



**INTERNATIONAL FEDERATION OF  
HEALTH AND HUMAN RIGHTS  
ORGANISATIONS**

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**SHORT REPORT**

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

**International Symposium**

**25-27 September 2008  
at the  
British Medical Association  
BMA House, Tavistock Square, London, WC1H 9JP**

## 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.<sup>1</sup> 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. The full report, which can be requested from the IFHHRO Secretariat, includes longer versions of the presentations, the various suggestions made, as well as some extra footnotes containing useful references.

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<sup>1</sup> A full list of all the Special Rapporteur’s reports including online access can be found on the websites of IFHHRO ([www.ifhhro.org](http://www.ifhhro.org)) and the Human Rights Centre ([www2.essex.ac.uk/human\\_rights\\_centre/rth](http://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 University of New South Wales Initiative for Health and Human Rights 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.

General Comment 14, **Paul Hunt** said, offers a common framework for unpacking the right to health.<sup>2</sup> 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?

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.

**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.

**Kgosi Letlape**, who is the past president of the World Medical Association and current chairperson of the South African Medical Association, stressed in his presentation 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.

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<sup>2</sup> 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.unhcr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En)

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

In January 2008, the Special Rapporteur published a report on health systems and their links with realising the right to health. In the second plenary session on Friday, 26 September, 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.

Over the years, the Special Rapporteur has stressed the important role of health systems. 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, the team drafted a list of conditions for an integrated health system, which was presented by **Gunilla Backman**, Senior Research Officer in the Right to Health Unit at the Essex University Human Rights Centre.

**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. Two important questions there are how to regulate the private sector and protect the public from malpractice, and how to solve the problem of financing health care – should this be done entirely through the national budget or could insurance systems play a role? 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 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.

**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. In his presentation, he addressed the need to translate rights language into medical ethics language for health professionals; the need to develop International human rights law to give some guidelines on how to address privatisation and private sector involvement in health care; and the practice of user fees and other fee-for-services approaches in health care.

**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. However, Yamin questioned the usefulness of his report for practical advocacy and activism: are the features identified by Hunt sufficiently tied to human rights? 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.

### 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, 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). Following the presentation, the working group listed some suggestions for the new Special Rapporteur and for health workers.

### **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** from the University of Oxford (UK) on the Special Rapporteur's work on indicators. 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.

Then, **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 impact assessment tool has been used to study various women-related issues, including maternal mortality, sex work and education on sexual and reproductive rights.<sup>3</sup>

After both presentations, the working group came up with a list of suggestions for the new Special Rapporteur and the health and human rights community.

### **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.

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. After this introduction, the working group came up with some suggestions for the new Special Rapporteur and for health workers.

### **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 (IAC). 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? Following the presentation, the working group drafted some suggestions for the new Special Rapporteur.

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<sup>3</sup> <http://www.aimforhumanrights.org/themes/women-s-human-rights/health-rights-of-women>

### 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** 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 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.

**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.

#### **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. 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. Further, **Claudia Trautvetter** of the German development agency GTZ highlighted the work of her organisation on the topic.

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 reproductive health rights is still difficult in many countries, as it is a sensitive issue. Cultural sensitivity is thus very important. After the presentations and discussions, the working group listed some suggestions for the new Special Rapporteur.

#### **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).

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, after which the participants of this working group defined some suggestions for the health and human rights community.

#### **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. 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. After the presentation, the working group discussed and listed some suggestions for the new Special Rapporteur and for the health and human rights community.

#### **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.<sup>4</sup> 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 working group then set out to list some challenges and suggestions for health and human rights educators.

#### **Plenary 4: The Special Rapporteur's Missions and Reports**

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

<sup>4</sup> [http://www.hsph.harvard.edu/pihhr/resources\\_hhrdatabaseintro.html](http://www.hsph.harvard.edu/pihhr/resources_hhrdatabaseintro.html)

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) and maternal mortality in India (forthcoming).

After Hunt's analysis, three representatives of civil society in Uganda (**Margaret Muganwa**), Peru (**Cesar Ugarte**) and Sweden (**Henry Ascher**) highlighted the progress (or lack thereof) in their country since the country report was published. They also formulated some suggestions for improvement of the missions as a tool for change. Also, **Rajat Khosla** of 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.

### **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 visits.

### **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. She presented some guidelines to ensure a fair and transparent process of participation.

### **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. After the presentations, the working group listed some suggestions for the new Special Rapporteur.

### **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. 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. In this report, Paul Hunt paid particular attention to intellectual disability, the right to community integration and consent to treatment. The working group discussed some issues related to this topic.

## 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** 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:

- There is a current need for strengthening health systems. But what are the priorities to set?
- 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.
- 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.
- 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**, President of Physicians for Human Rights, identified five main challenges for the future:

- Bringing right-to-health standards to critical actors in health policy, e.g. donors.
- 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.
- Determining the role of health professionals in the right to health.
- Solving problems of implementation: financing and the private market – a health systems issue.
- Having clear expectations of what the Special Rapporteur can achieve and what civil society needs to do.

From the perspective of a health worker, **Primrose Matambanadzo** of ZADHR (Zimbabwe Association of Doctors for Human Rights) summed up the challenges that lie ahead:

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

- 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.
- We should start utilising the Special Rapporteur; by using his reports or following up on his missions at the local level.
- How to mobilise resources for all this?

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:

- 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.
- 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.
- 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 challenges identified by **Daniel Tarantola** are:

- 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.
- 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.
- 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.
- 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*.
- 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.

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.

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 that are not present at the 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**