26] Following this session, one of the participants (Kirsteen Macleod) developed an online forum, which can be used for sharing resources, ideas and experiences: http://groups.google.co.uk/group/human-rights-and-health-education-forum. After registering for a Google account, anyone can apply for membership of this group and start uploading documents and posting messages.

5. Conduct more research on and evaluations on health and human rights education; what works and what doesn't? Develop a framework for the evaluation of courses.

6. Raise more awareness on the importance of human rights education for health professionals, for instance through a series of articles in a prestigious, well read journal.

Plenary 4: The Special Rapporteur's Missions and Reports

(Saturday, 27 September 2008)

In the fourth plenary, some of the country missions the Special Rapporteur undertook were discussed. In total, he visited 12 countries in his six years of office. Before giving the floor to representatives of civil society of three of those countries, **Paul Hunt** briefly summarised his working method and the challenges he encountered. After the three country examples (Uganda, Peru and Sweden), **Rajat Khosla** outlined the review of pharmaceutical GlaxoSmithKline, which is currently being finalised. The plenary was followed by four working groups on missions, participation, HIV/AIDS, and mental disabilities.

Because the UN requires that reports submitted to its commissions and the General Assembly are brief, **Paul Hunt** said that he had to be selective in choosing which topics to cover during his country missions and which not. The criteria have always been poverty and discrimination, thus focusing on the most marginalised and ostracised populations. However, he did not always choose the worst issues, but looked at which issues he could have an impact on. After a while, Hunt realised that it would be better to have single-issue reports. Examples are neglected diseases in Uganda (2006)[27] and maternal mortality in India (forthcoming). Some challenges identified by Paul Hunt are that:

- states have not always been welcoming to receive him;
- it is difficult to evaluate results of missions and establish causal linkages between the mission and policy changes;
- it is difficult to follow-up on a mission because of time and financial constraints.

Margaret Muganwa, AGHA, Uganda & IFHHRO African Regional Focal Point[28]

The first speaker to comment on Paul Hunt's missions was **Margaret Muganwa** of AGHA (Action Group for Health, Human Rights and HIV/AIDS) in Uganda. The Special Rapporteur visited her country twice, in 2005 and 2007. The first visit focused on the issue of neglected tropical diseases[29]; the second on the Swedish government's contribution to the realisation of the right to health in Uganda[30]. In June 2008, IFHHRO and AGHA held a consultative meeting to evaluate the progress made by the government of Uganda on the recommendations of the Special Rapporteur.[31]

Muganwa said that some modest achievements have been identified since those visits took place and the resulting reports were published. One of these is increased access to health

[27] Report to the Commission on Human Rights, 2006 (E/CN.4/2006/48/Add.2)
[28] PowerPoint presentation available on the IFHHRO website.
[29] Report to the Commission on Human Rights, 2006 (E/CN.4/2006/48/Add.2)
[30] Report to the Human Rights Council, 2008 (A/HRC/7/11/Add.2)
[31] The report of this meeting will be published on the IFHHRO website.

information and education on neglected diseases. Another one is increased community participation through the recruitment and training of Village Health Teams in 11 districts. Within the Ministry of Health a Right to Health Unit is now operational and the Uganda Human Rights Commission has set up a Health Rights Desk as recommended by the Special Rapporteur. However, the review also identified the issues that have not been achieved: There is limited debate on health and human rights at local and national levels. Reports of the Special Rapporteur have not been widely disseminated. Health professionals and their associations have not embraced human rights as would be necessary. The Right to Health Unit at the Ministry is in its infancy but questions are being raised about civil society and health workers' representation on the Committee. Limited resources for planned activities limited the progress.

Some suggestions for the new Special Rapporteur

1. Involve all stakeholders, including health professional associations and ministry staff.

2. Work with development partners in funding and monitoring the right to health.

3. Work more closely with sectors that have a direct relationship to health such as Internal Affairs (torture-related cases) and Agriculture (food and nutrition).

4. Disseminate reports and findings widely in a version and language that can be understood by the majority of the population.

Some suggestions for health workers

1. Provide the Special Rapporteur with the necessary information, during and after his visits.

2. Ask questions about accountability to stakeholders, including the health professions and the government.

3. Write reports and report incidences that work against the right to health.

4. Act as monitors on a continuous basis.

5. Participate in planning, implementation and evaluation of the Special Rapporteur's recommendations and other health-related activities.

6. Initiate ideas and programmes for better human advancements.

Cesar Ugarte, EDHUCASALUD, Peru & IFHHRO Latin America Regional Focal Point[32]

Cesar Ugarte of the Peruvian organisation EDHUCASALUD explained that since Paul Hunt's visit in 2004, Peruvian civil society has produced two follow-up reports, one in 2006[33], the other

[32] PowerPoint presentation available on the IFHHRO website.
[33] *Derechos Humanos en Salud en el Perú: Balance 2004 – 2006 desde la sociedad civil, a dos años de la visita del Sr. Paul Hunt, Relator Especial de Naciones Unidas sobre el derecho de toda persona al disfrute del más alto nivel posible de salud física y mental*, http://www.aes.org.pe/etnicidad/pdf/DerechosHumanosenSalud.pdf

in 2008.[34] He briefly described the limited progress made by the Peruvian health and human rights community and the government since the visit:

- Even though a Human Rights National Plan has been approved, it has not been implemented.
- Despite the efforts made to prepare a concerted plan with the participation of different institutions and civil society organisations, the State has not provided any political support.
- Regarding the budget, there is no progress that shows support to the Human Rights National Plan, and it is neither taken into consideration at the policy making of different sectors.

Some suggestions for the new Special Rapporteur

1. Devote more time to cover more topics and do more field trips in order to experience the complexity of health and human rights problems on the ground.

2. Promote more participation of the health professionals at the academic level (e.g., at faculties of medicine and scientific health organisations).

3. Increase participation of health students, for instance through their associations.

Some suggestions for health workers

1. Assist in diffusion of the recommendations, e.g., through national journals and newsletters.

2. Promote meetings for the discussion of the recommendations, between health workers, NGOs and the government.

3. Collaborate with academics in producing scientific data for monitoring the right to health and bring this information to the Special Rapporteur and/or the other participants of the visit.

Henry Ascher, Nordic School of Public Health, Sweden

In 2006, Paul Hunt undertook a vision to Sweden to study that country's health and human rights record. One of the findings was that explicit reference to the right to health was absent in Sweden's domestic health policies.[35] In his presentation, **Henry Ascher** of the Nordic School of Public Health in Gothenburg, Sweden, listed some of the achievements since the report came out two years ago:

- The right to health is definitely on the agenda now.
- There is more attention to the need for education and training on health and human rights.
- Guidelines for professional organisations have been drafted.

One of the issues he highlighted, which was also described in the report of the Special Rapporteur, is the issue of access to health care for undocumented migrants. Although there are no laws granting (or denying) access to health care to 'people without papers', several county councils and hospitals have developed generous policies to grant access to health care to these people.

[34] To be published in English and Spanish on the IFHHRO website.
[35] Report to the Human Rights Council, 2007 (A/HRC/4/28/Add.2)

Rajat Khosla, Human Rights Centre

Rajat Khosla, Senior Research Officer at the Human Rights Centre, presented the official review of GlaxoSmithKline (GSK) as an example of a case study on corporate social responsibility with regards to access to medicines. The review took place in June 2008 and the report will appear later this year. The Special Rapporteur met with several managers at GSK and also with representatives of civil society organisations.

Discussion

The main point raised during the discussion following the presentation is that it is not only the responsibility of the Special Rapporteur to follow-up on missions. Instead, it is everybody's business. Country visits can be used by local groups to advance issues of key concern. The involvement of civil society is vital, before *and after* the mission. NGOs can assist the Special Rapporteur in diffusing the ideas in the report to all levels of society, and in translating official indicators to the level of health workers.

Working Groups

Working Group 9: Further Discussion and Evaluation of Missions

In an interactive exercise, **Roos Terhorst** and **Alicia Dibbets** of IFHHRO stimulated the participants of this workshop on country missions to share their opinions and advice on how to improve this tool. The group came up with separate suggestions for the new Special Rapporteur and health workers, covering the preparation, implementation and follow-up of country missions.

Some suggestions for the new Special Rapporteur

1. Preparation stage
- Identify the various actors at the planning stage.
- Inform them about the visit.
- Ask them to sign up and keep them involved during the whole process/mission.

2. Mission implementation stage
- Inform all relevant stakeholders of the structure of the mission.
- Involve the Ministry of Health.
- Involve institutions instead of individuals to ensure sustainability.
- Involve partners throughout the mission.

3. Follow-up stage
- Involve other UN agencies in the follow-up.
- Consider follow-up as a shared responsibility of all actors involved.
- Share experiences with health workers in other countries to exchange knowledge.

Some suggestions for health workers (associations)

1. Preparation stage
- Organise a preparatory meeting to structure inputs/
- Publicise the mission among colleagues.

2. Follow-up stage
- Publish the results of the mission in locally relevant media, for example medical journals.
- Write follow-up reports for the Special Rapporteur in collaboration with other civil society organisations.
- Translate reports in local languages and adapt them to concepts/terms know by the target groups.

Working Group 10: Participation

Throughout the work of the Special Rapporteur, participation has been recognised as an integral component of the right to the highest attainable standard of health. It has been dealt with in several of his reports, including those of country missions. However, although recognising its critical importance, the health and human rights community has not given it the attention it deserves, mainly because it is such a complex and contextual concept. In her presentation, **Helen Potts** called it a "contentious term that can mean anything and nothing". The Human Rights Centre at Essex University is currently preparing a publication on participation in relation to health policy development, written by Potts.[36] She presented some guidelines to ensure a fair and transparent process of participation.[37]

The working group acknowledged the following achievements of the Special Rapporteur:
- The way he has stressed the need for participation has been very helpful.
- The identification of key words to understand and analyse the concept: fairness, transparency, active and informed partners, leading to free and meaningful participation.
- The description of a range of new methods to involve grassroots participation.

Some challenges identified by the group:
- The need to stimulate authorities, health workers, and others to support participation.
- The need to build capacities to overcome physical, psychological, geographical and financial barriers to participation.
- Participation should lead to concrete results as much as possible.
- The need to bridge the gap between the human rights community and health workers.

Some suggestions for the health and human rights community

1. Involve more people in the decision-making who have experienced human rights violations themselves.

2. Empower constituencies to become more involved in the decision-making.

[36] *Participation and the right to the highest attainable standard of health.* Helen Potts, Human Rights Centre/University of Essex, 2008 (forthcoming)
[37] See the PowerPoint presentation on the IFHHRO website.

3. Implement already defined indicators.

4. Define incentives and disincentives for participation.

5. Criticise the role of partners who deliberately inhibit participation.

6. Disseminate achievements (concrete results) of participation.

7. Involve students permanently in the decision-making.

Working Group 11: HIV/AIDS

In this working group the new Special Rapporteur, **Anand Grover**, presented his own experiences as an 'HIV/AIDS lawyer' in India. Grover called the fact that people living with HIV in India, as well as elsewhere, have organised themselves to fight for their rights "a historic shift". He also said that HIV can be seen as "an opportunity for addressing a lot of wrongs in society": for instance, the appearance of HIV in societies has provided a chance to talk about sensitive issues like marital rape, gender inequality and homosexuality.

Jonathan Cohen of the Open Society Institute called the appointment of Grover a victory for the HIV/AIDS community. He also said that human rights are still a marginal element of the HIV response. For instance, within UNAIDS – the UN agency focusing on AIDS – human rights are not integrated in policies and programmes.

Suggestions for the new Special Rapporteur

1. Use the strengths and lessons from HIV/AIDS to the broader right-to-health field.

2. Promote synergies with other human rights fields, by:
- supporting alliances between HIV/AIDS groups and other groups;
- working together with other Special Rapporteurs – HIV/AIDS can assist in synergising with other procedures as it is related to the mandate of other Rapporteurs.

3. Pay attention to the presumed or actual clash of interest between health systems and HIV/AIDS:
- define what health systems are and what issues should be included that are not traditionally seen as part of health systems;
- consider which parts of health systems need to be strengthened to make a change, for HIV/AIDS and other issues, e.g., training of health providers at the community level.

4. Mainstream human rights in UNAIDS – the staff should learn to see themselves as human rights advocates. The forthcoming leadership change provides an opportunity for this.

5. Pay attention to how donors influence the right to health through conditions or decisions to fund/not fund certain issues.

6. Continue working on the issues raised by Paul Hunt, e.g., harm reduction and the rights of drug users.

7. Find a balance between progressive work, e.g., on normative guidelines, and stopping regression, e.g., reacting against criminalisation, mandatory testing, etc.

8. Choose issues where you can make a difference.

9. Pay attention to 'neglected countries', especially countries where English is not the lingua franca, including China, Latin America and the francophone and lusophone countries in Africa.

10. Take into consideration the following issues:
- human rights defenders;
- attention for the boy child as a way to contribute to empowering girls;
- provider-initiated testing and counselling;
- prevention;
- male circumcision;
- the right not to be affected by AIDS;
- the position of community workers in the health system;
- reproductive health needs of women living with HIV/AIDS.

Working Group 12: Mental Disabilities

The working group on mental disabilities started with a presentation by **Alicia Yamin** on some challenges with regards to mental care.[38] Even though an estimated 450 million people around the world suffer from mental or neurological disorders or from psychosocial problems, more than 40 percent of countries have no mental health policy and over 30 percent have no mental health programme. In general, the main problems are non-consensual treatment; the bad state of facilities (seclusion, restraint, overcrowding, lack of sanitation, food, etc.); the lack of treatments offered; and the continuation of abuses in facilities (e.g., rape, physical abuse by staff and patients). The Special Rapporteur's 2005 report to the Commission on Human Rights focused on persons with mental disabilities.[39] In this report, Paul Hunt paid particular attention to intellectual disability, the right to community integration and consent to treatment.

1. Some issues discussed during the working group are:

2. The need to reiterate AAAQ (Availability, Accessibility, Acceptability, Quality) and other elements of General Comment 14 in relation to the Convention on the Rights of Persons with Disabilities: dealing with terminology and concepts in mental health.

3. Some difficult issues:
- Community care may have gender implications.
- Deinstitutionalisation needs to be worked out as there could be resistance from health workers (associations) and the community to receive people back and offer adequate continuation of care at the community level.
- Legal obligations related to protecting the individual and the community.

[38] PowerPoint presentation available on the IFHHRO website.
[39] Report to the Commission on Human Rights, 2005 (E/CN.4/2005/512)

4. National plans of action – legal reforms and accountability, services reform, non-discrimination (beyond the health sector)

5. International Assistance and cooperation: learning from good practices in different countries.

6. Technical assistance from international agencies on what community care would mean.

7. Linking to civil society initiatives.

8. Role of health professionals:
- Giving more value and resources to mental health in the curricula, changing the paradigm.
- Addressing resistance to change in approach from institutionalisation to community care.
- Recognition of various disciplines within mental health services in caring for patients (psychiatrists, psychologists, counsellors, nurses, community health workers, etc.).

9. Notion of social determinants of health should give more importance to social determinants of mental health and focus on primary prevention.

10. Changing community attitudes is essential – we need to focus on:
- the role of media in both positive and negative senses;
- human rights education for communities;
- stigma reduction (using lessons from HIV prevention).

Plenary 5: The Way Forward

In the final plenary, some key speakers reflected on the lessons learned and issues raised during the symposium. Each of them presented their own views nurtured by two days of discussion. Facilitator **Daniel Tarantola** shared that he was impressed by the well-structured and participatory process during the symposium and that he was glad that there were a lot of young people present. The suggestions made during the plenaries and working group sessions will offer the new Special Rapporteur a menu from which he can choose at will. Tarantola also said that Anand Grover cannot be held accountable for the results of this meeting. Rather than speaking of recommendations, Tarantola called them ‘expressions of interest’.

Dragana Korljan, Office of the High Commissioner for Human Rights (OHCHR)

Dragana Korljan said that within the UN system, this conference could serve as a good practice to establish a handover activity between past and new Special Rapporteurs. According to her, this is the first time ever this occurred. Even though a meeting like this does not always lead to practical recommendations, they offer excellent opportunities for reflection.
The challenges she identified are:
1. There is a current need for strengthening health systems. But what are the priorities to set?

2. Traditionally, the human rights community uses the strategies of letter-writing and 'naming and shaming'. However, time has shown that a critical, constructive dialogue is a better approach for advancing health and human rights, as Paul Hunt's work demonstrated.

3. A two-fold approach is recommended: first, to continue already established initiatives/topics such as maternal mortality and second, to take on board new topics.

4. We should be realistic and aware of the global political set-up. The health and human rights movement needs to capture and sustain attention of governments on human rights.

Len Rubenstein, Physicians for Human Rights

Len Rubenstein, President of Physicians for Human Rights, identified five main challenges for the future:

1. Bringing right-to-health standards to critical actors in health policy, e.g. donors.

2. Communicating the right to health to a larger public. People should react to right-to-health abuses in the same way as people 'normally' react to serious human rights violations such as took place at Guantanamo Bay.

3. Determining the role of health professionals in the right to health:
- bear in mind that health professional organisations are conservative by nature;
- not too much advocacy in transforming health organisations but to work with health professionals directly, enlist them.

4. Solving problems of implementation: financing and the private market – a health systems issue.

5. Having clear expectations of what the Special Rapporteur can achieve and what civil society needs to do – we have to strengthen our own community and not leave all responsibilities with the Special Rapporteur. In this regard:
- resources are needed;
- new advocates, including health professionals need to be trained;
- more civil society collaborators need to be trained.

Primrose Matambanadzo, Zimbabwe Association of Doctors for Human Rights (ZAHDR)

From the perspective of a health worker, **Primrose Matambanadzo** of ZADHR summed up the challenges that lie ahead:

1. Moving from the prioritisation of conceptual work/advocacy/synergies to bridging the gap between the Special Rapporteur and the local level.

2. Health workers should be seen as pivotal resources in realising the right to health. But how to change them into activists? By letting them feel they are being part of the process. They could take forward the right-to-health framework, and assist each other in using it.

3. How do we let health workers participate in the right to health? Education on the right to health for health professionals and students is very important. We need to engage them if we want 'true' participation.

4. We should start utilising the Special Rapporteur; by using his reports or following up on his missions at the local level.

5. How to mobilise resources for all this?

Judith Bueno de Mesquita, Human Rights Centre

According to **Judith Bueno de Mesquita**, Senior Research Officer and Coordinator of the Right to Health Unit at Essex University Human Rights Centre, there are some unresolved questions about future directions of the mandate. One of these is whether the new Special Rapporteur should choose a more contextual focus. Does the new Rapporteur need to give greater focus to not just the role and responsibilities of different actors, but how these actors affect the right to health in practice?

Some challenges identified by Bueno de Mesquita are:

1. The issue of follow-up to country missions: there clearly is a need for more follow-up as the plenary and workshop on this issue showed. However, is that the sole responsibility of the Special Rapporteur or not? The Special Rapporteur and others will need to establish what will be an effective and appropriate division of responsibility.

2. Continuity or change? Many people have urged the new Special Rapporteur to continue to work on issues and initiatives addressed by the old Special Rapporteur. At the same time, this symposium came up with many important suggestions for work in new areas, notably the importance of focusing on undocumented migrants, asylum seekers and internally displaced people; and the right to health in complex humanitarian situations.

3. A focus on sensitive issues. Many people, including UN staff, have stressed that the Special Rapporteur has an important role to play addressing difficult issues that UN agencies cannot easily address. Since the Special Rapporteur is an independent expert, he has the advantage to take on critical issues such as sexual rights or safe abortion.

Some suggestions for the new Special Rapporteur

1. Continue to reach out to and interact more with the health worker community:
- pay attention to those health workers who find themselves in trouble because of where they work or who they treat;
- perhaps even consider their working conditions as a determinant of health;
- continue to recognise the fundamental role of health workers as promoters and defenders of the right to health;
- ensure that the right to health is conceptually accessible to them.

2. Continue to unpack the meaning of aspects of the right to health, e.g., the concepts of 'minimum core obligation', 'maximum available resources', etc.

3. Ensure that the output is communicated in a way that is accessible to the health and human rights community, including health workers – as many people do not read long, technical reports.

4. Work with other UN Special Rapporteurs, treaty bodies, international audiences and civil society organisations.

Daniel Tarantola, University of New South Wales Initiative for Health and Human Rights

Some challenges identified by **Daniel Tarantola** are:

1. Accountability by actors is crucial. We need indicators and benchmarks to be able to monitor progress. Indicator development and monitoring and evaluation are a joint responsibility, in which also health workers play a role. The Special Rapporteur should prepare missions with participation/involvement of civil society so that they can concentrate on local follow-up activities.

2. The social determinants of health framework, recently reported by WHO, is not enough. It is lacking a human rights framework. We should use the opportunity of the recent release of the WHO report and build upon it with the added value of a human rights framework.

3. Some issues that should stay on the agendas are the right to health in international assistance and cooperation, maternal mortality, HIV/AIDS, and neglected populations.

4. The crisis in human resources for health should be addressed, also by the Special Rapporteur. Health workers could become human resources for health *and human rights.*

5. With regards to human rights and health education, we have seen a growth in the number of courses in the past few years. Although this is encouraging, there is a need for more exchange between health and human rights educators.

6. Tarantola then invited participants from the audience to identify challenges overlooked or that need more specific attention. The three issues raised were:
- Translation of health and human rights into real-life situations.
- Participation of affected groups in the debates, including at meetings like this.
- Supporting professional autonomy of health professionals to remain advocates of patients' rights instead of instruments of government.

Anand Grover, Special Rapporteur on the Highest Attainable Standard of Health

Before the symposium was concluded by words of thanks by the official organisers, Paul Hunt and Adriaan van Es, **Anand Grover** was given some time to comment on the suggestions given and the issues raised during this plenary session and the whole symposium.
He praised his predecessor for the good work and his commitment to continuity and he also thanked the Essex team for their work. What he will bring home from this meeting, he shared, is that broad consultation is of key importance to decide "what gets into the new agenda". He also said that he will bring communities into discussions to be able to correct his mistakes and

misconceptions. Grover said that he supports the idea to have some kind of input mechanism, for instance through an interactive website.
Except for the three main activities developed (conceptualisation, advocacy and creating synergisms), this new mandate intends to bring activism as a key factor. Concepts of 'rights' and 'equality' are not fully understandable in many countries, Grover said. We therefore need to communicate better and perhaps use more analogies and create better language to convey important messages. The country missions have been very good vehicles for change and good examples of follow-up have been conducted. This process should certainly continue.

With regards to all the suggestions given, Grover said that he will look at them, but that it should be clear that he cannot address all those issues. Besides, there are other organisations and individuals outside this symposium, that may have different needs and requests. However, he will make sure that the work that was done by Paul Hunt and his collaborators will not be lost, he said. With regards to country visits, organisations in the countries already visited can contact him to discuss follow-up.

Programme

Thursday, 25 September 2008

1530-1630	**Arrival, Registration and Coffee**
1630-1700	**Welcome and Introduction** Welcome by Julian Sheather and Adriaan van Es Introduction by Paul Hunt and Rajat Khosla
1700-1715	**Break**
1715-1900	**Plenary 1: The Right to the Highest Attainable Standard of Health, the Special Rapporteur and Health Workers** Facilitator: Aminata Toure Resource Persons: Paul Hunt, Kgosi Letlape and Daniel Tarantola

Friday, 26 September 2008

0915-1100	**Plenary 2: Health Systems and the Right to the Highest Attainable Standard of Health** Facilitator: Alicia Yamin Resource Persons: Gunilla Backman, Adriaan van Es and Amar Jesani
1100-1130	**Coffee**
1130-1300	**Working Group (1): Accountability** Facilitator: Duncan Wilson Resource Person: Helen Potts **Working Group (2): New Tools and Techniques with a focus on Indicators and Impact Assessment** Facilitator: Saskia Bakker Resource Persons: Gillian MacNaughton and Marije Nederveen **Working Group (3): Determinants of Health** Facilitator: Jim Welsh Resource Person: Pascale Allotey **Working Group (4): International Assistance and Cooperation** Facilitator: Judith Bueno de Mesquita Resource Person: Stephen Marks
1300-1400	**Lunch**
1400-1500	**Plenary 3: Mainstreaming a Human Rights-Based Approach to Health** Facilitator: Hans Hogerzeil Resource Persons: Helena Nygren-Krug, Ariel Frisancho
1500-1530	**Coffee**
1530-1700	**Working Group (5): Sexual and Reproductive Health Rights, including Maternal Mortality** Facilitator: Luz Melo Resource Persons: Judith Bueno de Mesquita, Ariel Frisancho & Claudia Trautvetter

Working Group (6): Neglected populations with a focus on Neglected Diseases
Facilitator: Juana Sotomayor
Resource Person: Francesco Rio

Working Group (7): Skills Drain
Facilitator: Primrose Matambanadzo
Resource Person: Mariska Meurs

Working Group (8): Human Rights and Health Education
Facilitator: Jawaya Shea
Resource Person: Sofia Gruskin

Saturday, 27 September 2008

0900-1030	**Plenary 4: The Special Rapporteur's Missions and Reports** Facilitator: Dragana Korljan Resource Persons: Paul Hunt, Margaret Muganwa, Cesar Ugarte, Henry Ascher and Rajat Khosla
1030-1100	**Coffee**
1100-1230	**Working Group (9): Further Discussion and Evaluation of Missions** Facilitators: Roos Terhorst and Alicia Dibbets Resource Person: Dragana Korljan
	Working Group (10): Participation Facilitator: Ariel Frisancho Resource Person: Helen Potts
	Working Group (11): HIV/AIDS Facilitator: Sofia Gruskin Resource Person: Anand Grover, Jonathan Cohen
	Working Group (12): Mental Disabilities Facilitator & Resource Person: Alicia Yamin
1230-1330	**Lunch**
1330-1430	**Plenary 5: The Way Forward** Facilitator: Daniel Tarantola Resource Persons: Anand Grover, Primrose Matambanadzo, Len Rubenstein, Dragana Korljan and Judith Bueno de Mesquita
1430-1500	**Closing Remarks** Adriaan van Es and Paul Hunt
1500-1530	**Coffee**

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