

INTERNATIONAL FEDERATION OF HEALTH AND HUMAN RIGHTS
ORGANISATIONS



IFHHRO Mumbai Meeting – December 2006

**MONITORING THE RIGHT TO HEALTH IN ASIA:
TOWARDS A (SUB-)REGIONAL NETWORK**

REPORT

**This meeting was hosted by the Centre for Enquiry into Health and Allied Themes (CEHAT)
Mumbai**



Preface

IFHHRO hereby presents the report of its first regional meeting in Asia. The meeting attracted a range of participants, including representatives of various health and human rights organisations, key representatives of the medical profession (including the President of the Malaysian Medical Association and the President of the Indian Association of Medical Consultants), a representative of the Indian National Human Rights Council, the Senior Research Officer to Paul Hunt, the United Nations Special Rapporteur on the right to health, and the Human Rights Officer of WHO Viet Nam. IFHHRO would like to thank all of the participants of the meeting for their constructive and important input. In particular, IFHHRO would like to thank Padma Deosthali (Coordinator, CEHAT), Kamayani Mahabal (IFHHRO Asia Regional Focal Point and member of CEHAT), and Swati Mankar (Administrative Assistant, CEHAT), whose assistance in the preparation and hosting of the meeting was invaluable. Further thanks go to Mr. Rajat Khosla for his attendance and crucial contribution to the meeting and to Ms. Rogayah Jafa'ar and Ms. Nighat Huda for acting as facilitators of various sessions.

IFHHRO would like to thank Project Officer Aleid Bos, who did not attend the Mumbai meeting due to her taking maternity leave in December 2006, for all of her assistance in preparing for the meeting. We would also like to thank Gemma Connell (Intern, IFHHRO) for her work in preparing the meeting in all of its detail and subsequently writing this report.

This meeting was financed by IFHHRO.

We are very pleased with the results of the meeting and look forward to the follow-up meeting, planned to take place in May 2007, with much anticipation.

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Introduction

With the aim of developing a network to monitor the Right to Health in Asia, the International Federation of Health and Human Rights Organisations (IFHHRO), in collaboration with its Asian regional focal point the Centre for Enquiry into Health and Allied Themes (CEHAT), organised a meeting in Mumbai, India from 1-3 December 2006 entitled: “Monitoring the Right to Health in Asia: towards a (sub)regional network.”

IFHHRO views the interaction between health and human rights organisations and associations of health professionals as essential to the development of a network that is able to effectively monitor the Right to Health at different levels in Asia. The participants of the meeting therefore included representatives of various health and human rights organisations, key representatives of the medical profession (including the President of the Malaysian Medical Association and the President of the Indian Association of Medical Consultants) and a representative of the Indian National Human Rights Council. The participants came from Bangladesh, India, Indonesia, Malaysia, Philippines, Pakistan and Viet Nam. Furthermore, the Senior Research Officer to Paul Hunt, the United Nations Special Rapporteur on the right to health, and the Human Rights Officer of WHO Viet Nam attended the meeting.

The meeting involved a combination of training and networking activities, with the dual goals of creating a network to monitor the right to health in Asia and simultaneously to strengthen the capacity of organisations in Asia to monitor the right to health. At the end of the meeting, the participants came to a consensus on the activities that are to be taken towards establishing a network to monitor the right to health in Asia. These were:

1. Involving students in monitoring the right to health;
2. Establishing a network for knowledge sharing;
3. Collating legislation on the right to health in each of the network countries; and
4. Sharing experiences in training health professionals and medical students on the right to health.



Day 1

Introductory presentations: Monitoring the right to health in India, Bangladesh and Philippines

The first session of Day 1 provided an opportunity for three of the participants in the meeting to present the work of their organisations in monitoring the right to health in their respective countries.

Monitoring the right to health in India – rural health watch JSA¹

Due to the unavailability of Dhananjay Kakde of JSA, Amitre Pitre, Joint Coordinator of CEHAT, provided the meeting with a presentation on the background of People's Rural Health Watch (PRHW) Jan Swasthya Abhiyan (JSA).² The presentation outlined the background to JSA, including the contributions of the Medico Friend Circle,³ the India Drug Network, and the women's movement in India, in establishing JSA; the adoption of the Indian People's Health Charter at the National Health Assembly in 2000;⁴ and the series of steps taken to monitor the right to health following the adoption of the Charter, including the National Workshop and Public Consultation held by JSA, in collaboration with the National Human Rights Commission of India, in September 2003.⁵

Amitre Pitre then gave a brief overview of the establishment of the National Rural Health Mission (NRHM) by the Indian government in April 2005⁶ and the subsequent development of PRHW JSA to monitor the implementation of the NRHM. PRHW JSA aims to:

- involve common people in monitoring the right to health;
- assess whether health care and services are structured appropriately;
- monitor the government's commitments under the NRHM not to decrease public funding.

PRHW JSA is composed of a 2 member Secretariat which functions out of the Christian Medical Association of India (CMAI), Delhi. It has composed six different questionnaires which will be used to assess and analyse the NRHM.

Discussion

Following the presentation, questions were raised regarding how PRHW JSA has engaged doctors, whether any policy changes have been seen as a result of the project, and who is involved in the monitoring process. Amitre Pitre noted that doctors and doctors associations have been important in brainstorming ideas but that the participation of health professionals in the actual project has been limited. She also responded that, while no policy changes have been seen as a result of the project, the budget outlay has been increased in some instances.

Follow-up: presentation by Dhananjay Kakde on Day 2

Dhananjay Kakde of PRHW JSA was able to attend Day 2 of the meeting and provide participants with a brief description of his experiences and the monitoring tools used by the project. He first showed a film which documents public hearings on the Right to Health with, amongst others, speakers from the Indian

¹ For further information regarding People's Rural Health Watch JSA see <http://phm-india.org/campaigns/prhw/index.html>.

² JSA is the title for the Indian Chapter of the People's Health Movement. For further information regarding PHM see: <http://phmovement.org/>

³ An Indian non-governmental organisation (NGO). For further information regarding the MFC see: <http://www.geocities.com/mfcircle/>

⁴ For the text of the Indian People's Health Charter see <http://phm-india.org/charter/iphcharter.html>.

⁵ For further information regarding the consultations see <http://phm-india.org/events/2003/5sept03-nhrcmumbai.html>.

⁶ For further information regarding the NRHM see http://mohfw.nic.in/national_rural_health_mission.htm.

government and National Human Rights Commission. Mr. Kakde then went on to describe the PRHW JSA project stating that it was launched in 2005 as an independent way of assessing the work of the NRHM. The NRHM provides explicit guarantees of health services at each level and PRHW JSA therefore works to monitor:

1. the policy documents and operational framework of NRHM; and
2. information at the state level by level directly observing and collecting data.⁷

Mr. Kakde then provided, as an example of a monitoring tool, the *village calendar* developed by PRHW JSA. This tool was developed in response to complaints received by PRHW JSA that doctors were not visiting villages at the appointed time. PRHW JSA provides the villages with a calendar that marks the dates on which doctors are meant to visit and how frequently. Villagers then mark the calendar when doctors actually come, noting any delay in the visit and whether the visit is as long as mandated. PRHW JSA collects the calendars every six months and instructs officials on how to improve.

Mr. Kakde also noted that PRHW JSA plans to use questionnaires to assess the implementation of NRHM. He emphasised that the questionnaires have been kept short, and are no longer than seven questions, so that the participants will answer them. The questionnaires are to be distributed at state level.

Discussion

A number of participants expressed significant interest in the *village calendar tool* and Mr. Kakde elaborated on how the tool was used, as outlined above. A question was also raised in relation to how to go about organising a *public hearing*. Smt. Aruna Sharma of the National Human Rights Commission answered this question, explaining that, in this instance, four regional workshops were held as open public hearings where people could talk about the right to health. Specific complaints were received as a result of these hearings and these complaints were then documented and monitored. The National Human Rights Commission then began review meeting with national and regional health authorities and the issues raised in the complaints became recognised as policy issues to be monitored.

The discussion also dealt with the concept of ‘backlash’ against citizens and groups who go about monitoring and enforcing the right to health. Mr. Kakde emphasised that, in this instance, the cases of backlash were relatively few. Kamayani Mahabal provided an example of backlash, noting that in most instances it was limited to relatively trivial incidents such as patients being taunted by health authorities if it was known that they had been involved in the JSA campaign.

Monitoring the right to health in Bangladesh – Health and Human Rights Research Foundation

Dr. Abdul Matin, Executive Director the Health and Human Rights Research Foundation’s (HHRF) provided a presentation on two monitoring projects: monitoring budgetary expenditure on health in Bangladesh; and monitoring the right to health in Bangladeshi gaols. He illustrated that it is important to look at budget figures in context as the budgetary allocation for health has remained similar between 2002 and 2006 (with a significant drop in the year of 2003-2004) whilst the price of living and the cost of health services has risen considerably. In relation to monitoring the right to health in gaols, Dr. Matin provided information regarding the degree of congestion of the gaols and the poor physical conditions and facilities provided in the gaols. His presentation also contained information regarding the increasing documentation of incidences of cruel, inhuman or degrading treatment in Bangladeshi prisons, and the fact that only 37 out of 500 reforms proposed by the Jail Reform Commission’s report of 1980 have been implemented to date.

Discussion

Dr. Matin was asked to elaborate on what statistics are available in relation to the right to health in Bangladeshi gaols. He answered that the collection of data is not well organised by the Bangladeshi

⁷ 18 states are currently a part of the NRHM.

government and that it is full of mistakes but that HRRF is nonetheless dependent on some government data, including demographic data. He noted the general lack of access of inmates to health services but that government has allowed (very) limited access of NGOs to the hospital to monitor standards.

Monitoring the right to health in Philippines - implementing health programmes among workers and marginalised urban city dwellers

Maisie Dagapio, a member of the health programme team of Katilingban Para sa Kalambuan Inc, provided a presentation on her work over time in the Philippines: firstly in monitoring the right to health of workers, and secondly in monitoring the right to health of marginalised urban city dwellers. She began with a brief introduction to the right to health in the Philippines, including the beginning of the movement for the right to health, the slogan 'health is not just the absence of disease, but the state of well-being,' and the 1986 'bloodless revolution' which was followed by the President's request that health become a priority issue. Ms. Dagapio noted that, despite the new focus on health, repression continued. She then went on to outline her work with the Worker's Health Programme and its use of mechanisms to monitor the right to health.

The Worker's Health Programme used a survey to assess a number of elements of the right to health in the context of the workplace, including how workers define health and the situation of health in different sectors including plantations, factories and service. The survey also focused on monitoring the implementation of different laws including the Labour Code, the Constitution's Bill of Rights, and the Anti-Sexual Harassment Law. The findings of the survey were presented within the labour movement and to the parliament. The results of the survey prompted two main responses:

1. Recognition by management of workers' right to health:
 - o health and safety became part of collective bargaining agreements;
 - o there was an improvement in conditions in the workplace, including improved access to toilets for women;
 - o pesticide applicators stopped being penalised for refusing to work beyond the accepted number of hours.
2. There was an amendment to the list of officially recognised diseases.

Maisie identified the following challenges in implementing the survey:

- a) negotiating internal dynamics within workplace unions;
- b) lack of advocacy with health professionals, especially occupational medical practitioners;;
- c) shifts in political and economic conditions;
- d) translating medical terms into terms understandable by workers and vice versa.

Maisie then outlined how she subsequently applied the framework used in the Workers Health Programme to her work with urban dwellers and monitoring the implementation of laws in this regard. The monitoring process involved:

- organising health committees;
- conducting educational activities; and
- research and documentation.

Discussion

During the discussion that followed the presentation, Maisie addressed questions regarding the lack of participation of health professionals in the monitoring programme, stating that there had been a hesitancy to work directly with doctors because of the perception that doctors are not open to information from NGO workers. This led to a discussion on how to involve health professionals in monitoring activities. Amitre from CEHAT criticised the focus of most medical research on diseases that affect the wealthier population such as heart disease and cosmetics and the fact that doctors tend to mobilise only around issues directly affecting them, for example violence against doctors.

Group Work: exchanging experiences and definitions of monitoring the right to health

Roos Terhorst of IFHHRO facilitated this session, first explaining to the participants what IFHHRO does and the aim of the meeting, and then providing the participants with two tasks to complete. The participants were divided into four groups and were asked to:

1. Define 'monitoring the right to health'; and
2. Discuss their experiences with monitoring the right to health choosing one best practice from the group and one failure/lesson learned.

Definitions

The following definitions of monitoring the right to health were formulated:

- checking whether the right to health is being fulfilled;
- assessing whether people have their rights fulfilled and analysing the role of governments;
- analysing whether commitments made by the government at local, regional and national levels have been complied with; and
- using a list of adjectives: watch, count (data), understand, evaluate, document, disseminate, identify (who is responsible) and identify (who is entitled).

The positive examples that were identified included:

- o involving local leaders and medical students in changing medical curricula to adopt a rights-based approach;
- o A project in Bangladesh to address the problem of doctors not coming to work on time. NGO activists developed a survey and gathered data on the doctors' lack of punctuality. They then networked with journalists to raise awareness of the issue in two districts.
- o HRRF use of checklists with a common basis but varying specific questions to assess services provided and services accessed; and
- o implementation of the Health Rights of Women Assessment Instrument (HeRWAI)⁸ by Naripokkho in Bangladesh.

Examples of failures/lessons learned included:

- o completing surveys that are not comparable across countries. For example, while some participants found the World Health Survey a worthwhile project to participate in, they found the lack of comparability of results to be a flaw in the project. Participants also noted that the number of questions in the survey made it difficult to implement;
- o the lack of sex disaggregation contained in WHO Health Indicators, and their limitation to the health services and medical aspects of the right to health.

Training Session: Monitoring the Right to Health – concept, contents and UN monitoring mechanisms

In this session, Mr. Rajat Khosla, Senior Research Officer to the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (hereafter 'Special Rapporteur on the right to health'), provided an introduction on the right to the highest attainable standard of health and the role of the Special Rapporteur.

Mr. Khosla emphasised that the right to the highest attainable standard of health (his preferred wording) refers to health in a particular country context. He noted that the health and human rights communities have much in common and that there are now many international and regional conventions that recognise

⁸ Available online at: <http://www.hom.nl/publicaties/HeRWAI%20def05%20totaal.pdf>

the right to health as well as national constitutions. He then elaborated on the two elements of the right to health: the right to *health care* and the right to the *underlying determinants* of health, describing how the right contains both freedoms and entitlements.

Mr. Khosla then outlined two approaches through which the right to health can be “unpacked”. Firstly, he described the ‘AAAQ’ approach which elaborates upon state responsibilities for the:

Availability of health facilities, goods and services: governments are obliged to take conscious steps to increase availability;

Accessibility of health facilities, goods and services to everyone: governments must ensure that no obstacles exist;

Acceptability of the services provided in terms, including cultural sensitivity: governments must be balanced and implement a rights-based approach; and

Quality of the facilities, goods and services provided, including, ensuring that counterfeit drugs are not supplied.

Secondly, Mr. Khosla outlined the content of governmental obligations regarding the right to health through the *respect, protect and fulfil* framework.

Mr. Khosla emphasised that international human rights law recognises that there will be difficulties in achieving the highest attainable standard of health but that the right demands progression rather than retrogression. He noted the importance of indicators and benchmarks in monitoring the progressive realisation of the right and also the importance of the participation of all stakeholders.

In relation to the role of health professionals, Mr. Khosla highlighted the ability of health professionals to promote and protect peoples’ right to the highest attainable standard of health through documenting and redressing violations. He also noted that health professionals may be targets of human rights violations and, on the contrary, that health professionals may be complicit in human rights violations (using the examples of Guantanamo Bay and Abu Ghraib). He considered that the role of health professionals in violating human rights is often influenced by political and social factors but, in large part, is caused by a lack of training in human rights.

Mr. Khosla then provided an overview of the work of the current Special Rapporteur on the right to health, Mr. Paul Hunt, who is an independent expert appointed by the United Nations Human Rights Council. He noted that the Special Rapporteur has identified three main objectives in his work:

1. to encourage others to promote the right to health as a fundamental human right and thereby to elevate its status;
2. to clarify the scope and contours of the right;
3. to identify good practices in operationalisation of the right.

He also spoke of the country visits of the Special Rapporteur and the issues that the Special Rapporteur has taken up, including access to medicines. The Special Rapporteur provides periodic reports to the General Assembly and the Human Rights Council and receives information regarding alleged human rights violations of individuals and groups.

Discussion

In the discussion that followed Mr. Khosla’s presentation, participants of the meeting raised issues surrounding the:

- shift to the terminology of patients as consumers and doctors as providers;
- need to look at social and political conditions in order to see health in the context of human rights;
- need to look at ‘health professionals’ in broad terms so as to include, for example, hospital owners, pharmaceutical companies;
- process by which the Special Rapporteur selects countries for visits and any responses/changes that have occurred as a result of such visits;
- process by which the UN selects which issues/countries will have special procedures established;
- role of the World Health Organisation in the privatisation of resources and services that affect the right to health, for example, the privatisation of water in India.

Mr. Khosla emphasised that any discussion of health professionals must include *all* health professionals, including managers, nurses, doctors etc. He also noted that national medical associations have the potential to play a crucial role in furthering the right to health. Mr. Khosla elaborated on the procedure by which the Special Rapporteur will conduct a country visit, including the need for an invitation by the country concerned and consultations with UN agencies regarding the country. He stated that in relation to visits that have already occurred, some positive changes have taken place. For example, in Uganda, there have been policy changes, and in Peru the follow-up visit of the Special Rapporteur proved useful.

Workshop: Shadow Reporting and Investigation

This session provided participants with information regarding two possible methods of monitoring the right to health: investigation and documentation methods; and shadow reporting. This was followed by group work and a discussion.

Investigation and Documentation

Chandrima Chatterjee of CEHAT described the two main methodologies of monitoring human rights violation as:

- events (or acts-based) methodology; and
- indicator-based methodology.

Events-based methodology uses reports of events of denial of health care to monitor the right to health. The researcher documents representative cases, capturing the significance of the denial/loss to the patient and collecting all relevant evidence. Ms. Chatterjee noted that public hearings might be a useful tool in reporting/documenting events of denial.

Ms. Chatterjee then provided the group with the WHO definition of indicator-based methodology:

“a human rights indicator derives from, reflects and is designed to monitor realisation or otherwise of a specific human rights norm, usually with a view to holding a duty-bearer to account”

Ms. Chatterjee emphasised the obligation on states to formulate explicit, quantifiable and time-limited *objectives* for the purpose of meeting their obligations under international law, and the pursuant obligation on states to identify appropriate indicators and benchmarks with which they intend to measure progressive realisation. *Benchmarks* were defined as self-set goals or targets to be reached at some future date. *Indicators* were defined as signals that make it possible to determine the extent to which a particular obligation or standard has been, or is being, attained. They can be used to measure and monitor the:

- overall status of a particular situation;
- changes or trends over a period of time;
- achievements towards targets (benchmarks/objectives);
- differences between particular groups in the population; and
- differences between geographic regions within a country.

Types of indicators include: *policy measurement* indicators (ie outcome or impact indicators measuring the degree to which a government’s laws, policies and programmes are achieving an outcome consistent with enjoyment of the right to health) and *progress measurement* indicators. A good indicator was defined as being:

- policy relevant;
- reliable;
- accessible;
- consistently measurable over time;
- making use of disaggregated data;
- impartial.

Ms. Chaterjee also noted the importance of statistical information in monitoring the right to health. As a human rights-based approach to health places particular focus on the needs of the most disadvantaged and vulnerable individuals and communities, it is essential that statistical data be disaggregated so as to enable monitoring the status of, and changes within, such vulnerable groups.

Shadow Reporting

Ms. Kamayani Mahabal began by noting her dislike for the term ‘Shadow Reporting’ and her preference for other terms such as Alternate Reporting or Parallel Reporting. She then provided a brief introduction to the Committee on Economic, Social and Cultural Rights (‘the Committee’), the monitoring body of the International Covenant on Economic, Social and Cultural Rights. The Committee meets in Geneva, Switzerland twice a year and analyses the reports of States Parties. When a country ratifies the Convention they are required to submit their first report two years after ratification and then to submit a periodic report each 5 years thereafter. Ms. Mahabal emphasised the importance of the Concluding Observations that the Committee adopts in relation to each State Party’s report, highlighting that NGOs must use these Concluding Observations to hold governments accountable.

Ms. Mahabal then went on to outline the following steps in the process of *organising* an alternate report to the Committee:

1. Obtain the official government report to the Committee;
2. Coordinate with various organisations to get full range of inputs on the Convention (your organisation will most likely focus only on the health section);
3. Limit the report to *no more* than 30 pages and include an Executive Summary;
4. Include some background information;
5. Organise the information that you have obtained according to articles of the Covenant *not* on an issue basis;
6. Gather documentation including statistics, local cases, newspaper reports etc;
7. Describe the problems, evidence and suggestions for change including *who* can implement the requested changes;
8. Prioritise issues and provide a concrete list of recommendations eg which actors need to be involved, who needs to be trained, the need for community participation etc;
9. Include an analysis of your country’s reservations and request their removal.

Discussion

In the discussion that followed these two presentations, participants emphasised their own experiences in monitoring and issues in attempting to engage health professionals. *Nighat Huda* spoke of her own problems in attempting to engage health professionals and receiving a lack of support in such initiatives. *Rogayah Jafa’ar* then emphasised the potential role of medical education and the importance of partnerships between government and local communities, as well as that of students as change agents. *Dr. Matin* spoke of governmental obstacles encountered in HRRF’s monitoring work including the government telling hospitals not to respond to an HRRF survey and taking one year to give permission for HRRF to re-print the Client’s Charter of Rights. *Samia Afrin* of Naripokkho emphasised the need for good communication with government, including the Ministry of Health, for the purpose of sharing information. *Farid Abdul Hadi* of IFMSA spoke of IFMSA’s experience attending WHO meetings and preparing shadow reports. He noted the possibilities for sharing of information created by Information Technology: IFMSA uses a system where they collect information through the website and compile this information into a report. *Rosena Sanchez* of the Mindanao Working Group spoke of her experience in assisting with shadow reporting to the Committee on the Elimination of Discrimination against Women which involved a conscious raising process; consultative process (consultations were held on the three main islands of Philippines) and information about the provisions of the Convention on the Elimination of all Forms of Discrimination. The government provided the NGOs with a copy of its report to the Committee but the NGOs never provided the government with a copy of their report. *Datuk Dr. Teoh Siang Chin* noted that national medical associations are receptive but sometimes need to be engaged. He

suggested that if NGOs are conducting a survey, they could distribute it through the national medical association. The representatives of *People's Health Movement Bangladesh* described the experience of learning from Naripokkho's monitoring with the HeRWAI instrument and implementing different strategies, such as a public hearing on the accessibility of the health system for poor people, to monitor the right to health in Bangladesh.

Working Groups

The plenary then split into two working groups, one that learned to apply indicators-based methodology in practice, and one that developed a hypothetical shadow report. The reports of the groups were presented on Day 3.

Film Showing: Health Matters

The film depicted the Indian health system, contrasting the public and private systems and addressing the concept of 'health tourism.'

Day 2

Presentation of Working Groups on Indicator-Based Methodology and Alternate Reporting

Shadow Report Presentation

Farid Abdul Hadi presented the work of Group 1 with the assistance of Dr. Evi Douren of Indonesia. The Group had prepared a Draft Executive Summary for an alternate report to Indonesia's report to the Committee on Economic, Social and Cultural Rights using the 'AAAQ' approach and identifying the priority issues of maternal mortality, occupational and workplace health, and HIV/Aids. The group then provided a list of draft recommendations, including increasing the doctor/population ratio.

Discussion

Kamayani Mahabal emphasised that, in practice, the recommendations contained in alternate reports must be more concrete than those developed by the group. Recommendations should detail *what* and *how* recommendations should be implemented and should attempt to use wording that would be acceptable to the Committee. *Rogayah Jafa'ar* inquired as to whether statistics should be used. Farid responded that, although the group was unable to include statistics in its draft summary due to time and resources, in his experience statistics should be a first priority. *Sarah de Hovre* then emphasised the need to put in as many NGO statistics as possible to demonstrate difference between NGO statistics and government statistics.

The plenary then engaged in a very interesting discussion regarding whether NGOs should provide their alternate reports to their government in advance of the Committee meeting. Kamayani categorically stated that governments should not be provided with a copy of the report until the Committee session. Sarah de Hovre then pointed out that in Viet Nam, NGOs run a significant risk of being repressed if they don't cooperate and communicate with the government regarding alternate reports. In response, Rajat Khosla raised the possibility of anonymous reporting or collaboration by domestic NGOs with international organisations and having the international organisation submit the report in their name so as to avoid repression of local NGOs.

Indicator-based Methodology Report

The group's objective in the exercise had been to draw governmental attention and accountability to emergency obstetrics in subdistrict health complexes. They analysed current government policy including the number of beds that are meant to be available and the policy of having obstetric care posts in health complexes. However, despite the existence of a relatively promising policy, none of the facilities or services stated to be available in the policy was actually available. The group developed indicators using the AAAQ approach:

Availability:

- not only post but presence of obstetrician are necessary;
- essential infrastructure;
- public information regarding what services are available.

Accessibility:

- there must be at least one emergency transport;
- costs for services should be affordable: if health centres (which can be accessed for free) do not fulfil needs, there must be consideration of how to fund other services;

Acceptability:

- feedback on services to be obtained from mothers using an exit test;
- respectability of cultural and environmental factors.

Quality:

- assess the percentage of high risk mothers who seek emergency services in emergency health clinics and how many are going to other clinics;
- waiting and consultation time by obstetrician and other medical service providers;
- frequency of referral.

The group emphasised the need for data *disaggregated* by, for example, regions (rural vs urban), economic class/caste, educational level and parity. Chandrima reminded the group that data itself constitutes information and indicators. The group also identified *policy/process* indicators, including budgetary allocation for health complexes; and special programmes for vulnerable mothers.

Discussion

In the discussion that followed the presentation, *Rosena Sanchez* noted that it is important that *voices* be included in indicators, for example by using qualitative indicators such as testimonials to include the voice of women. *Sarah de Hovre* noted that, although there were policies/laws already in place in this example, it is important to add structural indicators (ie questions of whether there are laws, policies and programmes) in other situations. *Dr. Evi Douren* stated that it would be interesting to analyse the role of donors.

Summary by Rajat Khosla

Mr. Khosla described the two morning presentations as extremely useful, demonstrating the difficulties that arise in the monitoring process. He also emphasised the interrelatedness of the two processes: indicators are extremely useful when it comes to writing a report. He reaffirmed the need for alternative reports to be well structured and to include:

- Issue;
- Framework analysis (AAAQ);
- Identify priority issues and tie them to relevant Covenant articles;
- Importance of brief Executive Summary;
- Importance of concrete and specific recommendations based on indicators and data analysis.

In relation to indicators, Mr. Khosla described the following process:

1. Identify the issue: right to health;
2. Identify objective: emergency obstetric care;
3. Identify related policy: what is the structure in the country context;
4. Look at infrastructure: compare policy and practice.

He also reinforced the need for data disaggregation and the importance of qualitative indicators such as testimonials.

Presentations: Involving regional and national institutions in monitoring the right to health

Padma Deosthali of CEHAT chaired this session of three presentations with all questions for discussion held until the end of the session.

The WHO and developments in monitoring the right to health

In this presentation Sarah De Hovre informed the plenary of the role of human rights in the WHO and the structures relevant to health and human rights within the WHO. The WHO has two full-time staff at headquarters working on health and human rights. There are also elements of human rights in some of the other technical departments. At the regional level, there is usually a full-time health and human rights focal point.

The six official WHO regions are:

1. AFRO: African Regional Office
2. AMRO: Americas Regional Office
3. EURO: Europe Regional Office
4. EMRO: Eastern Mediterranean Regional Office
5. SEARO: South-East Asia Regional Office
6. WPRO: Western Pacific Regional Office

Sarah noted that Asian countries are split across four of these regions. These regional bodies are individually active around health and human rights in diverse ways including, for example, the EMRO regional consultation on health and human rights and publication of “Health and Human Rights in Islam,” and the SEARO has compiled resources on the Convention on the Rights of the Child for Health Professionals. There are also currently 3 country-based health and human rights posts: Mozambique, Uganda and Viet Nam.

Sarah provided an overview of the increased emphasis on human rights in the WHO since the 1990s and in the context of current UN reforms focusing on human rights. Examples of WHO health and human rights activities include:

- development and testing of tools to monitor maternal health in Indonesia;
- compilation of WHO 25 Questions and Answers on health and human rights as part of broader strategy to disseminate health and human rights publications;⁹
- guidelines for WHO staff and their national counterparts in relation to human rights are currently being developed.

The WHO also collaborates with UN Special Rapporteurs and treaty bodies, including providing information to the treaty bodies on States Parties reports, attempting to convince States Parties’ Ministries of Health to be a part of delegations to treaty body dialogues, and encouraging the Ministry of Health to implement concluding observations/comments of the treaty bodies.

Describing her own work in Viet Nam, Sarah noted that at this point in time, the Viet Nam country post is very much a work in progress. She is doing a lot of networking and awareness raising through information sharing with colleagues, including circulating documents/journal articles on human rights and now, having colleagues approach her for a human rights perspective on certain policies. She described the technical cooperation component of her work, including a workshop on domestic violence with the Ministry of Health and assisting in the development of legislation. Sarah then identified some of the main challenges of her work as: dependency of the WHO upon the cooperation of States; and a common misunderstanding that rights are for lawyers and not for health professionals. She also highlighted the lack of a regional human rights treaty in Asia, the Vietnamese government’s perception of human rights and civil society as a threat, and low expenditure on health. In relation to civil society and the government, Sarah indicated that the WHO is capable of playing the role of facilitator in contact between NGOs and the government.

Role of National Medical Associations: case study of the Malaysian Medical Association (MMA)

In an attempt to respond to many of the queries and criticisms raised in relation to doctors and medical associations on the first day of the meeting, Datuk Dr. Teoh Siang Chin (hereafter Dr. Teoh) provided a presentation on what the MMA is doing and has done in its day-to-day activities. The MMA is a voluntary professional association which was established in 1960. The day-to-day activities of the MMA include updating the skills of medical professionals, raising awareness about specific health issues (for example tobacco), conducting regular meetings with the Ministry of Health and working with the public services. The main issues that the MMA has focused on include:

- arguing for an increase in the health budget;
- aiming to increase quality of life for citizens and doctors;
- addressing issues arising from the privatisation of health care; and

⁹ See the WHO Health and Human Rights Publication Series, available online at: <http://www.who.int/hhr/activities/publications/en/>

- addressing inequalities in health.

The MMA also has a Committee on Human Rights which was established at the 41st MMA Council in 2000.

Dr. Teoh. provided an example of MMA action in relation to the passing of Regulations to the *Private Healthcare Facilities Bill 1998* in 2006. The MMA renegotiated some of the Regulations in light of doctors' concerns. Dr. Teoh also spoke of vision 2020 and the likelihood that the aim of a doctor/patient ratio of 1/600 will be reached if the current number of medical students enrolling and graduating continues. However, he noted that the increasing prominence of private medical schools is problematic given that the fees that medical students incur provide an incentive for them to enter private practice in order to pay off their debts.

Dr. Teoh also spoke of the "brain drain" phenomenon, referred to on Day 1 by Mr. Rajat Khosla. Dr. Teoh highlighted three elements of the brain drain that are not related to geographic relocation: public to private; GP to specialist; and specialist to interventionist. He also looked at the distribution of doctors across states in Malaysia: the richest state has a doctor/patient ratio of 1:401 whilst the poorest state has approximately 1 doctor per 2,500 people. He provided figures stating that 75% of admissions are to public health care services, while 75% of specialists are in the private sector. He also noted the increasing number of resignations.

Finally, Dr. Teoh provided the MMA's analysis of the budget allocation to health in Malaysia. The MMA has analysed trends in health expenditure and found that while expenditure on the Ministry of Health increased by 800 million, and the government emphasised this, the actual percentage of expenditure decreased from 5.5% to 5.1%. Dr. Teoh also used the Gini co-efficient to demonstrate that inequality for all racial groups has increased. On this note, Dr. Teoh suggested that the way forward requires that the public and private health sectors be brought together in some way to ensure that all people have access to health care services. Dr. Teoh also briefed the plenary on some of his own experiences in working with native Malaysians in the Baram area and his vision of medicine as a service.

In relation to networking, Dr. Teoh indicated the MMA's collaboration with the Citizen's Health Initiative and the Coalition Against Privatisation, as well as the MMA's networking with other national and regional medical associations.

The Role of National Human Rights Institutions: case study of the National Council on Human Rights of India

Smt. Aruna Sharma, the Joint Secretary of the National Council on Human Rights, provided a presentation that elaborated on the role of the National Council on Human Rights in monitoring the right to health. She noted that, given that the National Council works from the basis of the rule of law, there is no question of the government opposing its' rulings. Smt. Sharma emphasised that the right to health is not only physical; it is all encompassing and includes emotional, mental and physical health. Smt. Sharma then dealt with seven specific topics that the National Council has addressed: I. Safe Motherhood: Bringing Rights Home First; II. Ageing with Dignity: Health Care for the Elderly; III. Emergency Medical Care: Imminent Intervention Essential; IV. Children and HIV/AIDS; V. Environmental Degradation: Challenge to Health; : Protecting Silent Sufferers; VI. Human Rights of Prisoners: Victims of a Failed Justice System; and VII. Unethical Medical Practices: Spurious Drugs as a Threat to Health. Throughout each of these themes, Smt. Sharma emphasised the need for approaches to the right to health to be multi-sectoral and to cut across multiple ministries and the importance of the realisation of the underlying determinants of health, including the right to healthy conditions.

Smt. Sharma then explained that the National Council on Human Rights is funded by the Indian government but remains autonomous. Ninety-eight percent of the recommendations of the Council have been implemented. Smt. Sharma suggested that the efficacy of the Council's recommendations has been influenced by the media pressure that the Council has raised, and also the fact that the Council presents an annual report to Parliament which must be addressed.

In order to deal with the issue of a lack of availability of doctors, a number of programmes have been implemented including the Medical Council of India's introduction of a three year course designed for rural medical practitioners and a three year certificate of midwifery. The Council on Human Rights has also attempted to involve private practitioners at a rate acceptable to them, but lower than that usually charged by private practitioners to patients.

Smt. Sharma ended her presentation with the following recommendations to participants:

1. Get involved with your national human rights institutions;
2. Develop strategies that involve and collaborate with all social sector governmental ministries and not just health;
3. Assist ministries in achieving their qualitative targets. The National Council on Human Rights has the power to summon Secretaries of Ministries if targets are not being achieved.

Discussion

The discussion that followed these three presentations was extremely varied. A number of participants raised questions for Sarah de Hovre regarding the work of the WHO, including what the WHO does at the grassroots level to ensure realisation of the right to health. Sarah responded and clarified that the WHO works only at the policy level as working on grassroots policies is not a part of its mandate. However, she emphasised that the WHO can be seen as a link between the governmental and grassroots levels and that NGOs may inform the WHO of what is not working at the local level so that the WHO may raise these issues with the government. There was also a question concerning the method by which WHO funding is distributed and how NGOs may access such funding. Sarah responded that the WHO provides two years funding to the government and gives directions on how the money should be spent. There is no provision for the WHO to make funding available to NGOs. However, governments may decide to distribute money to NGOs. Sarah suggested that NGOs may wish to contact the WHO at country level to obtain suggestions of which other donors and bilateral funds are available as the WHO has very good contacts in this regard. There was also a question regarding the role of the WHO in the formulation of national health priorities given that the Minister of Health quite frequently will become very serious/concerned about an issue which, in reality, is not a priority. Sarah then explained that the WHO cooperates with each country to formulate a Common Cooperation Strategy (CCS). This is a joint document between the Ministry of Health and the WHO. Prior to the drafting of the CCS, the WHO conducts an evaluation of issues and liaises with the regional WHO office to see whether they identify the same issues. At the same time, the government conducts an evaluation of what it believes to be the priority issues in health. Subsequently, the WHO and Ministry of Health meet and negotiate what will be the priority issues in the CCS. A question was also raised in relation to *how* the WHO monitors the expenditure of the government under the CCS. Sarah responded that one technical officer is responsible for monitoring each (or a few lines) of the CCS. Thus, each time the government wants to spend money, it must approach the WHO and provide a budget for WHO approval. Once the project receives approval and is then completed, a technical report and financial report must be submitted to the WHO.

In relation to medical associations, Padma asked Dr. Teoh what strategies could be used to involve health professionals in human rights. Dr. Teoh responded that it is better to approach doctors as members of organisations than as individuals. It is therefore important to lobby national medical associations as they have full-time staff and develop position papers. There was also a question posed to Dr. Teoh about the role that he saw NMAs playing in monitoring the right to health. Dr. Teoh spoke of the possible role of NMAs in educating health professionals and also in attempting to bring about change in medical curricula. However, he noted that NMAs are not equipped to monitor but are more important in relation to monitoring. On Day 3, Roos Terhorst of IFHHRO recalled this remark by Dr. Teoh. and emphasised that what the MMA is currently doing, ie assessing whether legislation is appropriate in practice and analysing health expenditure, constitutes monitoring. Maisie Dagapio raised the issue of how NMAs interact with pharmaceutical companies and provided the example of research conducted in a hospital in the Philippines (where medical representatives are constantly seen visiting medical doctors). In that hospital, a notice on

the board inside the obstetrics/gynaecology room urged residents, in particular, junior residents, of obstetrics/gynaecology to prescribe a particular medicine brand for a particular condition.

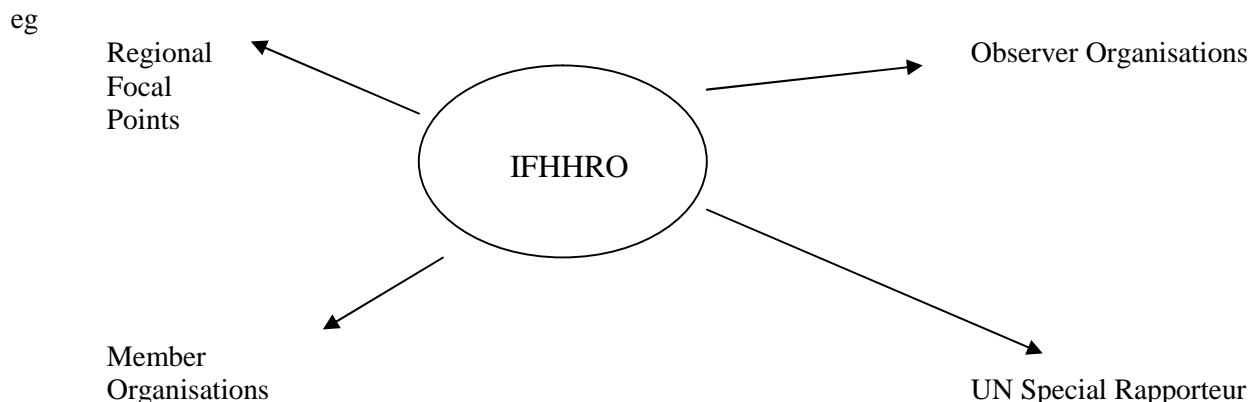
Dr. Teoh responded that the MMA has a great deal of interaction with pharmaceutical companies and that such pharmaceutical companies have signed an ethics agreement. However, he noted that problems remain.

There was also a discussion surrounding the accreditation of doctors and the bodies that are involved in such accreditation. Smt. Sharma emphasised that national medical associations should engage with the process of accreditation and the development of medical curricula. Dr. Matin of Bangladesh noted the issues with the Medical and Dental Council in Bangladesh, including lack of transparency and ineffectiveness. On this note, Sarah de Hovre suggested that countries where there are issues regarding Medical Councils could contact the WHO so that the WHO may raise the issue with the relevant government.

Finally, Sarah de Hovre noted that Viet Nam does not currently have a national human rights institution (Dr. Matin also raised this point in relation to Bangladesh) and asked Smt. Sharma for suggestions as to how to find further information and encourage the development of such an institution. Smt. Sharma referred the participants to the Paris Principles and the requirement therein that each government establish an autonomous national human rights institution.¹⁰

Developing a network: individual and group work

In the morning session of Day 2 Gemma Connell facilitated a session whereby participants were asked to individually draw a 'mind map' of their current networking activities. Each individual was provided with a blank piece of paper and was asked to place their organisation in the middle and then draw links out to each organisation that they were currently networking with, including whether they were networking with local NGOs, international NGOs, international agencies, health professionals etc.



The participants were then each asked to use a different coloured pen and draw onto the mind map which types of organisations and individuals they would *like* to network with. Following this exercise, four of the participants from different types of organisations were asked to present their mind map and explain which organisations/types of organisations they currently network with and which they would like to network with. Dr. Teoh. presented his current network and then presented his so-called 'wish-list' network which included more contact with the media. Sarah de Hovre then presented her current and wish-list networks as a WHO country representative and Aaro Samuli Seppanen Did the same for his role as the regional human rights officer for WHO. Rogayah Jafa'ar then outlined her current and wish-list networks as a university educator and member of The Network towards Unity for Health. Finally, Mr. Rajat Khosla presented the current and wish-list networks of the Special Rapporteur on the right to health, including the

¹⁰ For further information in this regard, refer to the United Nations Office of the High Commissioner on Human Rights Fact Sheet No. 19 on National Human Rights Institutions, available online at: <http://www.unhchr.ch/html/menu6/2/fs19.htm>

wish to have better networking with governments. At the end of this exercise, each participant pinned their mind map to the board so that other participants could see what types of networks currently exist and what each participant 'wished'.

Following the presentations of Sarah de Hovre, Dr. Teoh. Teoh Siang Chin and Smt. Aruna Sharma, participants were asked to work in country groups (with those who were representing specific organisations eg IFMSA and Mr. Rajat Khosla, moving between groups) on developing a strategy to achieve their wish-list networks and to discuss how they would go about attempting to involve health professionals in their work. Each group was asked to develop a country plan for 2007-2008 including what they would like to achieve at 3mths, 6mths and 1yr.

Once the country-specific plans had been developed, the meeting was split into two groups, with representatives from each country divided between groups. The groups were then asked to come up with a *regional* networking and action plan for monitoring the right to health and involving health professionals in Asia 2007-2008. The groups discussed numerous issues, including ideas on how to further involve medical students in monitoring the right to health, the acceptability of the terms 'medical ethics' and 'human rights' in the medical community, the need for further training of medical professionals and students (possibly with the endorsement of the WHO), the discrepancy between what is taught in medical schools and how medicine is practiced in terms of ethics and human rights, the sharing of information and ideas regarding monitoring the right to health, and the possibility of IFHHRO providing summaries of the reports of the Special Rapporteur in terms understandable to NGOs and health professionals.

Film showing: 'Another World is Possible'

The movie examined the use of CEDAW by NGOs and activists in South East Asia.

Discussion: Following the film, Kamayani updated the meeting on the passage of the Domestic Violence Act in India on 26 October 2006. There had been much discussion regarding the role of health professionals in the implementation of the Act. Dr. Teoh. then commented upon the 'One Stop Shop' model of dealing with sexual assaults in hospital emergency centres which brings together the services of nurses, doctors and social workers, as well as negating the need for the victim to attend a police station to report the crime. Sarah de Hovre noted that the WHO WRPO has published a source book for health professionals on domestic violence.¹¹ There was then a discussion between members of the meeting as to the reporting procedures used for gender-based crimes in their respective countries.

¹¹ 'Integrating Poverty and Gender into Health Programmes: A Sourcebook for Health Professionals' available online at: http://www.wpro.who.int/publications/PUB_9290611944.htm. For further information regarding the WHO and its work regarding gender-based and sexual crimes, see: <http://www.who.int/hac/techguidance/pht/SGBV/en/>

Day 3

Presentation of Draft Working Plans for 2007-2008

Group 1

The draft Working Plan formulated by Group 1 contained two elements:

1. IFMSA and the participants committed to involving students in the development of a network to monitor the right to health. The group had discussed commitments to:
 - establish a new IFMSA member organisation in Bangladesh;
 - reactivate organisation in India which has been inactive and is likely to lose its membership;
 - work to revive network in Malaysia with assistance of Datuk Dr. Teoh Siang Chin;
 - consider ways of working with private students in Indonesia;
 - put Philippine participants in contact with Philippine student organisations.
2. To create a knowledge network. This network would function in the following way:
 - CEHAT would act as the secretariat;
 - Participants at the meeting would ensure that all experiences in monitoring the right to health and involving health professionals are shared so that they can be replicated (where possible) and learned from. This will allow members of the network to know what is occurring in other countries of the region and to participate/collaborate where possible.
 - Students and student networks would be integrated in the knowledge sharing network. It was acknowledged that the involvement of students is crucial.
 - Rogayah Jafa'ar also indicated that it could be beneficial to carry out a 'knowledge workshop' in each country so that the participants could share their experiences with colleagues from their home countries.

Group 2

Group 2 formulated five main activities as part of its draft Working Plan:

1. Compilation of national health legislation, including the existence of constitutional protection. This will result in a final working paper/publication which outlines how the right to health is codified in each of the countries in the network;
2. Sharing experiences in the training of health professionals and medical students, including attempting to involve WHO in such trainings so as to grant them further legitimacy in the eyes of the medical profession;
3. Sharing of experiences in relation to conflict studies. Group 2 came to a consensus that studies on the impact of conflict on the right to health are crucial in the Asian region. Maisie and Rosena from the Philippines are currently involved in a study regarding conflict. Once this is completed they will share their experiences. It is hoped that this will lead to the development of a general framework to study the right to health in the Asian region that can be implemented within each country;
4. CEHAT to take on role as regional 'clearinghouse' for all information and initiatives that are being undertaken regarding monitoring the right to health and engaging health professionals;
5. IFHHRO will distribute summaries of the reports of the Special Rapporteur in language that is understandable and usable by NGOs and health professionals.

Discussion/Summary: Roos Terhorst

Roos Terhorst of IFHHRO then provided a synopsis of the summary so far, in the context of IFHHRO's overall vision of what is to come. Roos explained that this meeting was to be the first in a series of three meetings that will take place within the time frame of two years. The second meeting is planned to take place in six to seven months time and will aim to further the initiatives developed at this meeting. Roos emphasised that a lot of the work that the participants of the meeting are already undertaking in fact constitutes monitoring, although they frequently do not identify it as such (for example Dr. Teoh. and MMA's monitoring of the health budget). Roos then went on to explain that, at this stage, IFHHRO is holding meetings in 3 regions - Asia, Latin America and Africa – in order to see what type of monitoring mechanism each of the regions creates. Having seen the initiatives proposed in the morning session for the Asian region, Roos proposed that the following process for regional monitoring could be possible:

1. Each country to gather information regarding existing legislation on the right to health;
2. Analyse the information gathered in step 1 in light of commitments made under international human rights law;
3. Gather data to analyse whether legislation is being appropriately implemented in practice.

Padma then emphasised the need for the meeting to create a *concrete* plan of action for the following year, detailing what each member of the network is willing to *actually* commit to and what is achievable within the time frame. She also highlighted the lack of a discussion of the role of health professionals within each of the groups' Working Plans and the need for this issue to be incorporated in any working plan.

Finalising the Working Plan for 2007-2008

The meeting then engaged in a plenary discussion of how to operationalise the above aims. The following actions were decided upon and committed to by the participants of the meeting.

Involving Students in Monitoring the Right to Health

Bangladesh – plan has been created and committed to by the participants and IFMSA representatives.

India – CEHAT has provided a contact to IFMSA for a potential collaborator in reactivating Indian students. CEHAT suggested that the contact would like to be provided with a concept note from IFMSA stating what is expected of member organisations and how it is to be achieved.

Indonesia – Farid is to work on reactivating students.

Malaysia – Rogayah will work with IFMSA in an attempt to engage students and connect them with attempts to monitor the right to health.

Pakistan – Nighat Huda will contact the IFMSA member organisations in Pakistan and attempt to create connection and involvement in networking.

Philippines – Maisie and Rosena will obtain the list of active students and then continue to update them on health and human rights activities.

Farid also suggested that members of the network consider involving students in training sessions that may take place and also in any discussions that occur on national medical curricula.

Network for Knowledge Sharing

Kamayani (Regional Focal Point) will provide a template to each organisation/country, which is to be used when submitting information. All information is to be submitted to CEHAT as the 'clearinghouse' for the region. In order to ensure that information is shared there will be established:

- a) a regional email group; and
- b) a section of the IFHHRO website containing information and updates from the Asian Regional Focal Point.

This network for knowledge sharing is to begin as soon as possible.

Collating legislation on the right to health

- c) 3 months (by March 2007): CEHAT will develop and provide each country with a set of guidelines on what should be analysed;
- d) 3-6 months (by June-September 2007): Each country will apply the guidelines to assess what legislative (and constitutional) provisions exist regarding the right to health and health matters in their own country and then send the information back to Kamayani. Note: countries should have something to report on regarding this process by the next regional meeting in May 2007;
- e) Kamayani, in collaboration with IFHHRO, will compile the information into a Working Paper. This will then be distributed for each countries' comments and finally the Working Paper will be published and distributed (by end of 2007).

Further developments in the training of health professionals and students

Given the amount of variance between countries as to what does and doesn't work in the training of doctors and health professionals (eg some countries found the terminology of medical ethics acceptable to doctors, while other countries found that human rights was more acceptable), no regional plan for training can be developed at this point. However, participants committed to share their experiences and tools in relation to training. In particular, Rosena from the Philippines will share the experiences of her colleagues in having their module on gender, domestic violence and reproductive health acknowledged and approved by the WHO, and any further developments of the module to include a rights-based approach.

Planning and ideas for a follow-up meeting

The plenary was split into three groups of five people from different countries and asked to draft plans for a follow-up meeting, including indicating what format the meeting should follow (eg lectures or workshops), what topics they would like to address, and any further countries that they thought should be invited. The groups then reported back to the plenary with their range of ideas for the follow-up meeting.

Group 1

Possible topics for sessions:

- Update results of tasks assigned during this meeting (ie status of analysis of legislation, work of IFMSA and engaging students in networking, knowledge network and conflict studies);
- Promoting and monitoring the right to health: what can the network do to address gaps in national legislation?
- Consider input into medical ethics guidelines – are there any guidelines that have adopted a rights-based approach?
- Overview of UN documents that address the right to health, and instructions on how to incorporate such documents/statements into the practice of monitoring;
- Development/discussion of common indicators regarding the right to health;
- Mapping current status of rights-based approach in medical curriculum.

Possible countries to be included:

Thailand, Cambodia, Laos, Sri Lanka, Myanmar, Nepal, Viet Nam, Bhutan; countries with the greatest number of vulnerable groups.

Possible participants:

- need to attract media attention;
- invite those NMAs that are open to adopting a rights-based approach and also make sure that other health professional associations (eg Nursing Councils) are invited/involved;

- try and involve governmental institutions such as the Ministry of Health and national human rights institutions;
- human rights lawyers and NGOs;
- medical students;
- politicians who are involved in the development of health legislation.

Possible format:

- field trip to NGO in host country;
- workshops, plenary sessions, movies, sharing and training similar to those in current meeting also beneficial.

Group 2

Suggested themes:

- Concept of the Right to Health: legal framework; linking to Millennium Development Goals;
- Tools to Monitor the Right to Health: more examples of monitoring tools and *how* exactly they are used in practice;
- How to Train Health Professionals and Medical Students.

Format:

Right to Health:

- small groups to discuss definitions;
- lectures followed immediately by question and answer sessions (no more than one lecture in a row);
- country presentations: team of participants from each country to present experiences.

Monitoring Tools:

- presentation on how to *use* tools;
- exercises in small groups on *using* tools.

Who to invite:

Countries: Thailand, Nepal, Japan, Laos, Brunei, China, Taiwan, Sri Lanka, Korea, Cambodia.

Participants: public health workers, nurses, midwives, dentists, social workers, teachers, pharmacists.

Suggestions for follow-up meeting:

Speakers should be provided with, and follow, a clear set of guidelines.

The list of invitees should be shared in advance so that prior networking can occur.

Presentations should not occur immediately after one another, there should be space for discussion in between.

Group 3

First session: report back on what has been achieved in relation to commitments made at this meeting, including the possibility of a report back from other IFHHRO regions and focal points so that the Asian region is aware of what is occurring in other regions.

Second session theme: How to Involve Health Professionals.

Third session theme: Gender and Health.

Fourth session theme: Vulnerable Groups – possibly show films on these issues as well.

Fifth session theme: The Rights of Health Professionals.

Format: Group 3 raised the possibility of having debates included in the programme, for example, regarding the involvement of health professionals and what should be the priority issues for monitoring. Also, possibility of a panel addressing the possibilities of an '*Inter-sectoral approach to the right to health*' involving media, NMAs, lawyers etc.

Participants: health professionals, human rights lawyers, medical students and 3 stakeholders from each country (ie national medical association or other health professional representative; medical students (where active) and NGO representative). Also, the possibility of including health economists and also traditional practitioners was raised.

Adoption of date, countries and title for follow-up meeting

Further countries to attend

The plenary session decided to expand the network by including the following countries in the next Asian network meeting (in brackets following the country title are the types of contacts that members of the meeting have in the countries):

- Sri Lanka (NMA contact and NGO contacts);
- Thailand (NMA contact and medical schools contacts);
- Cambodia (Roos Terhorst contact);
- Viet Nam (Sarah de Hovre contacts); and
- Nepal (CEHAT contacts).

Date

The plenary then discussed when they believed the most suitable date for the follow up meeting would be and settled on the month of *May 2007*. The meeting should be held in early May so as to come prior to the World Health Assembly in Geneva which is to be held in the third week of May 2007.

Location

The location for the next meeting was then discussed and participants settled on a choice between two locations:

- a) Davao, Philippines; and
- b) Bangladesh.

IFHHRO is to assess the cost and accessibility of each of these two locations and inform participants of which location has been selected.

Title

The meeting proposed the following title for the follow-up meeting in May: *'Building Partnerships for the Right to Health in Asia'*