Lessons Learned from Rights Based Approaches to Health Conference Proceedings

May 2006

The Institute of Human Rights at Emory University
In collaboration with:
CARE USA
The human rights offices of the Carter Center
The U.S. Centers for Disease Control and Prevention (CDC)
Doctors for Global Health
The World Health Organization (WHO)

Conference Overview

In April 2005, the Institute of Human Rights at Emory University, in collaboration with CARE USA, the Carter Center human rights office, Doctors for Global Health, the U.S. Centers for Disease Control and Prevention, and the World Health Organization sponsored the conference, *Lessons Learned from Rights Based Approaches to Health*. The primary goal of the international conference was to explore evidence-based relationships between health and human rights through the sharing of successful evidence-based models of rights based approaches to health.

Over 350 practitioners and scholars from more than 40 countries gathered in Atlanta to explore how the world can make progress toward achieving adequate standards of health as a fundamental right of all people. More than 50 panel presentations and a dozen workshops took place over the course of the three-day conference.

Featured speakers included U.S. President Jimmy Carter, Former United Nations High Commissioner for Human Rights Mary Robinson, United Nations Special Rapporteur on the right to the highest attainable standard of physical and mental health Paul Hunt, and United Nations Independent Expert on Human Rights and Extreme Poverty Arjun Sengupta, along with other leaders in the fields of health and human rights. The conference benefited middle- and senior-level program managers, students, as well as community-level practitioners, from the public, non-governmental and private sectors. The atmosphere was one of candor, resourcefulness, and reflection.

President Carter, a Nobel Peace Laureate and revered human rights supporter, provided opening remarks. "It's a basic human right to have a chance for good health care, decent health care. There is no reason for a child to die of diarrhea, of malaria, of measles." He advocated unwavering dedication to the cause. "All of us need to defend these rights, just as much as we would defend the right to freedom of speech. Health ought to be just as high a priority."

Over the course of three days, several key themes emerged from the thought-provoking proceedings:

❖ Moving the health and human rights dialogue from primarily rhetorical to principally operational;
❖ The need for adaptable and practical toolkits for practitioners; and
❖ Methods for measuring the fulfillment of the right to health.

The following text provides a summary of each presentation given at the conference.

Lessons Learned from Rights Based Approaches to Health Proceedings
Table of Contents

April 15, 2005
Concurrent Sessions on:

Concurrent Sessions on:

Concurrent Sessions on:

Concurrent Sessions on:

April 16ᵗʰ, 2005
Concurrent Skills Building Workshops on:

DAY ONE: Thursday, April 14, 2005

Session 1.1: Opening Plenary

Lullwater Ballroom
Moderator: Dabney Evans
Speakers: President Jimmy Carter, Dixie Snider, Peter Bell, Jennifer Kasper, Kerstin Leitner, Holli Semetko
Rapporteur: Megan Price

Former President Jimmy Carter opened by stating that the greatest challenge to human rights today is the growing chasm between rich people and poor people. Article twelve of the Universal Declaration of Human Rights states that everyone is entitled to an adequate standard of living for health and well being, yet how can someone have health on a dollar a day, Carter asked? Much can be done towards achieving this right, he noted, with minor increases in monetary aid by wealthy countries, and the political determination to educate and empower residents of less wealthy countries to correct their own health problems. Yet Carter questioned whether powerful countries like the Unites States care enough to do so. There is no reason why children should die from preventable diseases such as diarrhea, malaria or measles, he added. Health should be just as high a priority as basic rights to freedom of speech or to worship God as we choose.

Next, Dixie Snider (U.S. Centers for Disease Control – CDC) talked about how the CDC is working to promote health and human rights through its international work. The usefulness of the health and human rights approach, he said, has already been demonstrated through efforts to aid the victims of the recent South Asian tsunami. Indeed, interventions to address HIV, for example, are hampered in environments where human rights are not respected. The CDC recently established a health and human rights working group, Snider explained, and intends to make human rights central in their efforts to reduce the spread of disease among vulnerable populations and train leaders in public health for the future.

Peter Bell (CARE, U.S.A.) explained CARE's mission to help bring about a world of hope, tolerance, and social justice, where poverty has been overcome and everyone lives in dignity and security. As part of this mission, they are intent on pooling collective knowledge to improve the health standards and dignity of the poorest and most marginalized communities. In Bangladesh, Bell explained, CARE is working with commercial sex workers who are especially vulnerable to violence and disease. To date, they have educated sex workers about sexually transmitted diseases, worked to reduce extortion by police, pledged for government assistance, and helped them form their own self-help groups and alternative businesses.

Jennifer Kasper (Doctors for Global Health – DGH) described how DGH is working to administer liberation medicine as an instrument of radical change. Liberation medicine involves a deliberate and comprehensive use of health to promote human dignity and social justice. Health itself is a liberation, Kasper explained, and represents not just freedom from pain and illness, but freedom to create, to inhabit a space, and to live in and share the world around us. DGH does not do things 'for' people or 'to' them, she said, but endeavors to work together 'with' people to share the risk and responsibility.

Kirstin Leitner (World Health Organization – WHO) shared how the legal basis for health as a human rights is getting stronger around the world. Leitner mentioned several examples in this regard, such as the emphasis on global health in the Millennium Development Goals and the recent celebration of the 25th Anniversary of the Declaration of Alma Ata in 2003. In addition, she

explained that the notion of a rights-based approach to health is increasingly embraced by colleagues in the United Nations system and is being incorporated into country assessments and programming.

Finally, Holly Semetko (Emory University, Office of International Affairs) talked about Emory University's commitment to human rights. This can be seen, Semetko explained, in Emory's Vision Statement and its interdisciplinary programs in global health and human rights (including a new graduate certificate in human rights). Indeed, Emory has become a prime destination for those conducting cutting edge research in human rights.

Concurrent Sessions 1.2: Thursday Morning, April 14, 2005

Session 1.2.1: Theoretical Approaches to Health and Human Rights

Oak Amphitheatre
Moderator: Sofia Gruskin
Speakers: Stephanie Nixon, Katie Schenk, Daniel Tarantola
Rapporteur: Raj Panjabi

Sofia Gruskin (Associate Professor, Program on International Health and Human Rights, Francois-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health) opened this session with a discussion of how to integrate human rights into public health programming. While there is no 'common understanding' of how to do this, she offered several guidelines. First, there needs to be an analysis of the health situation of a particular population. Second, a rights-based approach requires the process of determining and shaping an intervention. Third, the intervention needs to be implemented as well as monitored. Fourth, a framework must be developed so that the success or failure of the intervention can be monitored and evaluated. According to Gruskin, the next steps toward integrating health and human rights include building evidence, responding to challenges, and furthering links.

Next, Katie Schenk (Horizons, Population Council) spoke about protecting children's rights in health and welfare data collection. She discussed her involvement with a group of experts on children with HIV that produced a publication entitled, "Ethical guidelines for gathering information from children and adolescents in international settings." Schenk emphasized two rights in particular that are central to these guidelines. The first is the right to protection. She suggested that extra precautions are needed when working with vulnerable children, such as those afflicted with HIV, because they are especially dependent on adults and may be vulnerable to perpetrators. The second is the right to participation. According to Schenk, incorporating children's views in the process of gathering information is important and will improve effectiveness. She also urged the need to engage the local community in research activities and provide services to deal with potential consequences of the research process.

Stephanie Nixon and Lisa Forman (University of Toronto) addressed how public health ethics and human rights can reinforce each other. They discussed three main issues in this regard: 1) How ethics can reinforce international human rights law, for example, by putting moral pressure on states; 2) How ethics can act as a bridge between debates over population health versus individual rights; and 3) How human rights can contribute to public health ethics by re-focusing attention on the obligations of states and highlighting the effects of human rights standards on health. This perspective, Nixon and Forman contend, can give activists new ways of framing demands, researchers new areas of inquiry, and policy makers new ways of tackling health and disease.

Finally, Daniel Tarantola (MD, New South Global Professor in Health and Human Rights, University of New South Wales, Sydney, Australia) addressed the issue of surveillance and human

rights. For Tarantola, surveillance is the guardian of public health. A rights-based approach to surveillance, he explained, must encourage non-discrimination, empowerment, participation, and accountability, but also has various linkages to human rights themselves. For example, rights to 'equality' and 'participation' must be taken into account in all major phases of surveillance – case definition, data collection, data analysis, dissemination and use of results. On the other hand, rights 'to benefit from scientific progress' and 'freedom of movement' are relevant only to the dissemination and use of results. While the right to health is integral to both the data analysis phase and the dissemination phase.

Session 1.2.2: Breastfeeding (Nutrition)

Dodwood Room
Moderator: George Kent
Speakers: George Kent, Elaine Petitat-Cote, Ruzan Gyurjyan
Rapporteur: Shelby Grossman

George Kent (Professor of Political Science, University of Hawai'i) began this session by addressing the human right to adequate food and its relation to infants and mothers. The human right to adequate food is well established in international human rights law but must be articulated in greater detail in national law, Kent argued. An effective national rights system, he said, should include clear specifications of individual rights and government obligations, as well as response and accountability mechanisms. International human rights law says virtually nothing about infants, Kent reported, but such legislation could begin with the following basic principles: 1) Infants have a right to be free from hunger, and to enjoy the highest attainable standard of health; 2) Infants have a right to adequate food, health services, and care; 3) The state and others are obligated to respect, protect, and facilitate the nurturing relationship between mother and child; 4) Women have the right to social, economic, health, and other conditions that are favorable for breastfeeding; 5) Women and infants have a right to protection from factors that can hinder or constrain breastfeeding; 6) states have an obligation to protect, maintain, and promote breastfeeding through public educational activities; 7) no woman should be prevented from breastfeeding.
    Elaine Petitat-Cote (Geneva Infant Feeding Association) spoke about how a non-governmental organization, such as the International Baby Food Action Network (IBFAN), can participate in the accountability process with a large human rights body, such as the Committee on the Rights of the Child (CRC), to improve the health of infants and children. The CRC and other human rights bodies, Petitat-Cote explains, have a review mechanism that allows non-governmental organizations (NGOs) the opportunity to participate in monitoring and implementation. In general, the CRC's review process involves 18 experts who convene three times a year to review state reports, prepare concerns and recommendations for states, and meet with NGOs. Three months prior to their sessions with participating states, NGOs can meet with the CRC in a 'pre-session' where additional reports can be presented on specialized topics (e.g., breastfeeding). Entities such as IBFAN and the Geneva Infant Feeding Association have also joined NGO coalitions and issued follow-up recommendations to pressure states into compliance.
    Finally, Ruzan Gyurjyan (MD, MPH) discussed the need for an initiative on baby friendly polyclinics in low resource countries, such as Armenia. Polyclinics can be an effective investment, according to Gyurjyan, by providing education, training, and support services as well as health services. The objectives of a baby friendly polyclinic include: 1) to give care takers the opportunity to make informed choices regarding infant feeding and nutrition; 2) to improve the knowledge and skills of health providers regarding infant feeding and nutrition; 3) to allow holistic approaches to

child health; and 4) to support implementation of the International Code of Marketing of Breast Milk Substitutes. In the small city of Yerevan, for example, Polyclinic #19 has been particularly successful by providing mother support groups, regular training for care takers, and open sessions for breastfeeding advocates.

Session 1.2.3: Client Rights in Sexual and Reproductive Health

Salon III
Moderator: Therese McGinn
Speakers: Socheat Chi, S.M. Muhsin Siddiquey
Rapporteur: Sarah Roberts

Therese McGinn (Deputy Director, AMDD Program, Columbia University) opened this session with concerns about how to measure progress and ensure that overall improvements will be made using a rights-based approach to health. To this end, McGinn argued that practitioners need to define terms more precisely and improve measurement techniques. In the case of client rights, even though there is clear agreement that discrimination and inequities need to be eliminated, she said, different definitions regarding other rights also exist. There also needs to be a commonly accepted way to define the duties and obligations of societies. Regarding measurement, McGinn believes that indicators need to be developed to measure whether or not progress is being made and whether or not things need to be done differently. Similarly to the 'quality of care' movement, human rights is a guiding framework but not a precise, absolute model of action. Ultimately, she argued, human rights needs to be turned into something more concrete so that practitioners can be confident that their programs will enhance humanity's well being in the future.

Next, Socheat Chi (CARE, Cambodia) discussed his involvement in the Sewing a Healthy Future (SHF) program which started in 1998 and works to improve the sexual and reproductive health of garment workers in Cambodia. The garment sector here, Chi explained, currently has the highest adult HIV/AIDS rate in South East Asia. It also employs a predominantly female population that moves away from home and often engages in risk-taking behavior. Among their achievements, the SHF program has trained and mobilized over 3000 peer educators and 60 health staff, developed health promotion services, and helped implement an HIV/AIDS workplace policy. In addition, many of the female employees have become peer educators and are active in the dissemination of sexual and reproductive health messages. The next phase of the SHF project hopes to support and implement an HIV workplace policy in all 25 garment factories in Phnom Penh, support local non-governmental partners to 'market' health programs, assist and encourage factories to take over responsibilities of workers' health, and train and assist the Ministry of Social Affairs on the SHF project model.

Finally, S.M. Muhsin Siddiquey (CARE, Bangladesh) discussed her involvement in a 'safe motherhood' project in Bangladesh. This project was started by CARE in 1998 in collaboration with the government of Bangladesh, UNICEF, and local non-governmental organizations. The goal of the project was to reduce maternal mortality through identifying and removing barriers between women and emergency care facilities. Their main interventions included the promotion of birth planning, establishing a community support system, and improving quality of care. Ultimately, this project helped lead to a dramatic drop in maternal deaths and an increase in female utilization of emergency care. While the project concluded in 2001, its success has led to applications in other areas of the country. For example, the country's Food Security Program now uses lessons learned from CARE's safe motherhood program.

Session 1.2.4: Theorizing Measurement

Salon IV
Moderator: Paula Braveman
Speakers: Mariana Chilton, Leslie London, Lexi Bambas, Abhay Shukla
Rapporteur: Whitney Fry

Mariana Chilton (PhD, MPH, Drexel University School of Public Health) opened with a presentation on measuring violations of dignity for policy relevant research. According to Chilton, human dignity is the foundation that holds all rights together and unifies civil and political with social, economic, and cultural rights. In addition, violations of dignity have potentially severe and negative effects on physical and mental health and are related to various health issues such as depression, malnutrition, HIV/AIDS, and post traumatic stress disorder. Therefore, understanding dignity violations, and creating a measure for them, is the first step in ensuring rights, she argued. If dignity violations were measurable, then policy makers could be held more accountable to the health of populations.

Next, Leslie London (University of Cape Town) discussed how human rights can be used as a tool for achieving health equity. This is an important question, London stated, because global health inequalities are increasing, globalization is increasingly disempowering the nation-state, and developing countries are experiencing increasing resource constraints to deal with health problems. Based on her research in Africa, she concluded that equity is best promoted by human rights approaches that: 1) emphasize a full spectrum of rights, including economic, social, and cultural rights as well as civil and political; 2) link community demands to national and international levels; 3) emphasize groups as well as individuals, specifically vulnerable groups; 4) confer agency on those most affected by health problems; and 5) build alliances between vulnerable and non-vulnerable groups.

Lexi Bambas (PhD, MPH, Health Metrics Network Working Group on Equity) talked about efforts to integrate equity into health information systems. Basic information on inequalities in health, he said, is a human right, not merely a strategy for health policy-making. According to Bambas, the ability to conduct large-scale equity analyses requires data on both health and social position. Core health indicators should cover information on health status, health care, determinants of health, and the social and economic consequences of ill health. While, core social position indicators should cover socio-economic position, sex or gender, ethnic or racial groups, and geographical area. Such efforts require a major international initiative, Bambas noted, that prioritizes the development of information systems (e.g., censuses, vital registries, and household surveys) in the poorest countries and defines a plan for cooperative development with the ability to link records.

Finally, Dr. Abhay Shukla (Senior Programme Coordinator, SATHI-CEHAT) discussed public use of information to promote health rights and efforts to document human rights violations. Specifically, Shukla talked about six tribunals that were organized in India to document the 'structural denial' of various abuses related to health. These tribunals were followed by regional public hearing and then selected cases were presented to the National Human Rights Commission. Ultimately, she argued, 'structural denial' must be documented to prevent violations from being portrayed as merely 'individual instances'. This can be done if human rights are linked with community involvement.

Session 1.2.5: Incorporating Human Rights Principles in HIV/AIDS Health Programming

Salon V
Moderator: Andrew Jones
Speakers: Aliou Ayaba, Syed Asif Altaf Chowdhury, David Patterson, Aziza Ahmed, Paul Spiegel
Rapporteur: Megan Gaydos

Aliou Ayaba (MD, MPH, Health Sector Coordinator, CARE) and Andrew Jones (JD, Assistant Country Director, CARE Rwanda) opened this session by discussing how CARE is trying to incorporate rights-based programming into the President's Emergency Plan for AIDS Relief (PEPFAR) in Rwanda. Their objectives include: 1) to ensure equitable access to HIV/AIDS prevention and support services ; 2) to empower and strengthen the capacity of people affected by HIV/AIDS; 3) to reinforce and promote community involvement; and 4) to strengthen the capacity of local government and civil society to advocate for and provide quality services. Their achievements to date include stronger participation of authorities, community bodies, and people living with HIV/AIDS in program implementation as well as stigma and discrimination reduction.

Next, Dr. Syed Asif Altaf Chowdhury (CARE, Bangladesh) shared his experience in a program to help achieve 'the right to health care' for transport workers in Bangladesh with the help of unions. Here unions are encouraged to share the responsibilities of the program's main components, such as community outreach activities, support services through a Drop In Center, clinical services, and social marketing of condoms. While HIV prevalence remains low among transport workers, Chowdhury hopes to continue to attract donors to continue the program in new areas, build the capacity of the union in program management, and involve different department of the Bangladesh government.

David Patterson (LL.M., M.Sc., Dip. RSA) discussed his involvement in the Canadian HIV/AIDS Legal Network, which was founded in Montreal in 1992 and works to hold governments and decision makers accountable to ethical and legal health standards. Their current project has developed a rights-based programming tool on HIV/AIDS for development agency staff. This tool includes principles of rights-based approaches, checklists for reviewing proposals and programs, and good practice examples. In the future, they hope to identify funding and hold training workshops, revise the programming tool based on workshop feedback, and circulate it to the wider community in Canada.

Aziza Ahmed (UNIFEM) talked about her research on integrating gender into regional HIV/AIDS initiatives, particularly in the Caribbean. Some of the challenges of incorporating a gender perspective, she reported, are a lack of capacity in terms of appropriate resources and training, a disconnect between theorists and practitioners, and lack of region-specific tools. While an overall goal of this effort is for women to be recognized and included, Ahmed recommends several 'first steps' for institutions: 1) begin an internal gender review; 2) define a methodology; 3) begin a process of capacity building; 4) ensure that gender tools are distributed; 5) encourage partner organizations to be more inclusive of gender; 6) identify staff that would like to undergo further training around gender.

Finally, Dr. Paul Spiegel (UNHCR) shared lessons learned from the UNHCR's HIV/AIDS policies over the years. These lessons include the following: 1) inclusion and integration into country policies and interventions; 2) integrating HIV and protection, such that asylum, refoulement, and return is not based on HIV status; 3) provision of antiretroviral treatment; and 4) a sub-regional approach that ensures continuity of care and improves efficiency and costs. He recognized the need for future sub-regional initiatives, as well as additional funds for refugees to be included into host country HIV programs, integration of programs in surrounding regions, HIV

training with strong human rights component, and improved data collection to enhance policy.

Session 1.2.6: Roundtable on Sexual and Reproductive Health I

Silverbell Pavilion
Moderator: Roundtable
Speakers: Anne Eckman, Mehlika Hoodbhoy, Deborah Billings, Rebecca Schleifer
Rapporteur: Jennifer Scharff

Anne Eckman (Director, HIV Advocacy, POLICY Project/Futures) began this roundtable with a discussion of Sikanyekanye (we are together), a project to improve the reproductive health rights of Swazi women by focusing on personal choice, removing family planning barriers, and improving health services as well as access to them. According to Eckman, Swaziland has the highest rates of HIV in the world. Thus far, the has included a research assessment of existing policies and activities, information dissemination and instruction, and advocacy through the media. There have been numerous successes of the project to date, including opened dialogue on the subject, information that is now available to men as well as women, and increased leadership roles for women at the community level.

Next, Mehlika Hoodbhoy (Crowley Fellow in International Human Rights Law, Fordham Law School) talked about U.S. restrictions on foreign healthcare funding and their effects in Kenya. Hoodbhoy described the global gag rule, which refers to the fact that no program related to abortion will be funded with U.S. government monies. While there is great need for family planning services in Kenya, U.S. restrictions on funding have had negative effects. For example, both the Family Planning Association of Kenya and Marie Stokes International, both of whom run family planning clinics, turned down U.S. government money and, as a result, five clinics have closed. Interviews by Hoodboy have shown that women were generally satisfied with the quality of care in the old clinics and were dissatisfied with new options required by the conditions of U.S. funding.

Deborah Billings (Ph.D., Senior Associate, Research and Evaluation, Ipas/Ipas Mexico) discussed the work of Ipas Mexico, which includes training health care providers and students in comprehensive abortion care. According to Billings, one unsafe abortion occurs every 1.7 seconds around the world. In Mexico, complications from abortion are the third leading cause of maternal mortality. Death and morbidity from unsafe abortion, she argued, is a preventable human rights violation. Ultimately, Ipas hopes to enhance the accessibility, availability and quality of abortion care services to women who need it. From 2000 to 2005, the number of institutions offering safe and legal abortion services in Hidalgo, Mexico City, and the State of Mexico has increased from two to ten. Furthermore, medical and nursing schools throughout the country have begun to incorporate Ipas materials on abortion care and human rights.

Finally, Rebecca Schleifer (Researcher, HIV/AIDS and Human Rights Program, Human Rights Watch) talked about religion, politics, and the human right to health. She advocated the need for strategies to change policies which threaten such rights. For example, the United States restricts money to any organization that supports abortion or prostitution in any way, regardless of circumstance. Such restrictions can have negative effects on the health of women around the world, she stated. Furthermore, the U.S. government has an obligation to provide complete information about HIV/AIDS and prevention methods, but spends an overwhelming amount of money on 'abstinence only' policies. The U.S. government spends over $170 million on domestic 'abstinence only' programs, she reported, even though numerous studies have questioned the effectiveness of these programs. Signees of 'virginity pledges', for example, are more likely to engage in unprotected and risky sexual practices.

Session 1.3: Keynote Address

Lullwater Ballroom
Moderator: Dabney Evans
Speakers: Mary Robinson
Rapporteurs: Jie Liu, Emily R. Hencken

Former United Nations High Commissioner for Human Rights, Mary Robinson, discussed three lessons on rights based approaches to health that, she believed, have yet to be fully realized. The first lesson concerned the need for an 'advocacy frame' for work on health and human rights, which should be extended to every level of action – regional, state, international, as well as corporate – and reinforce the value of international human rights mechanisms. Robinson also advocated the need for reform in the United Nations that stresses respect for human rights and strengthens the role of the international community in proclaiming and protecting such rights. The second lesson concerned the difficulties of globalization. Here she echoed Former President Carter's concern for the growing gap between rich and poor. The main challenge of alleviating inequalities, Robinson argued, is one of implementation. If adequate health is everyone's right, we should ensure that everyone has access to it. A human rights approach can also mitigate the effects of globalization, she added, by increasing accountability, information, and protection. The third lesson concerned sharing responsibility to address human rights concerns. Like the recent outpouring of tsunami relief, Robinson urged the need to create a similar sense of responsibility and engagement where everyone contributes in a personal way, with talent, skill, and money. We must all share the responsibility and hold governments accountable to their commitments to human rights conventions.

Concurrent Sessions 1.4: Thursday Afternoon, April 14, 2005

Session 1.4.1: Maternal Health

Oak Amphitheatre
Moderator: Marianne Haslegrave
Speakers: Elena Esquiche, Luis Vega, Aparajita Gogoi, Adriane Hilber, Mindy Roseman
Rapporteur: Megan Gaydos

Moderator Marianne Haslegrave (Director, COMMAT) opened this session with a discussion of how to integrate reproductive health into the Millennium Development Goals (MDGs) for the eradication of poverty. Right now there are no goals relating to sexual and reproductive heath, she reported. While the Secretary General's report did include some recommendations on gender equality, which are essential for achieving the MGSs, more is needed. She suggested the introduction of some 'quick wins' (attainable goals within 3 years) that could bring vital gains in well-being to millions of people and start countries on a path to achieving the Goals. However, some of these would be related to reproductive health issues that are not included in the MDGs. Ultimately, the recommended 'Sexual and Reproductive Health Target' is to give universal access to reproductive health services by 2015 through the primary health care system, ensuring the same rate of progress or faster among poorer and other marginalized groups.

Next, Elena Esquiche Leon (MHP, Peruvian FEMME Project Coordinator) and Luis Vega (CARE) spoke about the promotion of a rights-based approach for safe motherhood in Ayacuchi,

Peru. Elena spoke about her work to improve the availability of emergency obstetric services in the northern region of Ayacucho. Implementation has been challenging, since women are frequently excluded from participating. However, her program has succeeded and is advocating human rights by promoting social responsibility. Ultimately, big funding sources and sophisticated technologies are not needed to promote a human rights strategy because large organizations and government authorities have an interest in reducing maternal mortality. Therefore, increased awareness about maternal mortality needs to be re-enforced. Also, participation by the government would help secure their interventions and advocacy efforts.

Aparajita Gogo (National Coordinator, WRAI; Senior Advocacy Advisor, CEDPA) talked about how to protect and improve motherhood through human rights. In India, for example, 100,000 deaths per year are related to maternal mortality. The White Ribbon Alliance for Safe Motherhood India (WRAI) was launched in November 1999 in response to this problem. WRAI works on several levels: 1) birth preparedness and complication readiness; 2) advocating for policy changes; and 3) awareness generation among families. WRAI launched a media campaign including print advertisements, talk show appearances, rallies, and exhibits to protect safe motherhood as a human right. The work of WRAI and its campaign have helped to raise the profile 'safe motherhood' issues, enable nurses and midwives to practice emergency obstetric care, and increase the awareness of the general public.

Finally, Adrianne Hilber (WHO Dept. of Reproductive Health and Research) and Mindy Roseman (HSPH, FXB Center) talked about promoting human rights regarding maternal and neonatal health as a strategy for strengthening laws, policies, and standards of care. Their objectives are: review and address legal and policy barriers to maternal and newborn health; engage participants in the health and non-health sectors to eliminate barriers to maternal and newborn health; review and document government efforts to respect, protect, and fulfil human rights related to maternal and newborn health. This process has 3 phases: 1) establish commitment & leadership; 2) adapt, compile data, and analyze data; and 3) prioritize action. Their first efforts took place in Mozambique, which are in the process of completion and will focus next on Brazil and Indonesia.

Session 1.4.2: Taking Opportunities for Education at the Country Level for Capacity Building

Dogwood Room
Moderator: Judith Bueno de Mesquita
Speaker: Joviana Stephan AbdelNour, Beth E Rivin, Joyce P Murray
Rapporteur: Katie Wootten

Joviana Stephan AbdelNour (Administrative Director, ASHTAR for Theatre Productions & Training) began this session by speaking about her involvement in ASHTAR, a non-profit organization founded in Jerusalem in 1991 that addresses theater development and training Specifically, she spoke about the Forum Theatre, which is a technique to address issues in the local community and simulate cultural awareness. The theatre is highly interactive and its goal is to promote human rights and equity, and to encourage self-help and effective participation in the areas of 'family' and 'civil society' in Palestine. Some of the topics covered in the theater are: sexual harassment, mental disabilities, honor crimes, violence in schools, and violence against women. So far, the Forum has been successful and is responding to community needs. ASHTAR is the only group in the Middle East that is professionally using such a technique. According to AbdelNour, ASHTAR is also becoming the center of the 'theater of oppressed' in the Middle East.

Next, Beth Rivin (MD, MPH, Research Associate Professor, University of Washington, Uplift

International) talked about the health and human rights project in Indonesia (HHR), which is a professional education and civil society capacity-building project. The HHR is working to put theory into practice in the field through collaborative projects between U.S. and Indonesian professional schools and NGOs. Their program approach involves professional education in health and law, while the capacity building intervention is focused on civil society, particularly professional communities. Their goal is to improve health and human rights by empowering health and legal professionals to improve practice standards while strengthening their professional societies to become engineers of social change and instruments to further civil society. Working with this set of integrated issues as well as civil society, she believes that professional organizations and the legal and medical communities can be engineers of social change in Indonesia.

Finally, Joyce P Murray (EdD, RN, FAAN, Professor of Nursing, Emory University) spoke about her involvement as Director of the Ethiopian Public Health Training Initiative (EPHTI). Health, she argued, should be one of the fundamental rights of every human being. However, by the early 1990s, the health care system in Ethiopia had deteriorated. Less than 50% of the population, at the time, had access to health care.   Furthermore, the government of Ethiopia decided to build 500 Primary Health Centers in rural areas, but did not have enough adequately prepared health professionals to staff the centers. This crisis led to the creation of the Ethiopian public health training initiative. The ultimate goal of EPHTI is to provide access to, and improve the health status of, all Ethiopians. More specifically, EPHTI is there to develop health learning materials, such as modules and manuals, to be used by students and faculty in universities and by staff in primary health centers, to strengthen the knowledge and skills of teaching faculty, and to improve their learning environments.

Session 1.4.3: Human Rights and Practices of Transnational Corporations

Salon III
Moderator: Stephen Marks
Speakers: Julia Kilbourne, Socheat Chi
Rapporteur: Jill Ford

Stephen Marks (François-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health) opened the discussion by talking about human rights norms that apply to transnational corporations (TNCs). According to Marks, TNCs and globalization threaten human rights because, in a TNC, the shareholders interest is based on his/her return on investment, not on human welfare. Furthermore, globalization creates harmful effects through environmental degradation, by a race to the bottom on labor rights, and by challenges to cultural identity. Finally, there are no human rights treaties that apply to TNCs. There are people that are trying to bridge the gap between investment and human rights by creating corporate codes of conduct, he explained, and through the U.N. Global Compact. In addition, there are strategies for improving respect for human rights by TNCs, such as: assisting governments in meeting their human rights obligations; monitor the U.N. Global Compact; promote voluntary guidelines; draft proxy resolutions by shareholders; and promote norms on the responsibilities of transnational corporations and other business enterprises with regard to human rights.

Julia Kilbourna (London School of Hygiene and Tropical Medicine) talked about 'ethical sourcing' within global supply chains. Ethical sourcing, according to Kilbourna, is a commitment by businesses to behave ethically and contribute to economic development by maintaining and improving the quality of life for their workforce and the larger community. There are a lot of organizations that are beginning to a adopt right-based approach to sourcing, she explained, by

adopting standards from the Universal Declaration of Human Rights. In fact, before rights-based frameworks were adopted from International Labor Organization conventions, there were other guidelines coming from industries themselves. A lot of businesses have had to adhere to local laws that promote decent working conditions. However, not all countries have decent laws. For Kilbourna, a rights-based approach to ethical sourcing needs to regulate relations not only within the business sector, but also between citizens and states in a globalizing world.

Finally, Socheat Chi (Reproductive Health Program Coordinator, CARE Cambodia) talked about working for the rights of 'beer promotion women'.   The 'Selling Beer Safely' (SBS) project was initiated in Cambodia in July 2003. It is a partnership between CARE Cambodia, Heineken International, Asia Pacific Breweries Ltd, and Cambodia Brewery Ltd. In Cambodia, Chi explains, beer promotion is looked down upon and women do not get the kind of benefits that regular employees get. Such women are constantly exposed to sexual advances and harassment, are only paid by commission, and receive very little protection by the police. The objectives of the SBS project are: to increase knowledge and awareness of women's health issues through 'life skills' education; to increase the availability of, and access to, quality women's health services; and to support the development of workplace guidelines and policies which promote a supportive environment for the promotion of women. According to Chi, there also needs to be more actions from companies, such as emergency care at work, mediation by the government, and a national media campaign to raise awareness.

Session 1.4.4: Sexual and Gender Minorities

Salon IV
Moderator: Paula Ettelbrick
Speakers: Lea Dooley, Monica Helms, Gregory Nevins
Rapporteur: Elizabeth Hamilton

Lea Dooley (HIV/AIDS Program Advisor, CARE Cambodia) and Sok Pun (HIV/AIDS Program Coordinator, CARE Cambodia) presented their research about the lives of men having sex with men (MSM) in two border towns in Cambodia, Koh Kong and Poipet. Some of their results show that such men are mostly between the ages of 22-40 and they have 6 years of education on average (none had more than 10 years). The majority of the subject population had a high awareness of HIV/AIDS and most recognized condoms as a means of preventing HIV/AIDS transmission, yet actual condom use was inconsistent. Also, an overwhelming proportion of the MSM interviewed recounted stories of abuse, including from police. Overall, MSM in border communities are highly mobile and are at risk of discrimination, violence, rape and HIV/AIDS. They contend that the development of MSM-focused programs is crucial for providing outreach, support groups, and condom/lubricant promotion to address vulnerability to HIV/AIDS. It is also important for generating awareness and avoiding stereotypes. Interventions should promote tolerance within the MSM population and the wider community.

Monica Helms (Executive Director, Trans=Action; President, Transgender American Veterans Association (TAVA)) then talked about how hate and discrimination affect the health of transgendered people. Violence is very prominent in this group – 20-30 individuals die each year. Such cases are also severely underreported and many medical professionals do not have the right training to treat these patients. They often ask inappropriate questions that lead to misdiagnosis and death. While some are denied any treatment at all. Transgendered people also face discrimination at the workplace, where many are fired or refused employment and do not have health insurance. Those that do have insurance are denied coverage for trans-associated (except AETNA). Insurance

companies feel such coverage is an extra cost, but Trans Activists at Work have estimated that the cost increase would be 10 cents per worker per year. Often, transgendered people sell sex for survival which leads to HIV, violence, and homelessness. There is also a lack of outreach services, such as women's shelters.

Finally, Gregory Nevins (Senior Staff Attorney, Lambda Legal) talked about the healthcare barriers and issues in the LGBT community. 35 U.S. states do not have laws forbidding sexual orientation discrimination in public accommodations, Nevins stated. Lesbians face legal barriers to fertility treatments. Many have been refused treatment by doctors citing moral objections and others have been denied insurance coverage for fertility treatments for failure to attempt pregnancy by intercourse. Many members of the LGBT and HIV+ communities are reluctant to 'come out' to their current or potential employers because of concerns about job security. They feel the same about their attendant health insurance coverage. Consistent access to medications is an acute problem for HIV+ and transgender inmates. Unfortunately, sporadic and haphazard administration of medications can result in the development of resistance to drugs that treat HIV. Barriers to consistent care are also a large problem for HIV+ patients dependent on government-funded access to medications (in programs such as ADAP) that are currently targeted for cutbacks in some jurisdictions.

Session 1.4.5: Youth Sexual and Reproductive Health Rights

Salon V
Moderator: Nicole Haberland
Speakers: Erica Chong, Marleen Bosmans, Brian Willis
Rapporteur: Norma Patricia Rivera Scott

Nicole Haberland (Population Council) began with a discussion of how to turn a rights framework on youth sexual and reproductive health into a mainstream, sexuality education. Studies from diverse settings such as China, Peru, the United States, and Uganda, she reported, have shown that traditional gender roles are independently associated with low rates of condom and contraceptive use, multiple sexual partners, more frequent intercourse, and early sexual initiation, which often lead to contracting sexually transmitted diseases and unintended pregnancies. Sexuality education has not done much to prevent this situation because of gaps in both access to, and the content of, the education. If we are to adequately consider the profound effects of gender on sexual and reproductive health, she contended, sexuality education must be fundamentally changed. According to Haberland, it may be more politically acceptable, perhaps even more effective, to start with a rights-based approach. Then, some of these fundamental rights can be used as a framework for critical thinking about gender. Such an approach, starting in primary school, may also have long term benefits in other areas of women's lives such as education, citizenship, and empowerment.

Erica Chong (Population Council) put forth a call for action on child marriage and human rights. Following the Convention on the Rights of the Child, which views the age of 18 as the outer boundary of 'childhood', child marriage is typically defined as marriage before 18, and there is an emerging international consensus that this practice should be banned. Although the average age for marriage is rising in nearly all parts of the world, she reported, child marriage remains widespread and is almost exclusively a phenomenon of girls. However, laws are only as strong as their enforcement. The minimum age of marriage should be 18, Chong contended, and children should be entitled to special protections to ensure the "free and full consent" of intending parties.

Marleen Bosman (International Centre for Reproductive Health, Ghent University) spoke about her research on adolescent sexual and reproductive health (ASRH) in the Democratic

Republic of the Congo. Her objectives were to assess how a rigths-based approach can contribute to an effective and appropriate response to sexual and reproductive health in war-affected areas. Her results showed that, while adolescent sexuality is a big taboo, adolescents often have multiple partners with little information about how to protect themselves. There needs to be a strong emphasis on HIV/AIDS prevention and the sexual and reproductive health needs of particularly vulnerable groups (e.g., girls and boys living on the streets), according to Bosman. In addition, it essential to integrate ASRH programming as a priority in humanitarian programs and to improve the prevention and protection of adolescents against all forms of sexual violence.

Finally, Brian Willis (Health Advisor, ECPAT-USA) testified that commercial sexual exploitation of children is both a global health and human rights issue. While there is no definitive data on the subject, it is estimated that approximately 2 million children per year are forced into commercial sexual exploitation, while 1 million are exploited through prostitution. According to Willis, some of the causes of this phenomena are poverty, child abuse, war, lack of political will or laws are not being enforced. Another cause is prostitution, which is very profitable for criminals and is accepted in many cultures. One of the biggest problems regarding prevention, he contended, is that sufficient data does not exist to properly acknowledge the existence of this problem. To change this we need real data and better funding, Willis believes, so that appropriate interventions and monitoring mechanisms can be developed, and to encourage more participation by governments.

Session 1.4.6: Roundtable on Theoretical Approaches to Health and Human Rights

Silverbell Pavillion
Moderator: Roundtable
Speakers: Claudio Schuftan, Eileen O'Keefe
Rapporteur: Julia C. Dawson

According to Claudio Schuftan (Adjunct Professor, Freelance Consultant, Tulane University School of Public Health), human rights theory is already well-developed, but its application on the ground has yet to be fully realized. In 1998, Kofi Annan declared that every agency in the U.N. must adopt a rights-based approach.   And, since late 1990s, there have been efforts to adopt a human rights approach towards development. However, there is a need, he said, to cross-pollinate best practices and other "field" experiences. The first challenge in applying human rights theory is to identify capacity gaps; practitioners need to find out what the duty bearers are claiming and not claiming. Ultimately, Shuftan contend that the strength of the human rights approach is that it draws attention to problems and promotes their resolution, rather than directly confronting duty bearers.

Eileen O'Keefe (Senior Lecturer Philosophy and Health Policy, Human Rights & Social Justice Research Institute) talked about her ethnographic work with migrant African workers living in the UK. Her research began by addressing physiological issues surrounding HIV, but switched to interpersonal and cultural habits that affect the health of HIV positive patients and their families. One of the questions she addressed is why an HIV positive mother does not explain to her child that she is infected, or the root cause of her illness. This would appear to violate the right of the child to very important and personal information. As O'Keefe related, 'the poor' view human rights as a foreign creation that belongs to the users of that language. They describe human rights principles as another device for outside personal agendas. Therefore, according to O'Keefe, if practitioners refuse to see themselves as duty-bearers, they will not have an entry way into achieving equality. Furthermore, the language that will help turn theory into action is the language of indicators. Practitioners need to take notions of human rights and create indicators that measure the

outcome one is interested in.

Concurrent Sessions 1.5: Thursday Afternoon, April 14, 2005

Session 1.5.1: Theoretical Constructs in Children's Health

Oak Amphitheatre
Moderator: Alan Hinman
Speakers: Vandana Tripathi, Mehlika Hoodbhoy, Isabel Lima, Pascal Villeneuve
Rapporteur: Katie Wootten

Vandana Tripathi and Mehlika Hoodbhoy (Doctors of the World, USA) opened this session by sharing their lessons learned from children's health projects of Doctors of the World (DOW). As they described, DOW was founded in 1990 and provides care and services while training local partners to create sustainable solutions to health problems created or worsened by violations of human rights and civil liberties. DOW work in four focus areas: children's health, tuberculosis and HIV/AIDS, women's health, and survivors of gross human rights abuses. Overall, their recommendations involve 3 steps: 1) assessment to address specific questions for project planning and implementation; 2) consideration of local factors such as the possibility of a rights threshold and the presence of a local civil society; 3) how to attend to various health populations (both large and small), since public health typically works with larger groups rather than smaller ones (e.g., children with disabilities).

Isabel Lima (Professor, Catholic University) talked her work regarding a child's right to health in Brazil. Although children's health rights are incorporated in recent Brazilian legislation, she explained, its implementation largely depends on conceptions held by 'legal protection agents'. Her recent investigations seek to analyze the conceptions of these legal protection agents. One of the most dangerous conceptions, Lima stated, restricts the concept of a child's right to health to healthcare, which negates all the gains made in the direction of total protection in the Convention on the Rights of the Child as well as Brazilian legislation.

Kopano Mukelabai and Akila Belembaogo (UNICEF, New York) ended this session by talking about how to enhance health programs for children by using a human rights-based approach. A child's right to life, they believe, is not enough. To survive, children must have proper development as well. Unfortunately, health policies and programs can promote or violate human rights in the way they are designed or implemented. 11 million children die each year from preventable causes. 54 % of these deaths are caused by malnutrition, while 90% of these deaths occur in sub-Saharan Africa and Asia. The Millennium Development Goals have several objectives to address the problem of children's health such as eradicating extreme poverty and hunger, achieving universal primary education, and promoting gender equality and empowerment of women. If these goals were implemented tomorrow, Mukelabai and Belembaogo stated, they can reduce mortality rates by 60%. While it is very necessary to implement affordable and cost effective interventions to reduce child mortality, the impact of ill health can be reduced by taking steps to respect, protect, and fulfil human rights.

Session 1.5.2: Law and Policy for Health and Human Rights

Dogwood Room
Moderator: Ashley Barr

Speakers: Antonio Filho, Pamela Pine, Lesley Jacobs
Rapporteur: Ali Khawar

Antonio Filho (Ph.D. Student, Fundacao Getulio Vargas) opened this session with a discussion of how collateral damages in the legal battle for health rights can be avoided. His research in seeks to understand recent conflicts among public health professionals and the courts in Brazil. The Brazilian constitution states that health is a right of everyone and that health assistance will be universal and integral. However, while the health care system in Brazil is universal, 20% of the population buys extra health insurance. Much of the problem, according to Filho, lies with that fact that legal terms are not adequately defined and there is little specification of legal authority to decide what is needed. Consequently, collateral damages occur because legal health acts are not adequately specified and result in misallocation of health resources and rights. Filho concludes that law makers should focus on the 'epidemiologic' aspects of legal health acts such as (mis)allocation of resources and the (mis)allocation of rights, as well as improve communication channels between law-makers and health professionals.

Pamela Pine (Founder, Stop the Silence, Inc.; Health Communications Director, Futures Group) discussed recent efforts to develop a 'children's bench book' (CBB) on child sexual abuse. The CBB is part of an overall prevention and treatment framework developed by Stop the Silence, Inc. in collaboration with Futures Group and service- and community-based organizations. The two primary goals of the CBB are to raise awareness about child sexual abuse as a social issue, and to generate funding for such programs. The CBB is designed as an educational instrument, not a human rights instrument, in order to improve efficacy. This group is also trying to reach out to a broad audience of service providers so that they know how to be sensitive to children who have been sexually abused.

Finally, Lesley Jacobs (Law & Society Program, York University, Toronto, Canada) discussed the practice of human rights during the SARS crisis. Her study focused on legal reactions in three major cities at the center of the SARS crisis – Hong Kong, Shanghai, and Toronto. The reaction of the three cities were very different, according to Jacobs. Shanghai was the least intrusive, where very few people were quarantined. People who came back from hard hit areas were told to stay at home for a few days. Hong Kong, on the other hand, was very sensitive to civil and political rights concerns. Here, the senior public health officials consulted regularly with human rights organizations. Finally, Toronto saw the most quarantines and the greatest exercise of legislative power. Indeed, Toronto ended up putting a whole town outside of Toronto in quarantine. Jacobs concluded that Shanghai and Hong Kong got rid of arguably a much bigger problem with much less restrictions on freedom of speech or assembly, while Toronto reacted as if the 'rights revolution' never happened.

Session 1.5.3: Access to Affordable Drugs and Intellectual Property

Salon III
Moderator: Maureen McCue
Speakers: Hans Hogerzeil
Rapporteur: Norma Patricia Rivera

Dr. Han Hogerzeil (World Health Organization – WHO) was the sole speaker for this session and discussed essential medicines as a part of the right to health. Conceptions of the rights to health have made the transition, he explained, from emphasizing basic needs and obligations (e.g., in the WHO constitution, Covenant on Economic, Social, and Cultural Rights) to emphasizing violations

of those needs and obligations (e.g., failure to adopt national health policies, misallocation of resources, failure to monitor and reduce inequities). While the 'right to health' is a progressive realization, there are two immediate obligations that must be addressed, according to Hogerzeil. First, efforts to ensure health rights must be equally available to everyone. This should be the primary responsibility of governments, not the WHO. A good essential drug program, for example, implies a rights-based approach and is an essential step forward. The state can be held accountable to human rights treaties by exerting pressure in various ways, such as shadow reports and the standardization of reporting techniques. Second, there needs to be increased support for individuals and non-governmental organizations to make claims on human rights. Litigation has been one option, but hard information regarding state ratifications of international treaties or lists of essential medicines would be easy and reliable means hold governments accountable. Finally, national constitutions are very important, according to Hogerzeil, and should specify the 'right to health' as central to the 'right to life'.

Session 1.5.4: Rights Based Frameworks for Vulnerable Populations with HIV/AIDS: Women and Children

Salon IV
Moderator: Brian Willis
Speakers: Farhana Zuberi, Michelle Munro, Voravit Suwanvanichkij
Rapporteur: Whitney Fry

Farhana Zuberi (Consultant, Centre for the Study of AIDS) began by discussing The Tswelopele Project through the Centre for the Study of AIDS, University of Pretoria, South Africa. The purpose of this project was to examine the impact of a rights-based approach to HIV/AIDS at the local level to determine if, and to what extent, local communities were able to access and enforce human rights. As Zuberi reported, people with HIV have to deal with human rights violations concerning privacy and disclosure, informed consent regarding HIV testing, and access to health care services. In addition, there are other human rights issues that need to be addressed such as access to social security, the rights of orphans and vulnerable children, and the role of stakeholders in the community (e.g., family, police, health care workers, faith based organizations). Zuberi recommended that more people be educated about human rights, especially older persons, and that police, traditional leaders, local government, family members, and faith based organizations receive basic training. In addition, she said it would be helpful to use plain language for a Bill of Rights and other important laws so that regular people can understand them.

Next, Michelle Munro (CARE, Canada) talked about her research regarding a rights-based framework to care for and support people living with HIV/AIDS. Her goals was to identify options for the delivery of good quality, client-focused HIV/AIDS care and support services in Cambodia, Lao PDR, Thailand, and Vietnam. She also focused on eight rights concerning health, participation, confidentiality, dignity, freedom from discrimination, information, and privacy and autonomy. Although there existed regional and national policies to support quality care and support, Munro reported, they had not been translated into action for various reasons (e.g., lack of knowledge or regulation, non-compliance by gatekeepers). Overall, she recommended better links between health providers in source and destination communities as well as greater education regarding human rights, especially for duty bearers.

Finally, Voravit Suwanvanichkij (Johns Hopkins School of Public Health) discussed his investigation of Burmese migrant women in Thailand. Overall, he studied how their living and working conditions make them more vulnerable to HIV/AIDS. Burmese migrant women, he

stated, often face the same issues of exploitation as trafficked women such as sexual abuse, debt bondage, transfer of debt to new employers, physical insecurity, harsh living conditions, and lack of access to health care. Women who live in brothels get provided with birth control pills but most clients do not want to use condoms. They have the option to refuse clients but will get charged a fine, which leads to further debt. Conditions for women working in factories are equally grim, he reported. They are not allowed sick days, pregnant women are often fired, and their children are often abandoned. According to Suwanvanichkij, the vulnerability of Burmese migrant women to HIV/AIDS is associated with the human rights abuses they experience. And, this is likely to increase because Burmese migrant women lack access to reproductive health services and have very little understanding of HIV/AIDS.

Session 1.5.5: Refugees, Internally Displaced Persons, and Human Rights along the Public Health Model

Salon V
Moderator: Jacqueline Weekers
Speakers: Eh Kalu, Catherine Lee, Lea Dooley, Sok Pun, Theresa Hwang, Paul Spiegel
Rapporteur: Emily R. Hencken

   Jacqueline Weekers (International Organization for Migration) opened this session with a discussion of migrant health and human rights. Migration itself is not a problem, she stated, but current conditions surrounding migration can lead to health problems. The migrant population represents roughly 2.9 percent of the total world population and many of the same inequalities that drive the spread of disease, also drive migration, according to Weekers. The challenge of human rights in this area, she believes, is the need to focus on irregular and forced migration and the issues that migrants will face when in their host community such as access to health, discrimination, child labor, unsafe working conditions, and sexual exploitation. Ultimately, well-managed migrant health benefits all, Weekers contended, because healthy migrants are also productive citizens.
   Eh Kalu (Secreatary, Karen Department of Health and Welfare) and Catherine Lee talked about mortality rates and conflict-related human rights abuses among internally displaced persons in Eastern Burma. For over fifty years, they stated, Burma has been in a state of civil war. This chronic conflict has had negative implications for the health and welfare of ethnic minorities of the region. In Burma there are some zones called "black zones," where there is no access to health or education services and residents are subjected to military brutality and other human rights abuses. In 1998, Kalu and Lee decided to form 'backpack health worker teams' to provide healthcare and monitor human rights violations in these black zones. The biggest violations, they found, occurred among internally displaced populations. In the future, they plan to continue to monitor health and human rights in this region and make their data available to the locally-run Health Information and Documentation Department.
   Next, Sok Pun (HIV/AIDS Program Coordinator, CARE Cambodia) presented his work on daily migrant laborers. His objective was to identify levels of knowledge regarding HIV/AIDS and sexually transmitted infections as well as risk behavior patterns. The biggest health issue, he found, was AIDS. The main problem is that there is a very low knowledge about the disease or prevention methods. There is also a high level of discrimination towards people living with AIDS. Many laborers do not seek or have access to health services, so self-treatment is cheaper and more convenient. Overall, Pun recommended that a system of education and information dissemination be established. In addition, he believes that the financial well-being of communities needs to be improved.

Theresa Hwang (Princeton Refugee Initiative) talked about the politics of health in the Kakuma Camp in Kenya. The Kakuma Camp, she explained, is a prolonged refugee situation where refugees are indefinitely stuck in camps because political inaction and organizational constraints prevent their integration, repatriation or resettlement. Essentially, they live in limbo with few rights or opportunities and inadequate health services. Refugees depend on the Office of the United Nations High Commissioner for Refugees (UNHCR) and non-governmental organizations (NGOs), she stated, to provide basic food, water, and shelter as well as to serve as their political proxy. However, because the UNHCR and NGOs are facing constraints on funding, refugee representation is falling to the wayside. Without basic political rights, Hwang contended, refugees lack any means to demand adequate provisions and improve their situation.

Finally, Paul Spiegel (UNHCR) talked about how to use HIV epidemiology to advocate for refugees and returnees. Interestingly, Spiegel noted that countries experiencing conflict actually have very low rates of HIV/AIDS. Similarly, refugees leave counties that have much a much lower prevalence of HIV/AIDS than their country of asylum. While refugee camps also have a lower prevalence of HIV/AIDS than surrounding areas, he stated, it is important to try to keep AIDS from spreading into the camps. Therefore, Spiegel recommended that there needs to be a decrease in mobility and accessibility, and an increase in resources and services in host countries. More quantitative studies and data are also needed to advocate against stereotypes and discrimination, and to improve programs and reduce mobilization.

Session 1.5.6: Roundtable on Social Participation in Health and Human Rights: Examples from the Field

Silverbell Pavilion
Moderator: none
Speakers: Mariana Chilton, Ariel Arroyo, Holman Phiri, Kathryn Mulvey
Rapporteur: Shelby Grossman

Mariana Chilton (Assistant Professor, Drexel University School of Public Health) began by discussing the perspective of the poor on health and human rights. Her recent research concerned lay perspectives on the relations between food and health, and what the definition of human rights meant to people living on the street in Philadelphia. When these people were asked about human rights, Chilton found that they wanted to talk about civil rights and racial discrimination. Human rights were also associated with childhood abuse and violence, as well as gender inequality in the case of women. These women have a fundamental understanding and acknowledgment about human rights and what they should be, Chilton said, but are viewed as "just a piece of paper" written by white women. In fact, the idea of human rights was first considered an insult to African Americans who were offended by the concept.

Next, Kathryn Mulvey (Executive Director, Corporate Accountability International, formerly Infact) talked about the framework convention on tobacco control (FCTC), which was the first corporate accountability treaty initiated and adopted by the World Health Organization in the mid 90s. We all have an interest in developing global mechanisms that have the capacity to hold transnational corporations (TNCs) responsible, Mulvey stated, since 51 of the 100 largest economies in the world are corporations. One prominent strategy for changing corporate behavior is to exert pressure through boycotts, for example. But the intent of the FCTC is to give first priority to health rather than trade, and this treaty makes it possible for governments to stand up to TNCs, Mulvey believes. Our countries already have enormous health problems, she said, and do not need to export a totally preventable epidemic to the rest of the world.

Ariel Frisancho Arroyo (CARE, Peru) presented on improving the health of the poor using a human rights approach. The purpose of his project is to strengthen relations between the Peruvian state and society in the health sector, and promote poor people's health rights. The project seeks to develop strategies to raise awareness and disseminate information about health rights at the national, regional, and local levels. In addition, Arroyo is also working on strategies to strengthen citizen participation and decision-making in the health sector as well as develop strategies for building partnerships and advocacy to improve health rights for the poor. In order to change the current situation in Peru, Arroyo believes there need to be more responsiveness from duty bearers and public health officials.

Finally, Holman Phiri (CARE, Malawi) discussed adopting a rights-based approach to achieve equity in the health sector in Malawi. His goal is to improve the ability of rural households to articulate, manage, and address their basic rights of health. According to Phiri, this approach needs to work with different levels of government to address the needs and rights of the vulnerable, as well as work with rural governments to provide quality services. In addition, he also emphasizes the need to work with community based health institutions to help them identify health issues, promote responsibility, and achieve mutual accountability.

Session 1.6.1: Health and Human Rights Curricula

Oak Amphitheatre
Moderator: Judith Bueno de Mesquita
Speakers: Nichole Haberland, Claudio Schuftan, Marcela Huaita, Jeff Goldhagen
Rapporteur: Jill Ford

Nicole Haberland (Population Council) began with a discussion of how to turn a rights framework into a mainstream, sexuality education. Studies from diverse settings such as China, Peru, the United States, and Uganda, she reported, have shown that traditional gender roles are independently associated with low rates of condom and contraceptive use, multiple sexual partners, more frequent intercourse, and early sexual initiation, which often lead to contracting sexually transmitted diseases and unintended pregnancies. Sexuality education has not done much to prevent this situation because of gaps in both access to, and the content of, the education. If we are to adequately consider the profound effects of gender on sexual and reproductive health, she contended, sexuality education must be fundamentally changed. According to Haberland, it may be more politically acceptable, perhaps even more effective, to start with a rights-based approach. Then, some of these fundamental rights can be used as a framework for critical thinking about gender. Such an approach, starting in primary school, may also have long term benefits in other areas of women's lives such as education, citizenship, and empowerment.

Next, Claudio Schuftan (Adjunct Professor, Freelance Consultant, Tulane University School of Public Health) talked about elements of a human rights activism course and curriculum. In order to train human rights activists of tomorrow, Schuftan believes it is necessary to create a working curriculum centered on the emerging trend towards rights-based approaches. Such an approach will build upon current work being done in the field and will soon be tested in Nicaragua. While it is important to train students in the field of public health, he said, it is also important to target students in social and political interventions. According to Schuftan, students also need to be taught about the power dynamics that are involved in this field – why the wealthy get certain types of diseases and the poor get other kinds of illnesses.

Marcela Huaita (Gender and Human Rights Specialist, Futures Group International-the Policy Project) talked about a reproductive health and human rights course. The general objective of this

course, she stated, is for government and NGO staff working in RH-HIV/AIDS policies to better understand and utilize a human rights framework in national settings. The students learn the relationship between women's rights, reproductive rights, discrimination, gender violence, and rights to health, among others. Through case studies, participants examine national legal systems and laws with respect to sexual and reproductive health problems and policies in the Latin American Region. The course is tailored to career professionals who are already interested in and working in reproductive and HIV/AIDS, and to people with professional degrees and working experience in the government or NGOs. The course will be available in English and Spanish and on CD. The length of the course is 45 hours and can be taken over a whole semester or combined with other existing programs.

Finally, Dr. Jeff Goldhagen (Associate Professor, University of Florida) presented a course on teaching children's rights. The aims of the course are: to raise awareness of the Convention on the Rights of the Child; to increase understanding of its direct application to health and health care policy; and to promote insight into how policy and practice can be improved to achieve greater respect for the rights defined in the Convention. It will also teach awareness about the relationship between public policy and the health rights of children as well as the development of advocacy on behalf of children's rights. Dr. Goldhagen is still working on case studies and hopes that people from outside the United States will contribute to this section of the course.

Session 1.6.2: Special Child Populations

Dogwood Room
Moderator: David Parker
Speakers: Donald Lollar, Leslie Snider
Rapporteur: Erin Jones

Leslie Snider (Tulane University) opened this session with a discussion about the care and protection of child-headed households in Rwanda. Here, children affected by AIDS are abandoned not only by parents and caregivers who die from illness, but also by their extended families, communities who stigmatize them, and the state which does not provide for their protection and care. Her research found that these children face several different kinds of hardship. The number one issue that was brought up was sexual and physical abuse. Other issues include exploitation and harassment, property violations, loneliness and isolation, stigma and discrimination, and emotional distress. Ultimately, the findings of her study helped mobilize local child-rights advocacy groups and child protection organizations, and provided details on the relevant laws and processes for reporting child rights violations. For protection to truly work, Snider stated, this awareness and commitment to children's safety and protection must engage communities and societies at all levels – from the household level through the highest legal structures.

Donald Lollard (National Center on Birth Defects and Developmental Disabilities, CDC) talked about improving the health and well-being of children with disabilities. According to Lollard, it is crucial to identify children with disabilities and implement interventions that comply with United Nations conventions. Issues such as stigma and shame affect the acknowledgment of disability, he noted. In addition, children with disability are defined differently in different countries. Lollard recommended a common global language of child disability that is sensitive to cultural variation. It is also important, he said, to identify and document individual differences and monitor demographic trends of children with disability to evaluate adherence to United Nations conventions.

Finally, David Parker (Medical epidemiologist, Park Nicollet Institute) discussed child labor, human rights, and public health. According to Parker, children's work that is carried out in sub-

human working conditions can create or perpetuate an intergenerational cycle of poverty, malnutrition, and social disadvantage. Harmful child labor affects as many as 350 million children worldwide, he said, and is linked to economic development, public health, and education. Ultimately, Parker contended that programs to eliminate child labor must be integrated into larger economic, social, and public health programs because of the relationship between child labor and so many aspects of community health. In addition, public health and educational agencies should be included in the planning, development, implementation, and evaluation of new programs.

Session 1.6.3: Water and HIV/AIDS

Salon III
Moderator: Madeleen Wegelin-Schuringa
Speakers: Virginia Molose, Robert Quick
Rapporteur: Matt Freeman

Madeleen Wegelin-Schuringa (Royal Tropical Institute) opened this session with a discussion about the linkages between water, sanitation, and HIV/AIDS. People infected with HIV, Wegelin-Schuringa argued, can delay the onset of AIDS through healthy living. However, because water and sanitation play an important role in this, hygiene education becomes crucial in assisting people manage this disease. The task of care givers is often made more difficult by a lack of water. Many home care manuals assume the availability of safe water and do not address situations where this is not the case. Therefore, many caregivers are not specifically educated in safe water handling practices and are insufficiently aware of the importance of safe water and sanitation, she reported. Furthermore, people living with HIV/AIDS are often denied equal access to water points and latrines, and to valuable information on proper hygiene. According to Wegelin-Schuringa, it is crucial that active steps are taken to ensure that 'the right to water' is respected and enforced for everyone, and that people who unable to realize their water rights are provided with sufficient access.

Next, Virginia Molose (Training Coordinator, Care South Africa-Lesotho/The Mvula Trust) presented on the Water, Health and Livelihoods Program (WHELL). This is a partnership, she described, between AusAid and non-governmental organizations to contribute to poverty reduction and the achievement of sustainable development in Southern and Eastern Africa. Interestingly, their biggest crises concerned water supplies. In many places, for example, toilets were built without water, which was so scarce that it was being used for washing clothes, cooking, and drinking. There were also links between water and gender, Molose reported, since water collection and caring for HIV/AIDS victims was the responsibility of women. Women should be allowed to take part in discussions about the watersupply and how they can most effectively use their time, she argued. It is also crucial to improve our understanding of the linkages between gender, HIV/AIDS, sustainable water, and sanitation services.

Finally, Robert Quick talked about 'safe water systems' (SWS) and AIDS. Safe water systems, he said, are important in preventing diarrhea and increasing access to safe water among resource poor populations in East Africa. Here, hundreds of millions of people have no access to safe water sources, Quick reported. One of the biggest problems is diarrhea, which kills 2.2 million people each year due to contaminated water, or no water at all. People living with AIDS are especially vulnerable to contracting diarrhea since they have even less access to safe water. A simple and relatively inexpensive short-term solution, he argued, is using SES that include water storage containers and disinfection methods. Such changes have been shown to reduce diarrhea by 25-85%. Two potential problems with SWS concern the sustainability of free programs and availability

to rural and remote populations.

Session 1.6.4: Participatory Strategies for Policy Development

Salon IV
Moderator: Rose Nathan
Speakers: Marcela Huaita, Helen Potts, Roberto Cabrero, Irene Hadiprayitno
Rapporteur: Megan Gaydos

Marcela Huaita (Gender and Human Rights Specialist, Futures Group International-the Policy Project) began this session with a discussion about alternative dispute resolution (ADR) mechanisms and their application to conflicts in the health sector. The Centers for Dispute Resolution and Conflict Prevention in Health Care (CEPRECS) uses ADR mechanisms such as negotiation, mediation, multi-actor dialogue, and conciliation to solve problems in this area. They also employ other startegies, such as public awareness, conflict resolution, national and local alliance building, and public policy lobbying. While their impact on health care services has been positive, CEPRECS are still facing challenges regarding sustainability; there needs to be new legislation adopting ADR mechanisms on health facilities and public allocation of resources.

Next, Irene Hadiprayitno (Netherlands Institute of Human Rights) talked about linking the right to development with the right to popular participation in the Sendang Agung village, Yogjakarta Indonesia. The issue of public health is very important in the Sendang Agung village, which has water and sanitation problems. According to Hadiprayitno, the local government does very little to provide sanitation, so it is important that people get together and actively propose improvements. By doing so, people will also see that there are others in the same situation. The benefit of linking participation to development, she concluded, is that people act as agents of change in their daily lives, which helps enhance the commitment of the people and the government, which then benefits the endurance of the projects.

Roberto Cabrero (MD, MPH, Program Manager, Project Concern International) talked about advancing human rights, leadership, and advocacy among rural Mayan women in Guatemala. Guatemala has adopted many human rights treaties, signed the Millennium Declaration, and has numerous laws regarding access to health services, Cabrero reported. While people living in the cities have access to information about sexual and reproductive health (SRH), those living in rural areas have little or no access and this information, especially women. Cabrero described his involvement in a project to provide SRH services and reduce the risk of maternal mortality through the Maternal House. This project hopes to achieve its goals by empowering women to organize and demand their SRH rights, and by building the capacity of grassroots NGOs to demand public policies for women. It is crucial for the Maternal House to exercise its role as social facilitator, he argued, to make the rights situation of women "visible" and propose feasible strategies to decision makers so that policy can be implemented.

Session 1.6.5: Health Accountability Through Legal Systems

Salon V
Moderator: Ashley Barr
Speakers: Mey Akashah, Chiseche Mibenge, Mike Perry
Rapporteur: Julia Dawson

Mey Akashah (Harvard School of Public Health) talked about methods for calculating compensation for human rights abuses. The purpose of her work is threefold: 1) to explore the emerging international legal framework for awarding compensation to victims of human rights violations; 2) to examine the use of income for estimating the health consequences of human rights violations; 3) to develop an equitable, transparent, and consistent methodology for calculating award sums. While principles of compensation are currently being developed by the United Nations Commission on Human Rights, they have several problems including an over reliance on income to calculate compensation, which can lead to the perpetuation of inequities, Akashah argued. A more sensible approach should include: treatment costs, foregone productivity loss of wellbeing, risk assessment, and projected losses.

Chiseche Mibenge (Netherlands Institute for Human Rights Research) talked about international criminal justice and the health needs of witnesses and victims of wartime sexual violence in Rwanda. Most women who survived the genocide were raped and infected with HIV, Mibenge explained. Furthermore, United Nations Special Rapporteurs stated that the infection of Tutsi women with HIV was premeditated. However, only recently has the international tribunal begun to hear testimonies regarding rape. Once the tribunal ends in 2008, she argued, it is up to the Rwandan government to offer a compensation package to the victims beyond AIDS medication. Ultimately, the positive contribution of this tribunal to the discussion of health and human rights was that it eventually decided that rape was a form of torture, Mibenge added, and should be applauded for setting that precedent.

Finally, Mike Perry (LL.B., LL.M., Barrister and Solicitor) discussed alien torte claims and non-citizens rights to redress for human rights abuses in national courts. According to Perry, there have been no successful cases of this except the class action suit against Ford by Holocaust survivors, which was settled out of court. The reasons for this are several, he explained. First, many victims do not have the money to take anyone to court. Second, many victims do not want to relive their horror again in court. Third, the evidence presented is often considered anecdotal, making the trial a matter of 'my word' vs. 'your word'. However, how can we fully address the right to health, Perry warned, if a legal remedy for human rights abuses does not exist? Ultimately, he argued, there should be a holistic approach to redress for human rights abuses that includes the mental and physical health needs of victims.

Session 1.6.6: Roundtable on Vulnerable Populations

Silverbell Pavilion
Moderator: Roundtable
Speakers: Katherine Dorsey, Stacy Laswell, Basia Tomczyk
Rapporteur: Whitney Fry

Katherine Dorsey (Director of Publications, Center for International Rehabilitation) presented

cross-national data on health care to assess broader understandings of the right to health as well as treatment for people with disabilities. Unfortunately, information on people with disabilities in developing countries is very hard to come by, Dorsey explained. Therefore it was necessary to collect information that was basic enough to ensure that populations could be reliably sampled and compared. The health data included twelve items covering information on funding, availability of detection programs, and legal protection against discrimination. Her results contrasted differences in the health provisions of countries at different levels of development. Among her conclusions, she stated that an over-emphasis on health care can overshadow a more comprehensive understanding of health that includes comprehensive protection to people with disabilities.

Basia Tomczyk (Epidemiologist, Centers for Disease Control) talked about the June 2004 survey regarding the health of Sudanese refugees in Chad. The United Nations High Commission for Refugees requested the information since it had never been documented before. People in Chad were alarmed and greatly suspicious of the endeavor, Tomczyk explained. The survey targeted three particular groups: 1) formally recognized refugees; 2) spontaneous refugees that moved from the border to live under plastic sheeting; and 3) populations on the northern-most border with Sudan who lived under trees without access to water or food. Three separate studies were conducted by participants from the World Health Organization, U.S. Center for Disease Control, United Nations High Commissioner for Refugees, and local non-governmental organizations. In addition, doctors from the International Committee of the Red Cross set up an extensive community health worker network which coordinated the interview of families.

Stacy Laswell (Guest researcher, ORISE/CDC) talked about the development of a toolkit to assess the reproductive health needs of refugees and internally displaced women. While more surveys of refugees are being done, Laswell reported, few methodologies exist to guide researchers. The purpose of such a toolkit is to create something that can be used by local female residents, with little service from researchers. One limitation will be the use of uncommon terms, she explained; details concerning reproductive health, for example, are not always easy to translate and can get muddled in translation. However, she expects that the experience of conducting the survey will be very empowering for local women.

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DAY TWO: Friday, April 15, 2005

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Concurrent Sessions 2.2: Friday Morning, April 15, 2005

Session 2.2.1: Measuring the Right to Health

Oak Amphitheatre
Moderator:
Speakers: Paul Hunt, Audrey Chapman, Dabney Evans, Sofia Gruskin
Rapporteur: Megan Price

Paul Hunt (UN Special Rapporteur on the right to health) began this session by sharing his experience in developing and implementing indicators of health. For better or worse, Hunt stated, the primary way to assess the progressive realization of the right to health is through numerical indicators and benchmarks. They have been a contentious subject over the last ten years, he added, and it has been difficult to get agreement even on the most basic ideas and language. While the debate is gradually moving forward, it is important not to expect too much from indicators and

benchmarks because they will never give a complete picture, according to Hunt; they can tell us whether the situation is worsening or improving by not 'why'. In the future, he hopes to see more 'fixed' indicators that do not necessarily vary over time, such as whether or not a country's constitution includes the right to health or specifies an essential drugs policy.

Audrey Chapman (Director, Science and Human Rights Program, American Association for the Advancement of Science) also talked about her efforts to develop statistical indicators of health from a human rights perspective. Thus far, three types of indicators have been employed (structural, process, outcome) in areas such as women's reproductive and sexual health, overall health system infrastructure, essential medicines, and environmental dimensions of health. Several manuals have also been developed regarding Environmental Health Indicators and Benchmarks and Structural Indicators to Monitor the Rights to Health.

Next, Dabney Evans (MPH, CHES; Executive Director, Emory Institute of Human Rights) discussed her efforts to develop a health and human rights (HHR) report card. The report card utilizes health indicators from the World Development Report (World Bank, 2004) to assess how well a particular country has fulfilled the health provisions specified in major human rights documents (e.g., Charter of the World Health Organization, Universal Declaration of Human Rights, International Covenant on Economic, Social, and Cultural Rights). Evans stated that the HHR report card is a first step in the development of an effective means to monitor health and human rights. She hoped that it would be used to educate and raise awareness among the general population about the right to health, as well as to help public health professionals and policy makers identify health priorities.

Finally, Sofia Gruskin (Associate Professor, Program on International Health and Human Rights, Francois-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health) questioned the mechanical pursuit of the 'perfect indicators.' What is being measured, Gruskin argued, is not more important than what occurs before, during, and after the process of measurement. Furthermore, it is important to keep in mind what an indicator was constructed to measure. There is a tendency to want to quantify everything, she said, even though more information may be derived from qualitative studies. In the end, it is important to measure progress, Gruskin added, but the design stage itself offers opportunities for debate and reflection on priorities, which can bring different groups together for a common cause.

Session 2.2.2: Public Health Methods During Conflict

Dogwood Room
Moderator: Barry Levy
Speakers: Chris Beyrer, Amy Finnegan, Mike Westerhaus
Rapporteur: Raj Panjabi

Chris Beyrer (Director, Fogarty AIDS Program; Associate Professor, Johns Hopkins Bloomberg School of Public Health) discussed his current project to assess the impact of war and political disruption on HIV/AIDS and malaria research initiatives in the Democratic Republic of Congo (DR Congo) between 1980 to 2004. DR Congo has experienced much political instability, Beyrer explained, which has lead to increased infectious disease, morbidity, and mortality. For this project, he used a 'hybrid bibliometric' approach and systematically searched the medical literature to create a political and human rights chronology and compared how well his research initiatives fit the timeline. Ultimately, he concluded that the process of bringing together systematic reviews of scientific studies with historical and human rights milestones illuminates both endeavors.

Amy Finnegan (Fletcher School of Law and Diplomacy) and Michael Westerhaus (Harvard

Medical School) presented on health and human rights interventions in Northern Uganda. The objectives of their study were to raise awareness on health and human rights in Northern Uganda, provide a critical analysis of interventions, and demonstrate how social justice is particularly important in war-time situations. They conducted participation observations, interviews, field notes, and follow-up correspondence to identify intervention models and the different assumptions that they employ. Charity, for example, is used to meet immediate survival needs but can cause a false sense of generosity because people assume that there will always be rich and poor, Finnegan and Westerhaus explained. Development models use socioeconomic indicators to measure 'linear progress', but often assume that the problem lies with the poor or the country itself. A social justice model, on the other hand, attempts to document how human rights violations are generated, and promotes peace building and community empowerment at the grassroots level. One prominent criticism of this model is that there is little emphasis on immediate service provisions. Therefore, charity and development models often prevail, they said, but social justice efforts deserve increased emphasis in conflict settings.

Finally, Barry Levy (Adjunct Professor of Public Health, Tufts University School of Medicine) presented on public health surveillance, before, during, and after conflict. Clearly, war is an impediment to public health, Levy stated. From 1990 to 2001, there were 57 armed conflicts in 45 locations, he reported, and all but 3 of those were civil wars. Civil wars generate refugees, indigent populations, as well as dead civilians. However, much of the public health impact in war is due to the destruction of societal structures, such as safe water systems. Ultimately, public health surveillance is data collection that can be used for the prevention of disease, Levy concluded.

Session 2.2.3: Financing of Development

Salon III
Moderator: Stephen Marks
Speakers: Aarthi Belani, Ted Schrecker, Ronald Labonte, Wendy Austin
Rapporteur: Daniel Abbott

Stephen Marks (Professor, Harvard University) talked about country level experiences regarding the right to development (RTD). The RTD has been criticized, he said, for lacking clarity and has been quite controversial. The Monterrey Consensus and the Millennium Declaration both point to RTD as a goal, but it continues to be absent from the policies of governments and international organizations. Donor countries, for example, resist the idea that they have the moral obligation to transfer money to developing countries. The most important objective, Marks stated, is to start with needed resources like food, education, and health. Unfortunately, the legal foundation of RTD is not working, he argued, since such rights in many countries only exist on paper.

Aarthi Belani (Junior Fellow, New York University School of Law Institute for International Law and Justice) talked about Haiti and the Inter-American Development Bank (IDB) as a case study in human rights accountability. Even though Aristide's 2000 election victory was not contested, Belani described, international sanctions followed because it was treated as a 'tainted' election. Furthermore, the U.S. administration requested the IDB to deny money to Haiti, which blocked water and sanitation projects in the country. According to Belani, one of the main reasons for doing this is that international lenders take over state functions as they prop-up Haiti's GDP. It is becoming apparently clear, Belani stated, that as IDB mandates take on more governance roles of a state, they should be partially accountable for what happens there. Independent accountability movements in international organizations are growing, and this is a very positive thing according to Belani. However, there is not enough pressure yet on states that are obligated to contribute to

international relief and stability.

Wendy Austin (Professor, University of Alberta, Canada), Ronald Labonte, and Ted Schrecker (Senior Policy Researcher, Institute of Population Health) discussed a relational perspective on G8 policies and the right to health. There are great differences between the health care services in different areas of the world, they stated. There are many countries, such as Ghana, that do not have enough money to provide basic health services. More than 95% of new HIV infections and the are in low and middle income countries. Also, malaria use to be an 'equal opportunity' killer, they shared. However, malaria death rates have dropped in countries with increasing wealth, but not in Africa. If we share the means to do better, why are we not doing more, they questioned? Human rights norms cannot be dependent on where you are born. If globalization is going to "work for all" in terms of human health, dramatic initiatives are needed in development assistance (including aid for health research and health systems), debt relief, and trade policy/market access.

Session 2.2.4: Human Rights Issues in Infectious Disease Control

Salon IV
Moderator: Dr. Tarantola
Speakers: Adam Richards, Htee Moo, Joia Mukherjee, Wun-Ju Shieh
Rapporteur: Shelby Grossman

Adam Richards (Associate Program Director, Global Health Access Program) and Htee Moo (Health Worker, Mae Tao Clinic) talked about malaria control among internally displaced persons in Eastern Burma. Burma's health system, they reported, is the second worst in the world. Transportation to Burma, for example, is often delayed, which means that medication for treatment is also delayed. This makes it even harder to consistently treat and control malaria. Non-governmental organizations have tried to help but are not able to replace government services because they are forbidden to travel freely in camps for internally displaced persons. In addition, Thailand recently forced all Burmese asylum seekers to camps without any form of communication. This led to the formation of the "Back Pack Health Workers" team, which is made up of hundreds of medical staff from different ethnic groups. Their Malaria Control Pilot Program seeks to implement early prevention and treatment, education, access to nets, and diagnosis. They conduct screenings twice a year on the entire population and monitor drug treatment. Today, over 90% of the population sleeps under nets at night and the prevalence of malaria has decreased significantly in every area.

Joia S. Mukherjee (Partners In Health Harvard Medical School) talked about the human rights of people with HIV/AIDS. The kind of human rights that should be safeguarded here include the protection of privacy, antidiscrimination, rights to treatment, and mitigation of risk factors. Mukherjee argued that implementation of the right to privacy needs to go beyond traditional civil and political rights in this context. The right to treatment, on the other hand, has not been recognized in the same way but is being put on the table through the activism of people living with AIDS. However, until we address the issue of poverty, Mukherjee said, we cannot fully address the issue of health in an honest way. People, mostly women, living in really poor conditions are often forced into sexual relations just to get food. Other risk factors for disearse include war and displacement. According to Mukherjee, there are two main ways to address HIV/AIDS – treating the sick and addressing global poverty.

Wun-Ju Shieh (U.S. Centers for Disease Control) talked about the investigation of fatal cases during the SARS outbreak in 2002-03. The containment of the outbreak, Shieh stated, was achieved in large part through the coordinated use of emergency measures, such as stringent infection control,

quarantine and isolation, and international travel advisories. Postmortem examination with pathologic studies and autopsy-based surveillance often were not performed during the SARS outbreak response, he said, because of biosafety concerns and for social, cultural, and personal reasons. However, prompt postmortem evaluation can accurately identify the cause of death, enhance diagnostic capacity of infectious or toxic exposures, and provide insights into disease pathogenesis or route of infection. This information can then be integrated directly and rapidly into the public health response to facilitate control of the outbreak. Implementation of an efficient system to enhance awareness of the benefits of postmortem examination and increase autopsy rate should be considered as a priority in any outbreak investigation, according to Shieh. The effective use of such a system, nevertheless, will require consideration of various public health, individual, social, cultural, and other factors.

Session 2.2.5: Sexuality

Salon V
Moderator: Alice Miller
Speakers: Angela Heimburger, Ilsa Lottes, Smarajit Jana
Rapporteur: Patricia Rivera Scott

     Ilsa Lottes (UMBC; Associate Professor, Univeristy of Maryland, Baltimore County) discussed the application of sexual rights in the evaluation and application of sexual health policy. By applying a sexual rights framework, Lottes argued, multiple factors can be identified that aid in the evaluation of sexual health policies of diverse nation-states. She identified various influences on sexual rights, such as health and social benefits, general education level, as well as political and economical power distribution. There are also several components of sexual health that should be evaluated when looking at sexual rights in a country, Lottes explained, such as: risk reduction of sexual misconduct, protection from discrimination, sexual pleasure, risk reduction of unwanted pregnancy and sexually transmitted infections, and reproductive health. All these factors are very important when evaluating the sexual rights in a country. According to Lottes, a sexual rights model gives us multiple levels of analysis and enables cross-national comparisons.
     Angela Heimburger (International Planned Parenthood Federation – IPPF) talked about linking gender and sexuality with sexual rights health programming. The IPPF established a charter in 1995 to raise awareness for sexual and reproductive rights as human rights, Heimburger explained, which is also being used to facilitate the monitoring of rights violations. The Profamilia Colombia, an alliance with the government to establish clinics to help women with health and education, is an intervention based on this Charter. In addressing gender-based violence, she added, it is crucial to link gender and sexuality rights. Violence affects men and women differently based on differences in beliefs, norms and social institutions. It takes a tremendous amount of time to build alliances, Heimburger concluded, and you may not agree on every cause, but it is important to find some common ground
     Smarajit Jana (CARE, India) talked about the dominant discourse in health interventions. Most health intervention programs, Jana argued, stress the transfer of knowledge and technology to change individual behavior. However, this discourse ignores the underlying causes that hinder availability and accessibility to information and services. For example, people with HIV/AIDS or drug users often face structural barriers because of their diminished social status. Jana described Community Led Structural Interventions (CLSI) which work with communities to address structural barriers and change existing power relations. CLSI's are needed, Jana contended, to address what makes an individual, group or community incapable of avoiding illness. CLSIs also ensure that

individuals and groups will be more than 'recipients' or 'beneficiaries' of services, but active participants in affecting change.

Session 2.2.6: Roundtable on Sexual and Reproductive Health II

Silverbell Pavilion
Moderator: Roundtable
Speakers: Adriane Hilber. Surabhi Kukke, Alinafe Kasiya
Rapporteur: Elizabeth Hamilton

Adriane Hilber (Technical Officer, World Health Organization) talked about transforming health systems, particularly in the areas of gender and reproductive health rights. Health interventions, Hilber argued, need to be rated on both public health and human rights quality. She described her involvement in a training initiative for health program managers. The goals of this initiative are to increase training capacity and introduce analytical methods to program managers, clinicians, nurses, and students. Gender and rights are woven into each module, which is designed specifically for low resource settings. Furthermore, the program is not violations-based, but focuses on identifying what rights are and how they can be respected or enforced. The main challenge, at the moment, is how to find trainers who have a human rights background.

Surabhi Kukke (Evaluation Coordinator, Margaret Snager Center International) discussed efforts to monitor and evaluate the effectiveness of rights-based sexual and reproductive health goals. For example, the Cairo Report contains approaches that are holistic and comprehensive, as well as gender and youth focused. However, the implementation of all these goals is not happening, Kukke argued. Even though there are local and international experts in the field, there is no body of evidence to tell us what is working on a human rights basis. Furthermore, the evaluation of these programs is too technical and out of reach. According to Kukke, we need to encourage a culture of evaluation that encourages self-critique and ensures rigor and validity. Definitions of rights and dignity are often context specific, she added, so there also needs to be mixed methods and balanced statistics to show any kind of consistent impact. Ultimately, rights-based changes are so long term that you need to evaluate progress with good data from local contexts.

Alinafe Kasiya (CARE, Malawi) talked about building community competence to address inequalities in maternal and newborn health through the Models for Inclusive & Equitable Sexual and Reproductive Health (MINESRH) program in rural Malawi. This research project worked with traditional leaders and institutions to improve support for mothers and pregnant women. The objectives were to understand and document reasons for inequalities within existing social support systems, to document the extent to which leaders and institutions were prepared to address social inequalities, and to develop models for improving the analysis of social situations by leaders and institutions. Among their results, they found that community leaders knew what inequalities existed and why they existed, but there was a reluctance to identify who was actually 'less supported' due to fears about interfering in households or that it may be a screening process for outsider support. While their findings will help improve the quality of services and reproductive health knowledge in rural Malawi, Kasiya argued, they need to find new ways of planning to overcome social barriers and enable women to realize their rights, and to hold state and community leaders accountable.

: Friday Afternoon, April 14, 2005

Session 2.3.1: Health Reparations Through Health Systems

Oak Amphitheatre
Moderator: Camara Jones
Speakers: Andrea Armstrong, Jana Asher, Leslie London, Tanya Raha, Bryan Lindsey
Rapporteur: Raj Panjabi

Andrea Armstrong (Research Consultant, International Center for Transitional Justice) presented her research on Chile, South Africa, and Germany as case models of how health reparations programs function. The main issues she addressed were: previous state complicity, quantification of harm, recognition and access, and agency. Among her findings, Armstrong's direct model was most effective, but only when some infrastructure was available, there was minimal state role in violence, and cash grants were flexible in amount and application. She concluded that reparations programs have political consequences and that international actors must work with government officials and connect to other programs and initiatives.

Leslie London (Health and Human Rights Division, School of Public Health and Family Medicine, University of Cape Town) evaluated health and human rights in South Africa, 10 years after democracy. Despite the elimination of race laws, expansion of basic services and constitutionally guaranteed human rights for all, London reported, post-apartheid South Africa still faces rising mortality, decreasing lifespans, high illiteracy, and AIDS denialism. While the anti-apartheid struggle spurred a human rights movement in health, a more nuanced view of human rights is needed today, she argued. There needs to be a strong engagement of civil society with the government on policies and programs, such as reproductive health rights. Ultimately, there are no guarantees for a better system, London concluded, even with a democratically elected government; the challenges are ongoing, and activists need to contest the terrain in professional organizations, councils, and the state.

Tanya Raha (Medical Student, Y3, University of Western Ontario) talked about understanding and addressing the health outcomes in post-genocide Rwanda. Post-genocide Rwanda has experienced greater numbers of mental and physical health problems, and a relative shortage of health personnel, Raha reported. Also, in recent years, life expectancy in Rwanda has greatly declined, and the rates of infant and maternal mortality, HIV/AIDS, cholera, and malaria have increased. She contended that the relationship between conflict, human rights violations, and disease, point to the need to prevent or mediate conflict. This may require action and skills beyond the traditional role of 'individual healer' to include social healing, peace-building, and advocacy. The Rebuilding Health in Rwanda Project, Raha said, will spend six years on professional curriculum development in HIV/AIDS and trauma for nursing in Rwanda to address these issues.

Bryan Lindsey (Ph.D., Manager, Tuskegee Health Benefit Program, Centers for Disease Control and Prevention) discussed the progress and remaining challenges regarding reparations for The Tuskegee Study. Since 1972, Lindsey reported, progress has been made in the form of changes in research practices, settlement of a lawsuit, formation of the Tuskegee Health Benefit Program and Tuskegee University National Center for Bioethics in Research and Health Care, and a Presidential Apology. The remaining challenges include educating researchers and the public, fostering dialogue about public health ethics that promote health and prevent disease, and ensuring that health and preventable services are more available and provided in a culturally appropriate manner.

Finally, Jana Asher (Consultant, StatAid) spoke about her survey of human rights violations

during the Sierra Leone armed internal conflict from 1991 to 2001. Asher conducted 3634 random sample surveys and reported a preliminary count of 65,054 violations by 3.634 households (an average of 18 violations per household). The main health problems from these violations include the following: lasting damage from sexual assault; tropical sores and festering wounds from physical assault; malnutrition and exposure to elements from forced displacement and/or imprisonment; lasting drug addictions from forced druggings; and injuries from forced work. Asher noted that the survey data could be used for potential health reparations by looking at the concentration of sexual violence victims for each district, for example, in order to determine where to build health clinics first. Similarly, one could look at the concentration of amputation victims to determine the placement of disability assistance.

Session 2.3.2: Health Systems

Dogwood Room
Moderator: H. Jack Geiger
Speakers: Justin Sanders, Joel Sawady, Ramiro Cortez, Albena Arnaudova, Robert Swanson, Shahana Singh, Sabita Tuladhar, Eva Slawecki
Rapporteur: Crystal Bailey

Justin Sanders (University of Vermont College of Medicine) discussed The Sphere Project Minimum Standards, which were compiled to address the issue of competence and accountability in the delivery of aid in complex emergencies. The Sphere Project also seeks to evaluate obstacles in establishing evidence. While there is limited evidence, Sander argued, to support the Minimum Standards, it is not standardized in a way that would make it useful. Nevertheless, this should not stop practitioners from evaluating their activities in the delivery of health care to populations in need. 'Best practice' guidelines are often developed by experience in the field, which is still a valid method for the formation of an evidence base in the delivery of health care, Sanders concluded.

Ramiro Cortez and Joel Sawady (translator) talked about health, human rights, and community development in rural El Salvador. After civil war ended in 1992, Cortez worked to create dignified living, health, and means of living which would his community develop. The first challenge was to organize the community in order to implement these principles. He has recognized several keys to success, which include: the need to teach their children so that they can recognize their own problems when they grow up; to connect with the outside world; and to invest in local leaders as a long term commitment.

Albena Arnaudova (WHO. Europe) discussed 'health for all' policy frameworks in the European Union. 'Health for all', Arnaudova explained, is a WHO standard that seeks universally available, accessible, and high-quality health care. However, one definitive goal cannot be set for all European countries because many former Soviet societies need special attention; different health targets need to be set for each country. At the same time, Arnaudova argued, governments need to minimize avoidable differences in service to different groups. Therefore, 'health for all' in Europe should be a values-based approach driven by core values, such as equity, solidarity, and participation. With a values-based approach, the health sector can also talk to other sectors (e.g., governance) based on similar principles.

Robert Swanson (Care for Life) talked about the link between a rights-based approach to health and health systems development. If health is the goal of all our work, he argued, then global health must continue to be a coordinated, professional endeavor with long-term strategic planning. This can only come, Swanson added, from improvements in health systems. The problem is that new health systems are created while neglecting the struggling ones that are already in place in developing

countries. For example, one of the challenges in developing countries is a lack of properly trained, local personnel. Therefore, new assessments should be done with the input of local health leaders and NGO's that are already working in the area.

Chahana Singh and Sabita Tuladhar (CARE, Nepal) talked about the Partnership Defined Quality (PDQ) project to improve the quality and accessibility of health services in Nepal with community involvement. While health systems are present here, they said, available services are not being utilized because there is a lack of understanding between community and health workers. In addition, there is also poor quality of service and poor client satisfaction. PDQ is there to build support, explore quality of service issues, and improve understanding of health rights. Singh and Tuladhar learned that once a good rapport with the community was established, voluntary participation and commitment could be gained in a sustainable way. Although initially started as a quality improvement approach, they concluded, PDQ is a powerful tool to address general issues on rights and responsibilities in other sectors of society as well.

Finally, Eva Slawecki (Canadian Society for International Health) talked about improving accountability for health in Armenia, Georgia, and Azerbaijan. There are scarce resources for health in these countries, Slawecki described, and very limited capacity in the area of health information systems. Patients must pay out of their own pocket to see physicians and there is a lot of corruption present. There are also discrepancies between the data collected by community-based NGO's and official government numbers. Ultimately, she argued, there needs to be a culture of accountability in these countries that can be sustained over the long-term. Good information and statistics can be used to drive discussions and debates, but there is also a great need to build management capacity at all levels.

Session 2.3.3: Evidence Based Models During Conflict

Salon III
Moderator: Barry Levy
Speakers: Leonard Rubenstein, Karen Leiter, Rachel Porter, Charles Clements
Rapporteur: Ali Khawar

Leonard Rubenstein (Executive Director, Physicians for Human Rights) talked about ending torture following U.S. actions at Abu Ghraib and Guantanamo Bay. U.S. Army policy says that the "use of force, mental torture, threats, insults, or exposure to unpleasant and inhumane treatment of any kind is prohibited by law and is neither authorized nor condoned by the U.S. Government." However, in January 2002, Bush Administration officials stated that the war on terror was a different kind of war, making the Geneva Conventions inapplicable. In the summer of 2002, the door was opening for a host of new techniques, Rubenstein reported, such as extreme isolation, sleep deprivation, and manipulation of diet. In response to these practices, the Physicians for Human Rights Campaign to End Torture recommends full disclosure of interrogation techniques, accountability up the chain of command, rehabilitation for victims, interrogation rules, as well as ethical rules and support for medical personnel.

Karen Leiter (Physicians for Human Rights – PHR) talked about evidence-based approaches for documenting war crimes and crimes against humanity. Human Rights violations usually occur on a large scale during armed conflicts, Leiter explained. These violation are usually acute (i.e., violent death or injury) or chronic (i.e., deterioration of health). Furthermore, in the last 5 years, 90% of the armed conflict victims have been civilians. There are four types of evidence that are particularly important to PHR's work in this area, she stated: medical evaluations (used to gather evidence of chemical weapons use in Iraq), forensic investigations (used to gather evidence of mass killing in

Rwanda), populations-based studies (used to gather evidence of mass rape in Sierra Leone) and documentation of testimonies (used to gather vidence of livelihood destruction in Darfur). These data are useful for developing policy, ensuring accountability, guiding humanitarian relief efforts, and planning treatment and prevention programs for survivors.

Rachel Porter (Doctors of the World) discussed the role and methodology of physicians in documenting evidence of torture. Porter talked specifically about how to train volunteers to identify torture and make a thorough evaluation. There are various ethical and evidentiary issues involved, she explained, such as how to determine whether or not a person is lying, how to probe for details, and the type of environment in which to conduct the interviews. Given a lack of resources, Porter said, it is incumbent upon health professionals to understand how best to document torture and improve the methodological efficacy that will be most persuasive to immigration and customs officials. Ultimately, she concluded, mobilization and lobbying are also needed to ensure that government policies live up to the obligations specified in the Convention Against Torture.

Charles Clements (M.D., M.P.H.; CEO and President of Unitarian Universalist Service Committee) talked about monitoring violations of the laws of war in El Salvador from 1987 to 1991. Continued violations from both sides of the civil war, the government of El Salvador (GOES) and the FMLN (Frente Farabundo Marti para Liberacion Nacional), provoked this effort, particularly violence directed against health care providers and patients. The International Commission on Medical Neutrality (ICMN) was created to gather data related to violations of medical neutrality from all existing human rights sources. A taxonomy was also developed to permit monitoring of violations of medical neutrality. This was divided into twelve violations that were seen repeatedly in El Salvador. Through the ICMN, a code of medical neutrality was created that would extend the Geneva protections to all civilians and civilian sectors. They were also able to negotiate with the GOES and the FMLN to sign the code and agree to periodic reports on compliance. In 1990, the GOES and FMLN signed an agreement on human rights, and in 1992 the civil war finally ended after 12 years of fighting.

Session 2.3.4: Water and Marginalization

Salon IV
Moderator: Audrey Chapman
Speakers: George Tobaiwa, Pavani Kalluri
Rapporteur: Daniel Abbott

Audrey Chapman (American Association for the Advancement of Science) talked about a human rights approach to water availability. Water is essential to the well being of humankind, a vital input to economic development, and a basic requirement for the healthy functioning of all the world's ecosystems, she stated. Yet, there is a growing water scarcity in many regions of the world, experienced mainly by the poor and other marginalized groups. A rights-based approach to this problem establishes minimum standards to achieve the basic amount of water for all. Chapman specified 'Core Minimum Obligations' that should take immediate effect: ensure access to the minimum amount of water to prevent disease; ensure the right of access to water and water facilities without discrimination; ensure physical access to water facilities or services; ensure personal security with physically access water; ensure equitable distribution of water facilities and services; adopt and implement a national water strategy and plan of action; monitor the realization or the non-realization of the right to water; adopt relatively low-cost water programs to protect vulnerable and marginalized groups; take measures to prevent, treat and control diseases linked to water, while ensuring access to adequate sanitation.

Next, Pavani Kalluri (MD, Foodborne and Diarrheal Diseases Branch, Center for Disease Control and Prevention) discussed point-of-use water treatment strategies for safer drinking water and improved health. The process of water collection, transportation, and storage in the home can contaminate water that was clean at the source, Kalluri explained. Safe Water Systems (SWS) provide families with the means to treat their drinking water at the point-of-use (by adding dilute sodium hypochlorite bleach) and the means for them to store treated drinking water safely (in a narrow-mouthed, lidded vessel with a spigot that can be used to collect, transport, disinfect and store drinking water at home). It also involves improvements in hygiene and sanitation, such as hand washing. According to Kalluri, SWS has consistently reduced bacteria in stored water as well as diarrheal disease incidence in areas where it has been implemented. Future challenges include sustaining current utilization of SWS and increasing accessibility to the poorest of the poor.

Finally, George Tobaiwa (CARE, Sierra Leone) talked about CARE's efforts to promote social reintegration in post-conflict Sierra Leone. One of CARE's tactics is to use water and sanitation as an entry to community development and the application of rights-based approaches. At the same time CARE encouraged communities to think beyond the provision of water and picture what they wanted their villages to look like. According to Tobaiwa, the water and sanitation project facilitated social re-integration in 97 post-conflict villages in Sierra Leone. The lessons learned from this project were documented and then replicated into CARE Sierra Leone's current program portfolio (13 projects).

Session 2.3.5: Mental Health and Human Rights

Salon V
Moderator: Timothy Holtz
Speakers: Lisa Laplante, Alicia Yamin, Eric Rosenthal, Brian Willis
Rapporteur: Megan Price

Lisa Laplante (Research Associate and Project Director, Praxis Institute for Social Justice, Boston, Massachusetts, U.S.A.) discussed the right to mental health in post-conflict Peru. After 20 years of internal conflict (1980 to 2000), Peru's Truth and Reconciliation Commission reported the following: 69,280 deaths, 6,000 disappearances, 40,000 orphans, 5,000 innocent people detained, 435 communities destroyed, and 1 million people displaced. In their Final Report (2003), the TRC also stated that one of the principle reasons why survivors of political violence do not seek public health care or use judicial mechanisms to demand the right to mental health is because the service does not exist within the public health sector. As an example of modern day conflict, Peru highlights the need for more resources to build skills in rights advocacy and towards appropriate approaches to attending psychosocial consequences of political violence, Laplante argued. In addition, national and international policy on the definition of mental health for populations affected by internal armed conflict needs to be clarified.

Alicia Ely Yamin (JD, MPH; Instructor, Harvard School of Public Health) talked about how to use human rights approaches to secure dignity and well-being for persons with mental disabilities. According to Yamin, people with mental disabilities are among the most abused and marginalized of any group in the world. In fact, more than 40% of countries have no mental health policy, while over 30% have no mental health program, she reported. Over 90% of countries have no mental health policy that includes children and adolescents. All states, regardless of resources, can develop national mental health policies and plans of action with measurable targets, Yamin argued. International agencies and professional associations can play critical roles in providing technical assistance to countries to develop rights-based, national mental health policies. Furthermore,

bilateral and multi-lateral donors should encourage rights-based policies through their funding prerogatives.

Brian Willis (End Child Prostitution in Asian Tourism – ECPAT) talked about mental health issues among prostituted women and children. While there are numerous health problems associated with prostitution (e.g., HIV, reproductive complications, violence), Willis contended that mental health is the largest problem. Prostitution often takes place in a conflict-ridden environment, he said, where prostitutes clash with other prostitutes, with clients, and with police. However, necessary interventions on behalf of this population suffer from several obstacles: 1) prostitution is not well defined in international law; 2) research is difficult and many studies are small and qualitative; 3) non-governmental organizations do not have the resources alone to launch a global effort. Nevertheless, regardless of whether the mental health of prostitutes is better or worse than the general population, this is still a human rights violation that needs to be addressed, according to Willis.

Session 2.3.6: Roundtable on Community Mobilization in the Fight Against HIV/AIDS: Focus on Youth

Silverbell Pavilion
Moderator: Roundtable
Speakers: Abel Mgimwe, Frederick Azode, Holly Burkhalter, Larissa Thomas
Rapporteur: Elizabeth Hamilton

Abel Mgimwe (Concern Worldwide, Tanzania) talked about building partnerships between communities and local governments to address HIV/AIDS in Tanzania. The prevalence of HIV/AIDS is high in this country (23% of blood donors were tested positive in 2003) and government commitment to addressing the issue is poor, according to Mgimwe. Her current project seeks to bring together community members and district officials to discuss basic HIV/AIDS services and agree on mechanisms to get these services to the community. More specifically, she has organized study trips for community representatives to view other regional services, invited district officials to visit remote rural communities and experience their needs, and conducted community training sessions on the rights and responsibilities of a national HIV/AIDS policy. To date, attendance at voluntary counseling and testing centers has gone up in some areas, community knowledge of HIV/AIDS issues has increased, and local governments have requested training on their roles and responsibilities.

Frederick Azode (UNICEF Trained—Master Trainer on Reproductive Health, HIV/AIDS Prevention Programming; Program Officer, Economic and Social Empowerment of Rural Communities) discussed his involvement in a nation-wide project in Nigeria to reduce the rate of new HIV transmission among young people (ages 15-34) using a rights-based approach. This was accomplished through peer education of Youth Corp members, use of mass media to reinforce sexual behavior changes, and working with policy makers at various levels to pass HIV/AIDS anti-discrimination laws. As a result, the overall rate of HIV/AIDS was reduced between 2001 and 2003, incidences of stigma, discrimination, and rights violations were reduced, and an anti-discrimination bill was passed in Enugu (on February 22, 2005). Azode concluded that youth participation, legislative advocacy, and mainstreaming education was crucial to the success of the program.

Finally, Holly Burkhalter (U.S. Policy Director, Physicians for Human Rights) and Larissa Thomas talked about the role advocacy in treating AIDS in Africa. According to Burkhalter and Thomas, advocacy for the 'right to treatment' in the U.S. helped bring about the tremendous support by the government on this issue. In addition, cooperation between treatment activists and

faith communities in Africa helped get the issue on President Bush's desk by promoting non-action as 'sinful', they explained. Currently, emphasis is now shifting to the need for health care professionals and creating a sustainable workforce in Africa. Emphasis in the activist community has also shifted, they said, towards the importance of using students because they are free of political ties and are seen as potential independent leaders. For health activists to be successful, Burkhalter and Thomas concluded, they need to stay away from abstract conceptions of human rights and use concrete examples that relate to our everyday lives.

Concurrent Sessions 2.4: Friday Afternoon, April 15, 2005

Session 2.4.1: Racism and Other Systems of Injustice

Oak Amphitheatre
Moderator: Camara Jones
Speakers: H. Jack Geiger, Fleda Jackson, Magda Peck, Stuart Berman
Rapporteur: Megan Gaydos

     H. Jack Geiger (Arthur C. Logan Professor Emeritus of Community Medicine, City University of New York Medical School) presented a human rights agenda for the next decade regarding racial and ethnic disparities in health care. Aspects of racism are best documented in the U.S., Geiger said, but the general body of evidence suggests that this is a global problem (e.g., regarding the Inuit in Canada, Kurds in Turkey, North Africans in France). The mortality rates of African Americans, for example, is now the same as it was for Whites 40 years ago. This, and other disparities in nutrition or access to treatment, are the result of social determinants of health, he argued, but we are still exploring the various factors that have an impact on this phenomenon. In addition, Geiger explained, advocates for racial and ethnic disparities in health care must contend with resistance by physicians and right wing think tanks (e.g., American Enterprise Institute, Hoover Project, Manhattan Project) to acknowledge discrimination, or racism altogether. These barriers, as well as a growing literature on biological determinants of race, provide more than enough work for advocates in the decade ahead, he concluded.
     Fleda Jackson (Ph.D.; Visiting Associate Professor, Rollins School of Public Health, Emory University) discussed her research on measuring stress and strain and its effects on African American Women's reproductive health. Through an ongoing series of interviews, Jackson measures various aspects of stress and found that burdens associated with societal racism, personal history, and the workplace were all highly significant contributors to anger, anxiety, and depression as well as associated concerns before and during pregnancy. Jackson has used this information to conduct conferences on how to deal with stress, provide mutual support, and take care of oneself. Policy implication for her research include supporting plans for comprehensive health care for women (and men), mental wellness services as a routine part of care, racialized and gendered specific approaches to mental wellness and health, and the destigmatization of mental health.
     Magda Peck (ScD, CEO/Senior Advisor of CityMatCH, Professor of Pediatrics and Public Health, University of Nebraska Medical Center) talked about creating a blueprint for action to undo racism in urban public health agencies in the United States. It was developed from September 2003 to February 2004 under the direction of CityMatCH, which is committed to the elimination of racial and ethnic disparities, pursuit of social justice, and accountability in the U.S. The Blueprint for Action lays out four areas of activities, Peck explained: 1) promoting learning on institutional racism; 2) promoting team-based, cross-community learning; 3) practice collaboration on specific

institutional issues; 4) collaborations with other national public health organizations. The next steps for CityMatCH include developing a business plan for implementing this blueprint, identifying partners and funders, and working together.

Stuart Berman (MD, ScM, Epidemiology and Surveillance Branch, Division of STD Prevention, Centers for Disease Control and Prevention) discussed the failure to address the growing disparity among Blacks and Whites with gonorrhea as a potential human rights violation. Gonorrhea rates are far higher among Blacks than Whites (and other racial groups), Berman explained. Yet, while these disparities are consistent and widespread, gonorrhea is not recognized or addressed as an 'endemic' disease requiring state action to prevent, treat, and control it (as mandated by the International Covenant on Economic, Social, and Cultural Rights). Ignoring the endemicity of gonorrhea, he argued, and avoiding relevant discussions of race and the stigmatization of sexually transmitted diseases, appears to be a violation of human rights principles that must be dealt with.

Finally, Camara Jones (MD, MPH, Ph.D., Research Director on Social Determinants of Health, Center for Disease Control and Prevention) talked about the international human rights context for addressing racism within the United States. While the U.S. signed the International Convention on the Elimination of All Forms of Racial Discrimination in 1966, it did not ratify the treaty until 1994. At the time of ratification, the U.S. issued several reservations and has been reluctant to issue reports to the United Nations Committee on the Elimination of Racial Discrimination, Jones explained. While not widely disseminated, the Committee's response to the most recent U.S. report in 2000 lists numerous concerns regarding lack of legislation implementing provisions of the International Convention, high incarceration rates of African-Americans and Hispanics, and persistent disparities in housing, employment, and educational opportunities as well as access to public and private health care. Nevertheless, despite U.S. reluctance to be held accountable, Jones concluded, this issue has generated international committees, conferences, working groups, and special rapporteurs as well as treaties that work to ensure progress toward ending racism and racial discrimination.

Session 2.4.2: Promoting Rights Based Approaches to Health: Perspectives from Stakeholders

Dogwood Room
Moderator: Kerstin Leitner
Speakers: Marcus Stahlhofer, Len Rubenstein, Sanjay Sinho, Jesse Rattan, Aun Lor
Rapporteur: Jed Stevenson

Dr. Kerstin Leitner (Assistant Director-General, Sustainable Development and Healthy Environments, WHO) talked about integrating human rights across WHO's technical programs. In general, there are several linkages between health and human rights, she described: reducing vulnerability to ill-health through human rights (via the rights to food, education); the promotion of human rights (e.g., right to privacy, information) through health development; and addressing human rights violations (e.g., slavery, torture) resulting in ill-health. Specifically, Leitner noted three core areas of work to integrate health and human rights within WHO: 1) advancing the right to health in international law and development processes; 2) strengthening WHO's capacity to integrate a human rights-based approach; and 3) supporting governments to integrate a human rights-based approach in health development. Challenges for the future include evaluating current evidence, tools, and partnerships, as well as how to best articulate WHO's role.

Marcus Stahlhofer (Family and Community Health Cluster, Dept. of Child and Adolescent Health and Development) talked about how to use the Convention on the Rights of the Child

(CRC) to improve child survival. This Convention is based on a deep understanding of the needs of children, Stahlhofer argued, and is a more complete base for programming child health and development. Furthermore, it is legally binding on governments and has a mechanism to ensure that countries act on their obligations. A rights-based approach to child health, he said, should ensure technical assistance that is informed by international human rights norms, such as those contained in the CRC, and assist countries in using the CRC reporting process. The reporting process of the CRC should monitor progress, Stahlhofer suggested, based on a core set of indicators for child survival at all levels (local, national, regional).

Len Rubenstein (Executive Director, Physicians for Human Rights) discussed the role of human rights international non-governmental organizations (HRINGOs) in advancing the right to health. HRINGOs set out primarily to document and gather facts regarding violations, Rubenstein said, and put pressure on offending governments to comply with universal standards. But what have they done specifically to advance the right to health, he asked? While similar methods can be used to promote the right to health, they are largely measures to stop bad things from happening, and do little to establish an effective primary health care system or maternal health program, he argued. According to Rubenstein, it is important that HRINGOs monitor violations, but they also need to engage in systems design and advocate for proper allocation of resources.

Sanjay Sinho and Jesse Rattan (CARE, U.S.A.) discussed the relevance of a rights framework to the development of health strategies in large relief organizations like CARE. The strength of the classic public health framework, they stated, is an emphasis on quantifiable behavioral outcomes as indicators of success (e.g., condom use, vaccination rates). These concrete indicators can provide an opportunity for rights-based approaches to demonstrate an impact on health and well-being. If health development work is grounded in the right of all people to the highest attainable standard of health, Sinho and Rattan argued, the field will move from just changing individual behaviors to identifying systematic patterns of ill health in different populations. Furthermore, such an approach will explicitly address the social inequalities that are often the root causes of disease, sickness, and suffering for vulnerable populations.

Finally, Aun Lor (Office of Workforce and Career Development, Health and Human Rights Workgroup, Centers for Disease Control and Prevention – CDC) discussed efforts to build a foundation for incorporating health and human rights at the CDC. In addition to the current Health and Human Rights Workgroup (HHRW, 2003-present), CDC also supports a Social Determinants of Health Workgroup (1999-present), a Measures of Racism Workgroup, and a Behavioral and Social Sciences Workgroup, Lor explained. The overall goals of the HHRW are as follows: to contribute to an ethical framework for public health; to create a more educated, sensitive, and effective public health workforce; to build a trusting relationship between public health professionals and the communities they serve; and to improve public health research, programs, policies, and practices. In the future, Lor hopes to see their work go beyond advocacy and education to policy development and implementation, as well as obtain adequate resources and commitment to sustain and expand on current HHR activities.

Session 2.4.3: Violence Against Women

Salon III
Moderator: Veronica Magar
Speakers: Luz McNaughton, Susanna Vardanyan
Rapporteur: Sarah Roberts

Luz McNaughton (Ipas Central America, Network for Women Against Violence in Nicaragua) opened with a discussion of forced pregnancy and the limits of international human rights standards. While safe abortion care is a reproductive health service that appears to be protected by human rights provisions, she stated, advocates face several challenges when invoking these laws, such as: 1) competing claims that uphold States' interests versus the interests of the pregnant woman; 2) ambiguous wording of national abortion laws and the absence of health system guidelines for legal abortion services; and 3) dependence of legal abortion on the medical diagnosis of health care providers. She highlighted these challenges with a case study involving Rosa, a 9 year old girl who was raped, became pregnant, and eventually had a controversial abortion. Ultimately, her right to an abortion became dependent on who could 'prove' that the pregnancy posed a risk to her health, McNaughton explained, which increased the politicization of the issue and denied her the ability to make a personal decision with her family. Human rights principles can serve as a framework to guide such debates, she added, but it cannot take the place of national dialogue on reproductive rights.

Next, Susanna Vardanyan (President, Women's Rights Center) talked about her work with the Women's Rights Center in Armenia, which specializes in domestic violence, trafficking of women, and reproductive and sexual health rights. Vardanyan explained that the right to be free from violence, for example, is incorporated into many legal documents in Armenia including the constitution, but is rarely implemented. Recently, the Women's Rights Center was the host organization for a pilot project to train health workers about violence against women as well as reproductive and sexual health needs to achieve the following: 1) give providers the relevant knowledge and skills to work with female victims of domestic violence; 2) improve the readiness of health care centers to help female victims of domestic violence; 3) enhance cooperation between the health sector and non-governmental organizations. In the future, Vardanyan hopes to coordinate health providers with the work of other agencies and professionals working on issues of violence against women.

Finally, Veronica Magar (Sexual and Reproductive Health Advisor, CARE - Asia regional Management Unit) discussed CARE's organizational change approach from a focus on protecting women to protecting their rights. This approach was informed by documentation of existing 'violence against women' (VAW) programs, a literature review on VAW, technical support and advice from regional activists, and a regional synthesis meeting. Characteristics of CARE's current approach include a shift from viewing 'women as victims' to 'woman as agent', focusing on establishing respect for women's virtue, redefining gender (including masculinity) and other sexualities, and promoting agency. The next steps for CARE include promoting a learning community on gender and sexuality.

Session 2.4.4: Structure, Policy, and the Role of the Media in HIV/AIDS

Salon IV
Moderator: Paul Spiegel
Speakers: Holly Burkhalter, Khairuzzaman Kamal, Peter Bourne
Rapporteur: Julia C. Dawson

Holly Burkhalter (U.S. Policy Director, Physicians for Human Rights) talked about a human rights approach to building a health infrastructure in response to the AIDS pandemic. Burkhalter explained that the Bush Administration's pledge to spend $3 billion per year over 5 years to provide care for 10 million African people with AIDS was a radical shift from past policies. Now that the Administration and congress are 1 year into this commitment, their goals are not being reached. Why? Not because of a lack of effort, she said, but because the government as well as health activists overlooked the degree to which local infrastructure needed to be rebuilt. Much a cart built without a horse, there are unprecedented amounts of money to fight AIDS in Africa, but no way to distribute it due to a lack of skilled health workers who often leave for better opportunities in the West. The issue can be fixed, Burkhalter concluded, but a health workforce will have to be built first (and fast) if there is any way that the Bush plan will reach the people that it planned to help.

Next, Khairuzzaman Kamal (Executive Director, Bangladesh Manobadhikar Sangbadik Forum – BMSF) discussed the role of the media on HIV/AIDS related human rights issues in Bangladesh. In 1993, he described, BMSF and the community of grass-roots journalists started an HIV/AIDS and human rights program. From 1993 to 2005, BMSF served 214 journalists in 64 districts of the country through motivational work and training, and built-up a media network to raise awareness about human right abuses related to this issue. BMSF is currently conducting refresher workshops on stigma and discrimination regarding HIV/AIDS and launching media campaigns through local newspapers. Through these efforts, Kamal contended that they have contributed to creating an enabling environment for people living with HIV/AIDS and fostered prevention through information dissemination. He hopes to involve more journalists in this program in the future and continue to conduct refresher courses for those already in the network.

Finally, Dr. Peter Bourne (Chairman, MEDICC) talked about HIV and AIDS in Cuba. Cuba, he noted, has the lowest prevalence of HIV infection of any country in the world. This is due to several factors: 1) Cuba was the first country to set up an HIV/AIDS commission even before their first documented case; 2) HIV/AIDS was treated as any other infectious disease; 3) a comprehensive health care system was already in place; and 4) Cuba uses widespread HIV screening, which has been controversial. During the 1980s, for example, Cuba required anyone who had visited from a country with an HIV epidemic to be tested. Their first screening identified 99 people with the virus. In 1996, it was decided to isolate and quarantine AIDS patients for 6 months. Now that AZT has extended the life span of AIDS patients, Cuba has stopped mandatory hospitalization, but still offers it to those who wish to receive a treatment regimen. Once patients return to normal life, they can continue counseling and participate in support groups.

Session 2.4.5: Reducing HIV Stigma and Discrimination Through Rights Based Programming

Salon V
Moderator: Sofia Gruskin
Speakers: Karen Leiter, Sok Pun, Martha Chinouya
Rapporteur: Jennifer Scharff

Karen Leiter (Physicians for Human Rights) opened by discussing population-based approaches to addressing discrimination in the context of the AIDS pandemic. This approach includes the following methods: random or cluster samples with the help of local partnerships; surveys and case testimonies to assess the dynamics of human rights violations; remedial activities to stop human rights violations and advocate for change. Leiter shared the results of three different projects regarding people living with HIV/AIDS (PLWA) in Nigeria, Botswana and Swaziland, and Thailand. In Nigeria she found that a considerable number of health care professionals engaged in discriminatory practices against PLWA. The main factors contributing to this, she concluded, were a lack of knowledge about HIV/AIDS and lack of protective materials. In Botswana and Swaziland, Leiter found that traditional gender relations led to unsafe sex activities and domestic violence. For example, 53% of the women surveyed said that their partner refused to use a condom. In Thailand, she reported that low status (derived from gender inequality, poverty, statelessness, discrimination against ethnic minorities) leads to vulnerability to multiple human rights violations (torture, rape, lack of HIV/AIDS treatment) among adult women participating in trafficking, migration, labor exploitation or sex work.

Next, Dr. Sok Pun (CARE, Cambodia) talked about reducing stigma and discrimination, and increasing support and treatment of PLWA in Cambodia. This was done through partnerships with community villagers, Buddhist monks and other religious leaders to stimulate Metakaruna (loving kindness), and through the involvement of PLWA. Pun reported several interesting findings: the monks were approachable and often wanted to participate in community work; respect for minority religions was essential to building trust and understanding; people in positions of power who were able to meet PLWA changed their response to HIV/AIDS. Pun concluded that improving the beliefs and actions of individuals toward PLWA is sustainable. However, addressing societal and individual fears related to HIV/AIDS is a long-term process that requires maintaining advocacy and community mobilization at the local and national level.

Finally, Martha Chinouya (Ph.D., Nuffield Foundation Research Fellow) discussed how migrant Zimbabweans in England have harnessed evolving traditions of Ubuntu and Hunhu to address living with HIV/AIDS. According to Chinouya, Ubuntu/Hunhu traditions stress 'inter-connectedness' with others, and concern for dignity, respect, and humanity. She described The Chiware Project, which sought to understand the disclosure of HIV and stigma among Zimbabweans in England guided by these principles and found that they were able to create non-gendered spaces conducive to confidentiality, disclosure, and mutual support. She concluded that Ubuntu/Hunhu can be used as a resource for culturally sensitive research ethics and human rights related to health, as well as for those fighting HIV/AIDS related stigma.

Session 2.4.6: Roundtable on Children's Health

Silverbell Pavilion
Moderator: Roundtable
Speakers: Dipak Naker, Mary Lung'aho
Rapporteur: Katie Wootten

Dipak Naker (Raising Voices, Uganda) talked about violence against women and children and how to advance it as a human rights issue in the developing world. As he explained, there has been little coordinated response to this problem until 2003, when the U.N. General Assembly appointed a Special Rapporteur to explore the issue of violence against children. Research was conducted in 5 regions (both nomadic and urban) and included interviews of 1400 children and 1100 adults about what they understood to mean 'violence against children'. Based on the findings of this report and his own work in Uganda, Naker made several recommendations. First, violence is more than just an event; it is a pattern of behavior that needs to be changed. Second, involving children should be an integral part of the solution-making process. Third, interventions should not be presented as adults versus children, but should involve a sensitive and long-term approach.

Mary Lung'aho (Consultant, "Improving Infant and Young Child Feeding in Emergencies" program, CARE) discussed her work in emergency situations (e.g., Darfur, Northern Kenya) to support mothers with early infant feeding and care. Work in this area has found that breastfeeding for at least six months, good nutrition for the mother, and proper emotional care have significant long-term benefits for child development. However, mothers in emergency situations are often cut off from traditional support systems and need help getting appropriate feeding techniques to prevent child morbidity and mortality, Lung'aho stated. CARE is working not only with women but with people along the chain of responsibility to help support the mother and get the child off to the best possible start in life.

Concurrent Sessions 2.5: Friday Afternoon, April 15, 2005

Session 2.5.2: Food Insecurity (Nutrition)

Oak Amphitheatre
Moderator: Jennifer Kasper
Speakers: Sue Booth, Varghese Devasia
Rapporteur: Crystal Bailey

Jennifer Kasper (MD, MPH, President, Doctors for Global Health) opened with a discussion of her work on hunger, health, and human rights among children of Latino families in Massachusetts. Overall, 9.4 million people (including 3.1 million children) experience hunger in the United States, which Kasper defined as recurrent and involuntary lack of access to food as well as an uneasy or painful sensation caused by lack of food. From February 15 to June 15, 2002, she conducted structured interviews with Latino immigrant families in the greater Boston area with at least one child under 18 years of age. Among her results, she found that nearly 1 out of 2 families are experiencing hunger, which is 10 times the national rate. Furthermore, children in 1 out of 6 families are experiencing hunger, which is 20 times the national rate. Children living in a hungry family, she reported, are more likely to be reported in fair or poor health, use the emergency room, and have academic or behavioral problems.

Next, Dr. Sue Booth (NSW Centre for Public Health Nutrition, University of Sydney, Australia) presented her research on food insecurity among homeless youth in Australia. Specifically, she sought to determine the food intake patterns and experiences of homeless youth (aged 12 to 24 years) in inner city Adelaide and their implications for nutritional health. Booth administered questionnaires and conducted interviews, and found a prevalence of both hunger and lack of food variety among her sample. Furthermore, she also discovered unorthodox food acquisition methods, such as theft, begging, scavenging, and deliberate incarceration. Booth concluded that the right to food is more than simply a matter of proper nutrition; it is also a matter of human dignity that needs to put back on the political agenda in Australia.

Finally, Varghese Devasia (Professor and Principal, MSS Institute of Social Work, Bajaj Nagar, Nagpur, India) shared his work on malnutrition and death among Korku tribal children in the Melghat area of the Amravati District in Vidarbha, India. According to Devasia, Melghat is one of the worst affected areas in terms of death due to malnutrition, and the State Government is trying to cover up the severity of the problem. Thirty-one percent of Korku children die from malnutrition by age six. Ultimately, this problem is symptomatic of the degeneration of an ancient community whose members were once self-reliant and prosperous, he explained. The Korku are political outsiders, whose elders lack access to work and are prohibited from collecting forest produces. Mothers also lack information on illness, medical care, and nutrition. In order to survive, Devasia concluded, these people need basic human rights provisions such as access to employment, sustainable agricultural practices, and vocational training for women and children.

Session 2.5.3: Violence Against Women II

Dogwood Room
Moderator: Dipak Naker
Speakers: Muhsin Siddiquey, Amita Pitre, Veronica Agborga
Rapporteur: Julie Solomon

First, Dipak Naker (Co-Director, Raising Voices, Kampala, Uganda) discussed his work on the Domestic Violence Prevention Project in the Kawempe Division, Uganda. This project has been underway since 2000, and is a partnership between community members and non-governmental organizations to apply a rights-based framework to domestic violence (DV). In all, 40 in-depth interviews, 5 focus groups discussions, and 100 questionnaires were administered among both men and women to explore experiences of DV with current partners. Following this intervention, the majority of women and men reported decreased experiences of DV and increased activism in the community against DV, although there were differences between women and men. Overall, Naker found that by popularizing human rights, women became more empowered, men were held more accountable, and a culture of activism was created.

Next, Muhsin Siddiquey (Project Coordinator, PHL, CARE-Bangladesh) talked about her involvement in community-based initiatives on violence against women (VAW) in Bangladesh. Major interventions included conducting research to better understand the issue, facilitating community mobilization, promoting quality services for victims, and coordination with relevant duty bearers. Among their results, Siddiquey reported that interventions led to more cases of VAW being reported and treated, reduced discrimination at the family level, and greater interest in women's rights. Several keys to success, according to Siddiquey, include the involvement of males and religious leaders, promotion of human rights through local cultural avenues (e.g., folk songs, drama), and participation of women in local arbitration.

Amita Pitre (Safe kit Project, CEHAT, India) discussed the development of a Sexual Assault

Forensic Evidence (SAFE) Kit for women in India. The SAFE Kit is based on the Ontario Police Force kit used in Canada since 1998, but has been modified according to the needs of law enforcement in India. In general, the Kit is an attempt to involve health care providers in issues concerning violence against women and increase the chances of conviction for perpetrators, Pitre explained. But, the Kit can also serve as an educational and motivational tool, she added. A standard examination involves the following: 1) recording a full description of the incident, including evidence; 2) listing the gynecological and contraceptive history of the survivor; 3) documenting the results of a full physical examination; 4) assessment of the risk of pregnancy; 5) testing and treating for sexually transmitted diseases; 6) providing emergency contraception and, where legal, counseling on abortion; and 7) providing psychological support and referral.

Finally, Agborga Veronica (Nigeria Youth AIDS Programme, Lagos, Nigeria) efforts to protect the rights and bodily integrity of the girl child through the Nigeria Youth AIDS Programme. The objectives of this program were to assess youth needs regarding reproductive rights of women and the girl child, increase knowledge of the plight of women and the girl child in Nigeria, and train students to be advocates of gender and human rights. This was accomplished through a needs assessment, peer education training, and materials development. Interestingly, youth participants showed an eagerness to learn and develop skills for personal protection and leadership, Agborga shared. They also came up with their own solutions for addressing these issues, such as educating parents and elders, exercising disciplinary measures against violence (e.g., rape, incest, child labor), and raising awareness through the media.

Session 2.5.4: Rights Based Frameworks for Vulnerable Populations with HIV/AIDS II: Substance Users and Sex Workers

Salon III
Moderator: Timothy Holtz
Speakers: Karine Markosyan, Geetanjalee Khosla, Bou Molika
Rapporteur: Sarah Roberts

Karin Markosyan (Ph.D., MPH, International Policy Fellowships Program, Open Society Institute) discussed her research on Armenian HIV- and drug-related policies and human rights. She seeks to identify areas of conflict between the two, demonstrate that the lack of human rights-based policies limits effective responses to drug use and HIV, and propose recommendations for bringing the legislature into compliance with international obligations. She found four main areas of inconsistency between Armenian drug- and HIV-related policies and international obligations: 1) violations of rights to autonomy and privacy; 2) lack of promotion of the right to non-discrimination; 3) drug reduction projects have controversial status; 4) lack of participation of IDUs in issues affecting them. Overall, her recommendations stressed that the legal framework in Armenia has to be brought into full compliance with international obligations, particularly in terms of the relevant anti-discrimination statutes. In addition, laws that violate the human rights of IDUs and HIV infected persons should be repealed or restructured to better reflect public health concerns.

Next, Geetanjalee Khosla (B.A., B.S.W., M.S.W., Research Analyst, Community Health Department, Aga Khan Health Services, Mombasa, Kenya) talked about the application of rights-based approaches to the plight of injection drug users (IDUs). According to Khosla, HIV/AIDS and IDUs are emerging under conditions of poverty, high unemployment, punitive drug policies, and inadequate health care. Furthermore, IDUs unknowingly transmit disease to partners because they lack access to basic health services and information about HIV, as well as socio-economic

opportunities. While traditional approaches have stressed abstinence, behavior modification or punitive sanctions, Khosla recommended a rights-based perspective that operates at both the macro and micro levels. At the macro level, she stressed recognizing the link between HIV and poverty, prevention and treatment approaches in line with public health aims, and a broad network of harm reduction programs. At the micro level, she recommended including IDUs in program planning and implementation, granting rights to a range of treatment and care options, investment in socio-economic development, and reform of drug, welfare, and economic policies.

Finally, Bou Molika (CARE, Cambodia) discussed her involvement in the Sex Worker's HIV/AIDS risk reduction, Advocacy, Facilitation, and Empowerment Project (SAFE) in Cambodia. Overall, the project seeks to develop and promote a rights-based empowerment program focused on HIV/AIDS prevention for approximately 1,000 male and female sex workers, Molika described. More specifically, it employs the following strategies: 1) development of leadership skills and self-confidence among sex workers; 2) implementation of HIV/AIDS risk reduction program; 3) participation with national sex workers union in national advocacy for human rights. To date, achievements of the SAFE program include a higher level of HIV/AIDS knowledge among sex workers, effective links with the sex workers union, and increased self-confidence among sex worker leaders and peer educators.

Session 2.5.5: Sexual and Reproductive Health Policy

Salon IV
Moderator: Maurice Middleberg
Speakers: Dina Bochego, Alicia Yamin, Eszter Kizmodi
Rapporteur: Erin Jones

Alicia Yamin (Instructor, Harvard School of Public Health) opened with concerns about how to merge the concerns of both public health and human rights advocates. In her experience, there is not enough collaboration in the field to help realize the goals of both groups. There is an inherent problem of understanding, Yamin stated, but both groups need to speak the same language in order to work together. Public health advocates, for example, put a greater emphasis on indicators than human rights advocates. Contextualizing and empowerment of local groups are common issues that need to be coordinated, she said. This involves the need to understand local settings and gain insight from local groups as well as creating avenues for locals to combat their own problems. While a lot of work has been done in certain areas, Yamin concluded, certain issues and strategies are still contested and require more conscious interaction.

Dina Bochego (Population Action International) discussed the effects of U.S. policy restrictions on women's reproductive health. Foreign non-governmental organizations now face an impossible choice, Bochego stated. If they refuse U.S. 'gag rule' restrictions on abortion, family planning aid (including funding, technical assistance, and donated contraceptives) will be lost. If they accept gag rule restrictions, they must give up all abortion-related activities (including counseling and referrals, as well as the right to participate in public debate about unsafe abortion). In her experience, the impact of the gag rule has resulted in the closing of clinics (e.g., in Kenya and Tanzania) as well as the curtailment of community-based services (e.g., in Ethiopia and Ghana). The gag rule has also weakened HIV/AIDS prevention efforts, she said, because it neglects prevention and does not meet the needs of women and girls.

Eszter Kizmodi (Human Rights Advisor, World Health Organization) discussed how the U.N. treaty monitoring system can be used to advance sexual and reproductive health and rights. Using the example of the World Health Organization (WHO), Kizmodi explained that their approach is

unique in the sense that different ministries can act independently of each other. However, by bringing together different ministires, the treaty monitoring mechanism provides an opportunity for the U.N. to be a stakeholder in the process of advancing sexual and reproductive health. It is also very important, she stated, for U.N. agencies to act as a third party and contribute data and influence. WHO has also been effective in linking existing projects and working with different countries to improve reporting and assistance programs.

Finally, Maurice Middleburg (Executive Vice President, EngenderHealth) talked about current U.S. restrictions on funding for any organization that do not have a policy against sex trafficking and prostitution. Middleburg warned against the potential for this provision to be misguided. By taking a judgmental posture and stigmatizing these issues, the U.S. runs the risk of alienating the people we are trying to serve, because aid workers are discouraged from working with people in these industries. This policy, he added, may also limit freedom of expression and open debate on these issues, and sets a dangerous precedent for legalizing particular views on controversial social problems. Expression of opinion and open debate are crucial for devising a comprehensive approach to sex trafficking and prostitution, he concluded

Note: One additional presenter in the Rapporteur notes (Elaine) who is not in the program. Don't know who she is, since neither her last name nor affiliation is listed. Not included above.

Session 2.5.6: Roundtable on Reparations

Silverbell Pavilion
Moderator: Roundtable
Speakers: Joshua Bloom, Zelda Holtman, Chante Lasco
Rapporteur: Trinette Lee

Zelda Holtman (University of Cape Town, South Africa, in collaboration with the Centre for Health Policy, University of the Witwatersrand) opened with a report on the status of the South African Patients Charter (1996). Before 1994, she explained, health in South Africa was fragmented and racialized, with different quality of services for different groups. However, in 1996 the South African Patients Charter was formed with 12 rights (e.g., access to safe and health environment, informed consent) and 10 responsibilities (e.g., assume responsibility for own health, do not abuse healthcare system). Holtman described her project to monitor and assess the implementation activities of the Charter from 2003-04. Among patients, she found that both the use and awareness of the Charter was low, and numerous complaints were reported (e.g., long waits, discrimination, long distance to health facilities). Among providers, she also found low awareness of the Charter, and numerous complaints (e.g., overemphasis on patient rights, under-emphasis on responsibilities, lack of resources). Her recommendations for better implementation included active community engagement, better information dissenmination, and better training for health professionals.

Next Joshua Bloom (Research Fellow, London School of Hygiene and Tropical Medicine) talked about including peace-building objectives in post-conflict health sector reform efforts.
He hypothesizes that by including peace-building objectives in the reform and development processes of health systems emerging from civil conflicts, health sectors can contribute to stability and security by addressing underlying issues of conflict within their spheres of influence. These objectives include an emphasis on equity, non-segregation, professional ethics, and human rights, which are applied to policies, service provisions, human resource management, and education. The adoption of peace through health objectives can contribute to stability and security within conflict-affected health systems, Bloom stated, but the success of these efforts is dependent on a series of

variables, including: 1) the greater socio-political environment; 2) the scope and length of the conflict; 3) whether peace-building is imposed by outsiders or domestically driven; 4) whether there is strong positive leadership; or 5) whether there is a surplus supply or demand of health workers. Ultimately, a rights-based approach to health can lead to improved equity, transparency, and justice, but does not necessarily lead to improved health.

Finally, Chante Lasco (Clerk, International Criminal Court) spoke about addressing the healthcare needs of rape victims in post-conflict Sierra Leone. Among numerous atrocities committed during this conflict, anywhere from 215,000 to 257,000 women are estimated to have been gang raped, assaulted with foreign objects, or taken as sexual slaves, Lasco reported. As a result, these women continue to suffer from forced pregnancies, HIV/AIDS, fistulae, social isolation, and depression. While they urgently need proper treatment, rehabilitation, and counseling, several obstacles (e.g., limited resources, cultural attitudes toward rape) prevent these services from being properly implemented. While some programs have helped, more needs to be done to remove the stigma associated with rape, to pressure the government to prioritize women's health care needs when allocating resources, to include women in setting priorities, and to raise awareness of violence against women, according to Lasco.

DAY THREE: Saturday, April 16, 2005

Workshop Sessions 3.1: Saturday, April 15, 2005

Session 3.1.1: Working for Health System Equity – Strengthening Health Rights

Oak Amphitheatre
Speakers: Paula Braveman, Abhay Shukla, Thabale Jack Ngulube
Rapporteur: Jennifer Scharff

The first session in this workshop addressed the links between health equity and human rights. Paula Braveman (Professor of Family & Community Medicine; Director, Center on Social Disparities in Health, University of California, San Francisco, Center on Social Disparities in Health) referred to 'health equity' as eliminating disparities in health for socially marginalized groups. But, how does one measure this concept, she asked? There are conceptual, technical, and political difficulties involved in such an endeavor. Ultimately, measuring health equity requires examining differences between social groups, Braveman contended, and should involve three elements: 1) a measure of health; 2) a measure of social position; 3) a method of comparing the measure of health across social strata. Next, Thabale Jack Ngulube (Director, Centre for Health, Science & Social Research (CHESSORE)) discussed the Global Equity Gauge Alliance (GEGA) approach to health equity. GEGA activities, Ngulube explained, seek to convert research into action through three mechanisms: 1) assessment and monitoring; 2) advocacy; and 3) community empowerment.

The second session addressed advocacy for equity and human rights in health systems. Abhay Shukla (Senior Programme Coordinator, SATHI-CEHAT) described five phases of advocacy planning that included the following: determining advocacy goals and objectives; performing a stakeholder analysis; conceiving strategies and campaigns; formulating an action plan; and evaluating progress. There are also multiple groups who need to be influenced through advocacy, Shukla explained: those involved in the decision-making process; those who are affected; those with power and influence; those who have interest and can effectively support the cause. Next, Thabale Jack Ngulube shared his involvement in efforts to provide equity of access to cost-effective, quality health care to all Zambians. Ngulube described the key activities that were carried out in this regard,

including: conducting workshops to share information, identify issues, and stimulate action; community and public participation through drama, songs, religious sermons, and poems; monitoring and evaluation research to determine extent of the problems identified; advocacy and action; and determining the lessons learned.

Session three joined with the People's Health Movement Workshop for a presentation by Abhay Shukla on the Indian Right to Health Care Campaign as an example of a comprehensive approach to the 'right to healthcare'. In India, health tribunals are utilized to address different issues based on the needs of different areas, Shukla described. First, checklists are formed as a guide to what kind of services people should receive. Then, testimonies by community members are given to show how they have suffered physically and economically from lack of health care. The National Human Rights Commission has responded by holding monthly public hearings to address the denial of health care in various Indian states. Next, Paula Braveman discussed measuring health equity again, urging the need for disaggregated data that accounts for cross-cultural differences in how equity is defined. Data sources, she added, must have information on both health issues and the social group you are concerned with (e.g., socio-economic status, gender, race, etc.). Once this information exists, Braveman argued, it must be used for advocacy collaborations.

Session 3.1.2: Ethics and Human Rights

Dogwood Room
Speakers: Lesley Stone
Rapporteur: Whitney Fry

Stone (Senior Fellow, Center for Law and the Public's Health, Georgetown University Law Center) began this workshop by giving an overview of ethics from the standpoint of history and levels of moral discourse. She then presented a more lengthy discussion of bioethics, research ethics, and public health ethics. Bioethics are guided by specific moral principles of beneficence, respect for persons, and justice, she said. While guidelines for ethical research are contained in numerous documents (e.g., Nuremburg Code, Declaration of Helsinki, Belmont Report, and The CIOMS International Ethical Guidelines for Biomedical Research Involving Human Subjects). The general moral considerations for public health include producing benefits and distributing them fairly, preventing and removing harm, and ensuring public participation. Next, Stone presented a thorough introduction of the core principles and mechanisms of human rights (including the right to health), as detailed in several prominent declarations and treaties (e.g., U.N. Charter, Universal Declaration of Human Rights, International Covenant on Civil and Political Rights, International Covenant on Economic, Social, and Cultural Rights, and other regional and thematic instruments). Participants were then separated into three study groups and asked to analyze a specific issue area (public health, stem cell research or international research) based on the following questions: what are the human rights concerns that are involved?; what are the ethical concerns that are involved?; what are the ethical- and human rights-supportive actions that could be taken (before, during, and after)?

Session 3.1.3: Dual Loyalty and Public Health Policy

Hickory Room
Speakers: Laurel Baldwin-Ragaven (Henry R. Luce Professor of Health and Human Rights, Trinity College), Leslie London (Head: Health and Human Rights Division, School of Public Health and Family Medicine, University of Cape Town), Jack Bryant (Senior Faculty Associate, Johns Hopkins

School of Public Health), Len Rubenstein (Executive Director, Physicians for Human Rights)
Rapporteur: Megan Gaydos

The presenters started with a basic introduction to the topic of 'dual loyalty' (DL). Their attention to DL came out of the experience and role of health professionals in South Africa. During the apartheid era, they explained, the issue of medical ethics was severely compromised (i.e., white physicians compromised their care of black patients). The torture and death of Steven Biko is the most well known example. Therefore, this issue refers to the responsibility of a physician to a third party (i.e., someone other than the patient) and the conflicting interests that arise between the Hippocratic Oath and third party obligations. They shared other examples of DL, such as: the requirement in many U.S. states to report child abuse to authorities because it is believed to help the larger social good, even though it is also a breach of confidentiality; virginity examinations in Turkey to uphold social values, even though they have no medical value for women. Physicians should never be in the position to choose between patient and third party interests, they argued. The presenters then shared a set of guidelines and a catalogue of institutional mechanisms for clinicians to help protect against DL, which were developed by a working group that they organized with participants from approximately 18 countries as well as several non-governmental organizations (e.g., Amnesty International, International Committee for the Red Cross). Workshop participants also discussed personal experiences and several specific case studies involving DL, such as: a military physician who is asked to do non-medical work on sleep deprivation for policy formation; a school board that is interested in creating a sexual education curriculum and, because of funding availability, must consider whether or not to institute 'abstinence only' programs; responsibilities of NGO's toward the U.S. Global Gag Rule; the Von Mollendorf case – a hospital manager who provided ARVs to rape survivors at a time when the government opposed the distribution of these drugs.

Session 3.1.4: Using a Human Rights Framework to Monitor and Promote Health

Basswood Room
Speakers: Audrey Chapman, Judith Bueno de Mesquita, Eileen O'Keefe, Janet Asher
Rapporteur: Megan Price

Several references were suggested by way of introduction. Audrey Chapman (Program Director Science and Human Rights, AAAS) provided information about 'The Right to Health: A Resource Manual for NGOs'. Judith Bueno de Mesquita (Senior Research Officer (to Paul Hunt, Human Rights Centre) also recommended '25 Questions and Answers on Health and Human Rights' by the World Health Organization. Workshop organizers defined human rights monitoring as a systematic and preferably ongoing evaluation of the performance of governmental bodies, institutions, and other relevant authorities in meeting their legal obligations under international human rights law, regional human rights instruments, constitutional law, and specific legal statutes. de Mesquita talked about a variety of issues on this subject. She discussed the interconnectedness of human rights and health and the importance of collecting disaggregated data. This can be a problem, however, when insufficient information or budgetary allocations have been collected. Conflicts with donors can be a particular problem, de Mesquita said, because they have their own set of definitions and funding criteria. She also talked about the use of regional and national law, international treaties and covenants, and NGO reports to monitor human rights.

Next, Audrey Chapman discussed 'why' and 'how' people monitor. While states may ratify treaties, she noted, this does not mean that treaty provisions will be automatically implemented. Therefore, monitoring strategies are an important component of the implementation process. Yet,

this issue is complicated by the fact that different states have varying levels of resources to allocate to particular human rights needs. In this regard, it would be helpful if there were core minimum obligations which all countries needed to fulfill to be in compliance with a particular international human right, Chapman argued. The goal here is to make minimum standards as broad as possible but no unreasonable for states to implement. If a country does not fulfill its core obligations, 'naming and shaming' has been an effective strategy, she said. Eileen O'Keefe (Senior Lecturer Philosophy and Health Policy, Human Rights & Social Justice Research Institute) also talked about health impact assessments (HIA) as a method to monitor the effectiveness of proposed policies. At the moment, IMPACT is working to develop a methodology for HIA to be used in the context of European Union policies, she said. O'Keefe recommended a recent issue of the Bulletin of the World Health Organization (vol. 81, no. 6, 2003) which has many articles about HIA, as well as a book entitled 'Fatal Indifference' about the G8. Judith Bueno de Mesquita then discussed the difficulties in making budget monitoring a manageable exercise, such as the fact that some countries are unable or unwilling to provide budget data or that many countries have budgets allocated to different ministries, which write separate annual reports. She recommended FUNDAR (Mexico) as a useful resource on budget analyses for the right to health. Finally, Janet Asher (Consultant, StatAid) talked about data quality measures, such as the use of random samples, test questionnaires, and proper statistical techniques. Stataid.org is a non-profit that pairs statisticians with organizations that need help, she concluded.

Session 3.1.5: Human Trafficking, Health, and Human Rights

Azalea Room
Speakers: Jaime Calderon, Ashley Garrett, Alice Miller, Brian Willis
Rapporteur: Emily Henken

Ashley Garrett (Project Manager - Trafficking in Persons, International Organization for Migration) opened the workshop with an overview of human trafficking from a victim's perspective. She explained several root causes of this phenomenon, including: the globalization of poverty; lack of opportunities/unemployment; marginalization and abuse of women/girls; feminization of migration; lack of information on safe ways to migrate; and social and political conflicts. Garrett then talked about how trafficking works, describing several key stages (recruitment, transit, exploitation, escape and/or rescue, return, and reintegration or integration). She concluded by reminding participants that not all trafficking occurs in the same way. The local context and specific situation will determine who is most at risk and how they are exploited, which significantly impacts identification and assistance mechanisms.

Next, Jaime Calderon (Senior Migration Health Physician, International Organization for Migration) talked about health and the trafficking process from a service provider's perspective. Overall, the number of women and children who are trafficked is greatly increasing, Calderon stated. Furthermore, as the victims get younger, the prevalence of sexual exploitation increases. While there are numerous intervention strategies (e.g., information exchange, protection and assistance, and prosecution of traffickers) there is not enough attention to the serious health concerns that arise from this practice, Calderon stated. In general, the trafficking process at all stages involves various risks that will tremendously impact the health and well-being of a trafficked individual. These risks include sexual and reproductive health issues (e.g., sexual abuse, complications with pregnancy, HIV/AIDS) as well as mental health issues (e.g., depression, suicidal thoughts, schizophrenia). Trafficked children and adolescents are particularly vulnerable and need special health needs, according to Calderon. Brian Willis (Health Advisor, ECPAT-USA) also talked about public health

issues, but emphasized the need to use data to improve services to trafficked individuals. According to Willis, there is little data on this population, but it is greatly needed in order to protect other potential victims. He identified various barriers in this regard, such as the fact that victims are not allowed to share information, uniform data collection is not used, mutual goals go unrecognized, and non-governmental organizations are not trained or funded to collect data. What is needed to improve the quality of data, in addition to uniform collection methods, are increased monitoring of trafficking victims and evaluation of programs. Alice Miller (Assistant Professor, Law and Policy Project, Columbia University School of Public Health) also noted that state are using different definitions of trafficking in their quantitative data collection methods, even though the Palermo Protocol created a solid definition. Miller concluded that the codified principles in international treaties should be used to do several things: 1) stop the harm caused to trafficking victims; 2) hold the state accountable for these violations; 3) confirm the root conditions that make people want to migrate in the first place.

Session 3.1.6: Health for ALL NOW!: A Workshop on Mobilization and Action with the People's Health Movement and PHM: USA

Emory Amphitheatre
Speakers: Lanny Smith, Lexi Bambas, Abhay Shukla
Rapporteur: Raj Panjabi

Lanny Smith (Global Health Advisor, Montefiore Primary Care/Social Med, AECOM&PHM) opened the workshop with an introduction to the People's Health Movement (PHM). The PHM has a relatively long history, Smith explained, dating back to the Declaration of Alma Ata (1978) which sought to secure 'health for all' by the year 2000. In 2000, the Peoples Charter for Health was approved at the Peoples Health Assembly in Savar, Bangladesh. In addition to proclaiming health as a fundamental right, its preamble states that inequality, poverty, exploitation, violence, and injustice are the roots of ill health. Therefore, to secure 'health for all' means challenging powerful interests, opposing globalization, and drastically changing political and economic priorities. As a basis for policy, the Peoples Charter states that governments have a fundamental responsibility to ensure access and quality of health care, and that peoples organizations are essential to the formulation, implementation, and evaluation of health programs.

Next, Lexi Bambas (Consultant, Global Equity Gauge Alliance) talked about Global Health Watch and the mobilization of civil society around an alternative World Health Report. Global Health Watch, Bambas explained, seeks to achieve the following: counter-balance the prevailing orthodoxy around market-based health care reforms; shift from technocratic, disease-based approaches to ones that recognize the importance of comprehensive health care and multi-sectoral action; performance monitoring of key global health institutions; challenge commercial/corporate interests. A website has already been launched (www.ghwatch.org) as well as regular publication of the Global Health Watch Newsletter. In addition, they have entered into formal communication with the World Health Organization and plan to coordinate with G8 campaigns on poverty and climate change. Bambas urged people to get involved through various means: submit testimonies and case studies; initiate local, national or regional watches; fundraising; or translation.

Finally, Abhay Shukla (Senior Programme Coordinator, SATHI-CEHAT) discussed the Indian Right to Health Care campaign, led by the People's Health Movement. According to Shukla, this campaign emerged in India due to the serious deterioration in public services (including declining public health budgets) since the mid 1990s, a sharp rise in costs of unregulated private medical care, and a growing resistance to the negative social effects of globalization. One of the first steps in this

campaign was the organization of people's health tribunals. This is like a 'people's court', Shukla explained, which is attended by hundreds of community members, relevant health officials, and a 'judging' panel of experts. Affected persons (or family members) present their testimonies where basic health care has been denied. Health officials are allowed to respond and panelists give their opinions in the end. These tribunals are widely covered by local media and has the effect of identifying gaps in government services and puts pressure on the health department to make improvements. Shukla described several specific tribunals in Maharashtra, Mokhada, the Pune and Sangli districts, as well as public hearings on health care at the regional and national levels. Sangli concluded that the practice these efforts in India show that with some orientation and simple tools, ordinary people and local activists can document the denial of health care and audit health facilities.

Session 3.1.7: Human Rights Methodology for Human Rights Results: The Tostan Experience in Senegal, Africa

Beech Room
Speakers: Molly Melching
Rapporteur: Crystal Bailey

Melching (Founder and Executive Director, Tostan) started the workshop with a 'proverb exercise', where participants were given half of a proverb and told to find the person with the other half. Once they found their partner, participants had to get to know each other, and explain the proverb to the group. Then the group as a whole attempted to come up with a new proverb. In the next exercise, Melching conducted two mock sessions of village meetings that Tostan conducts in Senegal, Africa. Tostan is an international non-governmental organization that seeks to contribute to the dignity of African people through the implementation of a human rights-based, non-formal, participatory education program in national languages. The program has been implemented in over 1,500 communities in 11 regions of Senegal. It is funded mainly by UNICEF Senegal and has been extended to the Sudan, Burkina Faso, and Guinea. Each program session lasts 2-3 hours and covers topics ranging from hygiene and health to literacy training and micro-credit. It also seeks to actively involve participants with little or no formal schooling using a combination of modern and traditional techniques, such as theater, games, artwork, song, and sharing personal experiences. The mock sessions focused on issues of individual dignity and human rights using pictures and drawings.

The next part of the workshop focused on the right to be free from all forms of violence. The group discussed different types of violence against men, women, and children, as well as individual responsibility related to violence. After this discussion, they divided into groups and came up with forms of education (theater, poetry, etc.) that could be used to address this issue. Next Dr. Garry Mackie discussed the issue of ending excision in Africa. Mackie argued that if people used the same methods to end excision that were used by the Chinese to end footbinding, excision would be eradicated. The practice of footbinding ended through modern education campaingns, which explained the disadvantages of bound feet, and public declarations against this practice. Dozens of costly interventions across Africa have been conducted over the years, with almost no change in behavior towards excision, he explained. However, the work of Tostan in Africa utilizes a very similar approach to that used by the Chinese. Mackie concluded that a rapid and universal end to excision is possible with the appropriate strategy and effort through human rights based education, organized diffusion by people themselves, and a convention shift by public declaration.

Session 3.1.8: Structural Violence, Social Capital, and Sex Workers: A United States Perspective

Maple Room
Speakers: Alix Lutnick
Rapporteur: Elizabeth Hamilton

Lutnick (Research Coordinator, St. James Infirmary) prefaced her discussion by stating several general objectives: to talk about how human rights are applicable to working with sex workers; to use information about sex work to be instructive rather than 'titillating'; to abstain from notions of 'right' and 'wrong' regarding this issue. The workshop then moved to a discussion of defining sex work. The term 'sex work', Lutnick stated, was coined by Carol Leigh in 1979 and is intended to overcome division and hierarchy, and serve as a basis for advocacy. Next, Lutnick discussed relevant human rights documents that pertain to sex work (Articles 23 and 25 from the Universal Declaration of Human Rights; Article 11 from the Declaration on the Elimination of Discrimination against Women) as well as the World Charter for Prostitutes' Rights (1985) and draft statements from the 2nd World Whores' Congress (1986). The World Charter for Prostitutes' Rights brought attention to issues of economic and physical exploitation of those involved in sex work, Lutnick explained. Prostitutes are not provided the freedom to choose the conditions of their work, the Charter noted, and mandatory health checks are often stigmatizing and discriminatory. Lutnick added that prostitution laws violate the rights to personal autonomy, dignified employment, privacy, disclosure, and consent.

The situation of sex workers can be conceptualized as an instance of 'structural violence', according to Lutnick. The structural violence model, Lutnick explained, redefines violence as any barrier that limits or prohibits an individual from attaining desirable living conditions. Furthermore, it asserts that chronic and pervasive conditions of poverty, lack of resources, and racism result in some groups being targeted instead of others. Participants then discussed these different types and how they impact the health of sex workers. Lutnick also discussed the notion of 'social capital' and how it is related to the situation of sex workers. Social capital refers to the stocks of social trust, norms, and networks that people can draw upon to solve common problems, Lutnick explained. Those connected to these networks experience benefits which increase their value. Ultimately, Lutnick wanted to explore ways in which to eliminate the structural violence that sex workers experience by increasing their social capital. Examples of work by the St. James Infirmary in San Francisco, the Adult Industry Medical Health Care Foundation in Southern California, and in social epidemiology highlighted this concern. Lutnick concluded by discussing the tension between being political advocates while maintaining a non-profit status.

Session 3.1.9: Prison Health in U.S. Controlled Prisons: Uplifting Prisoners' Rights to Preserve Human Rights

Mountain Laurel Room
Speakers: Corey Weinstein, Bobby Cohen, Maddy DeLone, Gretchen Rohr
Rapporteur: Katie Wootten

The morning program examined the content of specific human rights instruments that relate to the incarcerated population. Dr. Corey Weinstein (Chair, Jail and Prison Health Committee, American Public Health Association) began by discussing the International Covenant on Civil and Political Rights (ICCPR) as well as the U.S. Constitution. He dealt specifically with how the ICCPR

addresses incarcerated persons in articles 2, 3, 6, 7, 8, 10, 18, and 27. Next, Maddy DeLone talked about the Convention against Torture. She looked specifically at how torture is defined and how it is related to issues of detention and restraint in articles 2, 4, 10, 11, 13, and 14. DeLone then reviewed the relevant provisions from the Standard Minimum Rules for the Treatment of Prisoners concerning young people, health/medical services, discipline/ punishment/restraint, and personnel, as well as guiding principles related to dignity and dehumanization. Dr. Bobby Cohen discussed the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. Dr. Cohen provided an overview of all of the chapters, including how committees gather reports and formulate standards. Cohen also talked about the WHO Health in Prison Project and how it is in the process of developing standards of care and the provision of technical assistance. Then, Dr. Weinstein highlighted relevant ideas from the Basic Principles for the Treatment of Prisoners that had not been discussed previously. Maddy DeLone reviewed various ethical and legal duties outlined in the American Public Health Association Standards for Health Services in Correctional Institutions as well as issues of consent/refusal, confidentiality, prisoner research, torture, and the right to life. Before the lunch break, Dr. Weinstein discussed the Oath of Athens within the context of 'dual loyalty' and violence within the prison system.

In the afternoon session, workshop organizers addressed how the principles and rights that had been previously discussed have been advanced or implemented. Gretchen Rohr and Maddy DeLone discussed the lack of attention to mental health issues within prisons. DeLone also talked about problems with the death penalty concerning convicted persons who are put to death but later found innocent. Finally, Dr. Cohen concluded with examples of 'routine' lack of medical care for prisoners with obvious medical needs. While these are extreme examples that get significant media attention, he said, they highlight the worst of what can still happen to imprisoned persons.

Session 3.1.10: Implementing the Right to Health of Indigenous Peoples

Poplar Room
Speakers: Clancy Kelly, Shaun Ewen
Rapporteur: Julia C. Dawson

Shaun Ewan began with a discussion of the relation of colonization to the status and health of indigenous peoples. Colonization, he argued, has structured not only how they experience health, but how they are defined as a people. There are various definitions of 'indigenous' put forth by the United Nations, International Labor Organization, and the World Bank, as well as individual nation-states, Ewan explained. Many of them rely on self-identification, identification by others, or genetic characteristics. This is intended to allow a person to choose how to be identified, but it is also more difficult to track genealogical connections since genocide and assimilation campaigns were so successfully implemented by colonizers. Recently, both the Canadian Aboriginal and the Aboriginal and Torres Island Approaches to have attempted to be more holistic in defining aboriginal health, emphasizing spirituality and 'well-being'. Nonetheless, available morbidity data shows significant disparities between indigenous and non-indigenous peoples. They also experience higher infant mortality and lower infant birth weight rates, while social exclusion has led to higher imprisonment rates. Ewan also showed that geographical areas which endure the greatest mineral/natural resource extraction also have the highest concentration of indigenous peoples. Ultimately, he concluded that international human rights mechanisms can be used to 'name and shame', as well as to identify disparities and hold government actors accountable.

Next, Clancy Kelly (Ph.D. Student, Melbourne Law School, University of Melbourne) spoke about indigenous peoples' right to health in international law. Due to their experience with

colonizers, Kelly explained, most indigenous groups do not strive to discuss rights in the context of a particular nation-state, but instead strive for self-determination and improved living conditions. To date, the right to health is explicitly recognized in five international treaties, all of which include indigenous groups. Australia and Canada have ratified all of these treaties. The United States, on the other hand, has on ratified two and therefore has limited obligations to indigenous peoples within its borders. Kelly reviewed the relevant provisions in treaties drafted by the United Nations, International Labor Organization, Organization of American States, and the World Health Organization. Many of these are more sensitive to the involvement and viewpoints of indigenous peoples as well as their way of life. Kelly also discussed the deficiencies of the monitoring process by the U.N. Economic and Social Council (which receives state reports on the performance of treaty obligations) and contended that its work with the rights of indigenous peoples could improve by creating general comments and naming benchmarks to measure and record progress on the status of health conditions. Kelly then a ddresses comments and questions about the 'general comment' mechanism as a tool to improve the U.N. infrastructure, as well as the role of NGOs in advocating for the right to health for indigenous peoples.

Session 3.1.11: Disability Rights as Human Rights: Applying a Disability Inclusion Lens to Public Health Programming

Salon IV
Speakers: Janet Lord, Kathy Guernsey, Nora Groce
Rapporteur: Julie Solomon

Kathy Guernsey (Director & Legal Counsel, Lord, Guernsey & Associates LLC) began the workshop with a discussion of how disability has been defined and conceptualized, as well as how it has been addressed in international human rights instruments. Guernsey noted that there is no internationally accepted definition of 'disability'. While it should be broadly defined to include the full spectrum of disabilities (physical, mental, sensory, learning, intellectual), previous medical models have led to stereotyping and discrimination, she argued. A medical model makes several assumptions about the disabled person, Guernsey explained: they are 'sick' and need to be cured by doctors; they need charitable assistance; they will always be dependent on others; and they are 'abnormal'. A social model, on the other hand, assumes that disabled persons are not the problem; they are normal people who need to overcome barriers created by society (legal, physical, attitudinal, informational). If barriers are removed, she argued, people with disabilities are fully capable of leading independent lives. Several core human rights instruments were also discussed in the context of disability, such as the Universal Declaration of Human Rights, International Covenant on Economic, Social, and Cultural Rights, and the Convention on the Rights of Migrant Workers, as current efforts to draft a formal disability convention following the U.N. General Assembly Resolution 56/168 introduced by Mexico.

Next, Nora Groce and Kathy Guernsey examined several examples of how disability has been integrated into public health programs, specifically regarding HIV/AIDS and landmines. In general, it is difficult to know the rate of HIV/AIDS infection among the disabled because there is no documentation or data on this population, Groce explained. In addition, there are no preventative awareness programs for the disabled regarding HIV/AIDS, especially in Africa where it is needed most. Land mine awareness, Guernsey explained, is growing as survivors have increasingly protested the use of these weapons. However, victims assistance has not been implemented successfully, partially due to lack of funding. The stigma attached to disability has often segregated land mine survivors from the rest of the population, and denied them the choice of being where

they want to be.

Finally, Janet Lord (Director, American University, School of International Service Summer Human Rights Institute) talked about disability as a component of inclusive development programs. Inclusive development, Lord explained, ensures that persons with disabilities are recognized as rights-holding members of society who must be actively engaged in the development process. It also means that development institutions, policies, and programs must account for their impact on the lives of persons with disabilities, consistent with international human rights standards. Rule 21 of the U.N. Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993) has already made such recommendations, but there is still a long way to go before disability is fully incorporated into development organization programs, she added. Lord also addressed efforts to address this issue by USAID, the World Bank, and the European Union. Finally, inclusive development reinforces the need for public health programming to include non-discrimination in access to health care services and health information, as well as recognizing sexual and reproductive health rights and the rights of people with mental disabilities.

Session 3.1.12: Promoting Social Reintegration Post Conflict Settings

Salon V
Speakers: George Tobaiwa
Rapporteur: Ali Khawar

Tobaiwa (Theme Group Advisor - Livelihood and Assets Creation, CARE Sierra Leone) began with background information on Sierra Leone and then talked at length about its ten-year civil war as well as intervention strategies by CARE to rebuild communities and promote social reintegration. During the war, 500,000 people were living as refugees and 4.4 million were internally displaced. The causes of the war, according to Tobaiwa, were numerous: Chiefs controlled all livelihood resources such as productive land; youth were denied access to rights and ownership of property, and made vulnerable to mobilization for war; and lack of transparency and accountability in the distribution of food aid. People experienced horrific human rights abuses during the war, he added, such as the destruction of property, social services (health, education) were destroyed, and children were recruited to fight as early as 5 years old.

A crucial element of CARE's approach to social reintegration and cohesiveness involved participatory planning. Mutual discussion, Tobaiwa said, is a platform to heal the wounds of war. In the process, residents forget about the war and their trauma, and start to thing about the future. The election of committees was very important, in this regard, as was the inclusion of women and children. Marginalized people also went through 25 training sessions where they were taught basic skills, which they shared with the rest of their village. Through this process, women built up a lot of confidence, he said. Through the inclusion of marginalized groups and skills development, villagers were able to assess their own resources and become primary actors for their own development. They are now working with the same communities on other projects and have built on what they originally started.

Following this information session, Tobaiwa had participants introduce themselves as an icebreaker for discussion. Then he had them look at one of CARE's survey reports and answer a series of questions dealing with the identification of major human rights issues. They reported these findings to the whole group and discussed a variety of issues regarding the inclusion of women, encouraging participation, the role of non-governmental organizations, the political implications of development work, and strategies for future work.