OPEN SOCIETY INSTITUTE
Public Health Program

Law and Health Initiative
Expert Consultation:
How Can Training of Health Providers Be Effectively Used to Promote Human Rights in Patient Care?

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Meeting Report

Jonathan Cohen, Director of the Law and Health Initiative[1] welcomed the participants and after a round of introductions situated the meeting and provided background information on the work that LAHI undertakes in the area of health and human rights and its focus on the marginalized populations. He highlighted LAHI's efforts in training lawyers and human rights advocates on specific health issues, and on strategies such as human rights documentation and strategic litigation. Jonathan cited examples of LAHI's previous and on-going activities, such as Practitioners' Guide project; work with law clinics; Health and Human Rights Resource Guide; integrating health and legal services; etc.

Jonathan explained that LAHI faces an **increasing demand to provide human rights training to health providers** as a complement to this strategy, however, LAHI lacks the experience or expertise with reaching out to this audience or evaluating proposals to do so. For LAHI, the ultimate goal of such trainings would be a reduction of human rights abuses against specific patient groups, i.e. people living with HIV, people needing palliative care, LGBTI communities, sex workers, IDUs, and Roma.

Among the **goals** for the Expert Consultation Jonathan specifically mentioned better preparedness to evaluate funding proposals for human rights trainings of health providers and to design our own initiatives in this area and expansion of the network of external experts who can assist us in these efforts.

Following Jonathan's introduction, Tamar Ezer, LAHI Program Officer, provided an overview of the agenda (please find complete agenda in the Appendix).

The meeting continued with a panel discussion on whether training can change practice. The panel was followed by break-out group work focused on mapping trainings of health

[1] Law and Health Initiative (LAHI) was established in 2006 as a division of the Open Society Institute Public Health Program. It supports collaborations between health and legal practitioners with a view to advancing the mutually shared goals of human rights, human dignity, and open society. LAHI both builds the capacity of health providers to use the law to advance their advocacy objectives, and supports legal practitioners in expanding their remit to include public health.

providers by audience and training type, evaluating a sample proposal, and designing a Law and Health Seminar on human rights training for health providers.

The meeting participants included OSI's Law and Health Initiative staff, coordinators, several consultants, advisors, as well as staff of the Public Health Program and Soros National Foundations[2], and six external experts on human rights training of health providers. Among the experts were Virginia Chambers, Senior Adviser at Ipas; Givi Javashvili, Head of Family Medicine Department and Full Professor at Tbilisi State Medical University; Sarah Kalloch, Outreach and Constituency Organizing Director at Physicians for Human Rights; Robinah Kaitiritimba from Uganda National Health Consumers' Organization (UNHCO); Suren Krmoyan, Legal Adviser to Minister of Health of the Republic of Armenia; and Millie Solomon, Associate Clinical Professor of Medical Ethics & Anaesthesia, Harvard Medical School and Vice President, Education Development Center, Inc., an expert in ethics education and behavioural change. For more details on the meting participants please peruse the Participants' List and Contacts in the Appendix of the present report.

Discussion on the meeting objectives

Participants shared examples of previous attempts providing human rights trainings of health workers and expressed initial thoughts on pertinent factors, i.e. legal frameworks, mobilization of necessary resources, barriers and limitations, appropriate timing, the role of professional societies, and the presence of a robust non-governmental sector.

The participants also commented on the importance of focusing on ethics and culture and transforming the health system. There is also a need to explore the extent to which human rights are in danger of being perceived as an impediment in the context of crumbling infrastructure and lack of resources, which is increasingly the case in Africa. In Africa, doctors may go to great length to provide care and do not resist the notion of human rights itself, but may feel violated themselves by having to work under inadequate conditions and with a deteriorating infrastructure. Human rights trainers need to reassure providers that their rights are important and work together to identify characteristics of environments that are conducive to respecting the human rights of both providers and patients.

In the traditional region[3], where patients' rights violations are pervasive, health care providers also tend to consider human rights as a barrier. Participants noted that whereas legislation is important as an external motivating factor, an ethical framework is much more effective as it cultivates an internal drive for professionalism and respect of human rights of patients.

Participants noted that trainings will have different approaches depending on how the audience is viewed - medical professionals as violators or protectors of rights of the vulnerable groups.

[2] LAHI consultant Judy Overall; LAHI advisors Balázs Dénes, Joanna Erdman, Liesl Gerntholtz, and Dmytro Groisman; Director of PHP Public Health Watch Cynthia Eyakuze; OSISA HIV and AIDS Program Director Vicci Tallis and OSIAF Deputy Director for Programs David Amiryan.
[3] Countries of the former Soviet Union and Central and Eastern Europe.

The WHO definition of health[4] was mentioned and it was noted that health should be viewed broader than lack of disease and that doctors are well positioned to act as not only protectors, but also as advocates of human rights.

Interest in exploring who is best positioned to provide trainings was expressed (lawyers or someone else?).

Jonathan concluded the discussion by affirming that transforming the ways in which medicine is practiced is LAHI's overall objective.

Plenary Panel: Can Training Change Practice?

The panel included Virginia Chambers, Givi Javashvili, Sarah Kalloch, and Millie Solomon. The plenary discussion was moderated by Jonathan Cohen and was aimed at identifying dos and don'ts[5] for ensuring that human-rights trainings actually change the behaviour and practice of health providers. Each panelist answered the following questions in relation to the human rights trainings they have conducted[6]:

- What change in behaviour or practice did you seek through training?
- How did you set about accomplishing this?
- What sustained or derailed this effort?
- If it did not work, why not?
- What would you have done differently?
- Any indications of success?

The panelists' presentations were preceded by a case study introduced by Delme Cupido, LAHI Coordinator from Southern Africa. Delme started the session by sharing with the panellists his own experience in conducting a series of human rights trainings of health providers, when employed by a public interest firm in Namibia that served as a one stop shop for human rights and health work. Delme identified a number of problems, including, but not limited to the following:

- No buy-in from senior leaders;
- Providers do not agree with the case against them and often feel defensive;
- Wrong assumption about the reasons why providers may not observe human rights of their patients;
- One off nature of the trainings.

According to Delme, it was difficult to tell whether the trainings succeeded or not, as they took place as ad hoc interventions with no follow up. Delme stated that behavioural changes did not occur as the firm's clients continued coming back with the same complaints of violations.

The panellists recognized the issues relayed by Delme and shared their experiences and methodologies for improving training outcomes and achieving behavioural change as a result of trainings.

[4] Health is a state of complete physical, mental and social well-being and not the mere absence of disease or infirmity.
[5] The full list of identified Dos and Don'ts can be found at the end of this report.
[6] Papers outlining training methodologies and outcomes, as well as on countries' contexts, drafted by the experts can be found on OSI's KARL Equal Partners community. Please also find the list attached at the end of the report.

Drawing on many years of experience of providing training to more than 40 thousand health care workers in countries with strong cultural taboos about issues such as abortion and sexual violence, **Virginia Chambers** suggested that among reasons why laws were not adhered to can be absence of knowledge of the legal requirements or presence of regressive laws. She underscored the importance of planning training as one of many interventions and tools to reinforce a message and asserted that the strategic approach involves initial assessments, mapping outcomes, and developing a strategy in which training is one of many components. She identified the following steps as important:

- Map out stakeholders;
- Think of the audience, make it simple for them;
- Consider the outcomes of specific trainings (outcomes will be different for managers, providers, etc.);
- Have a checklist of provider incentives for respect of rights within the system;
- Install visual reinforcements throughout the health system;
- Diversify the channels of communicating the message and use different tools;

Virginia highlighted the importance of making human rights concrete.

On reducing the costs of training, she made the following recommendations:

- Work collaboratively in teams to lower costs;
- Develop observational tools and audit occurring violations; then prioritize which violations must be addressed first (e.g. there are key 5 violations in this setting – here is what we focus on);
- Forge alliances with educational institutions.

Virginia mentioned the importance of utilizing appropriate adult education methodology; relational learning tools and materials; and engagement in systematic follow up.

Virginia agreed that measuring long-term outcomes of training can be difficult to gauge and that appropriate long-term process indicators are necessary. She said that at Ipas, they work on two levels. Firstly, when engaging medical students, they try to foster a culture of respect for human rights. Knowledge and behaviour change among students is assessed through immediate observational evaluation tools and a scheme of quantitative and qualitative indicators. Secondly, to truly evaluate change, there is a need to look at practitioners and undertake a long range study. Virginia mentioned that one of the difficulties with evaluating long-term outcomes is related to establishing direct cause and effect as there are many intervening factors at play. But she said it is still possible to collect self reporting data and other supporting evidence.

Millie Solomon who has more than 30 years' experience researching, designing, and evaluating a wide variety of education and quality improvement programs for health professionals, health care organizations, and the public, agreed with Virginia's laying out of the terrain and that one-off trainings focusing on an individual level cannot accomplish much. She outlined the following model for planning and conducting more effective trainings:

- Conduct a diagnostic workup to help identify the key players;

- Target multiple audiences and secure buy-in from senior level staff ("it is unethical to empower individuals of lower lever, unless they are going to be supported by their superiors");
- Training should be a piece of this overall effort of changing attitudes ("training is a term not capturing what education is all about. Education is more than training and is more concerned with ways to get in touch with our own spiritual ideals. Training creates an expert/non expert paradigm and is therefore less conducive to learning").

Millie advocated for a systems approach which needs to be aligned with the training participants' aspirations. She promoted a strategy of alignment, which as a concept requires an attempt to appeal to people and "get people to tap into something in themselves to connect with what we are promoting". On engaging the participants, Millie suggested that beginning with a case study, documentary or other video footage can be effective, yet low cost ways to achieve this. She said that films can be crafted carefully to frame issues in ways that are motivating and inspire leadership. "It is all about mobilising people from their positive place".

Millie emphasised the importance of fostering leadership and bringing opinion leaders who control their work environment on board and creating incentives for them. Millie cited an example of transformational learning from a pediatric palliative care training when bereaved relatives were brought in the room and given an opportunity to speak form their perspective. "The vibe was different".

In her presentation, Mille also underscored the significance of relational learning[7]. On the notion of relational learning, she made the following observations:

1) Relational learning is about learning from peers. Education often continues to be didactic ("pouring expertise into others"). The real learning has to come from how we treat and learn from each other.

2) Relational learning is interdisciplinary. Rather than brining nurses only, go across disciplines. Deal with power relationships. Identify contexts that would be stimulating to both groups and be creative about ways of bringing in participants' experiences.

3) Relational learning also looks across the entire continuum of care Patients travel through many settings. Bringing representatives of the various settings together can be very powerful.

In her presentation on the subject, **Sarah Kalloch** from the Physicians for Human Rights (PHR) emphasised fostering leadership. Her organization, founded 20 years ago, has rich experience in dealing with human rights in custody settings and conflict environments,

[7] Relational learning stems from the premise that the most important learning that needs to occur in healthcare will happen in the context of relationships – among colleagues of the same and different disciplines and with patients and families. According to this approach, professional education should not be construed solely as an independent process of acquiring knowledge and skills that solitary learners can do on their own. Rather, when social and ethical norms are the focus of the change effort, education should include opportunities for an interdependent process of social participation (as described in paper *Promoting Human Rights in Health Care Settings: Strategies for Aligning Organizational Culture and Professional Practice with Ethical Norms* by Millie Solomon).

where violence is always an issue, and has accumulated extensive knowledge on developing health systems with respect for human rights.

Sarah shared that most of the trainings conducted by PHR are not institution-based. Rather, these are NGO-based trainings aimed at nurturing advocates among healthcare professionals. Sarah described examples of working with partners in the famine driven regions of East Africa on trainings for medical students, doctors, and nurses aimed at improving clinical understanding of human rights and developing a change-driven environment. "There is a health and human rights quiet revolution happening in Uganda", she said. "Professional associations are coming on board, Paul Hunt[8] did a lot of work. But it is hard. Systems in Uganda and Kenya are overburdened and providers of care are overwhelmed".

Sarah warned against the pervasive "workshop culture" and stated that human rights training simply cannot be in this category. She recommended that the training context should ideally be set by participants and encouraged peer-led ToTs involving people who can bring the knowledge and skills back to their peers.

She suggested that one of the early priorities during the initial training stage should be clarification of values. It can take the form of fun exercises, e.g. human rights question challenges can be posed to the participants requiring them to "choose a side". Questions that have no easy answers work best. Since health professionals face horrible challenges in ethical area all the time, such examples are easy to find.

Sarah said that action orientation should always be a component of advocacy training. She said that training itself is just a door opener for inspiring participants to become change agents. She also pointed out that when including marginalized groups it is important to avoid focusing on how marginalized these groups are, but rather to involve them in a proactive way.

When elaborating on what does not work, Sarah mentioned one-offs and said that shaming techniques can backfire. She illustrated her point using an example from a ToT training at Malaga hospital in Uganda, which would have been very successful in helping practitioners to work out issues of stigma and human rights protection had it not been for a human rights report which undermined the progress by highlighting violations in a less constructive way.

Sarah also cautioned about the need for sensitivity regarding social and cultural taboos. She shared an observation that health professionals in Africa often have a hard time talking about sexual rights. Untouchable areas exist and training should be designed around the difficult issues to avoid confrontation.

Sarah spoke in favor of addressing institutional barriers in unconventional ways and through partnerships and quoted an example when a stigma book with poetry was written to pressure a hospital for prophylaxis and vaccine use.

Givi Javashvili praised the adoption of ethics education for providers. He also emphasised the importance of identifying desired outcomes and designing training interventions based on the real needs. He suggested using surveys, research, and fact finding exercises to help

[8] UN Special Rapporteur on the right to the highest attainable standard of health (from 2003 to 2008).

inform the decision-making and defining the desired behaviours and the audience. Training activities will depend on the answers to these questions. He also spoke in favor of utilizing clinical evidence for developing necessary guidelines and best practices.

Givi noted that there are many effective training strategies, didactic teaching being one of the least helpful. He advocated for the innovative of use of modern technology. He also said that desired educative effect can be achieved not only through traditional training programs. Givi supported the idea of targeting opinion leaders and using multiple channels and strategies for delivering a message. These strategies should be aligned with the needs of the audience and take into consideration local traditions.

Givi identified potential entry points for human rights trainings, including students, family doctors or general practitioners. The latter have strong links with community, yet are often culpable in most violations. He also suggested targeting professional codes of conduct.

Discussion

Dima Groisman shared with the group his experience of conducting human rights trainings and raised the issue of finding the right audience and reaching out to them where severe political barriers exist. In Ukraine, the state-run system does not allow inviting anyone without the consent of their superiors, and advertising a seminar in a newspaper is impossible.

In response, the participants suggested that targeting the Minister of Health as an option. They recommended conducting a diagnostic of the system and trying to find the answer to the questions: what would motivate the Minister of Health to change; are there other gatekeepers; is a top down approach more appropriate in these circumstances? Cultivating relationships can be also instrumental in achieving desired goals.

Participants also emphasized the importance of creating a prestige factor associated with the trainings. This can be achieved by partnering with prestigious educational establishments and inviting celebrity keynote speakers. Seeking not only permission, but also engagement (by inviting to attend, introduce the event, etc.) can be also helpful for securing buy-in from the senior officials.

It was noted that a balance should be found in order not to water down the content.
It was also underscored that local activists should be involved in human rights trainings of health providers to enhance credibility. There is a broad understanding that identity comes from the community and good trainings can be undermined when local reality is not taken into account.

Judy Overall cited the experience of OSI's Law and Health Practitioner Guides project and said that involving stakeholders has been instrumental to the success of this large scale initiative. She highlighted the importance of achieving the right balance and working within the parameters.

David Amiryan compared the situations in Ukraine and Armenia and said that in Armenia conducting trainings is not problematic. He also said that in Armenia there are numerous professional associations. However, he highlighted the problem of being able to monitor the outcomes of these trainings, as the picture shown in reports can be quite different from

reality. Moreover, some organizations in Armenia can be rather politicized. David identified journalists as another target group for trainings. Indeed, being charged with the responsibility to present the issues to the public at large, they also need to understand the issues at play and be able to benefit from appropriate training.

Millie Solomon noted the striking difference in the experiences of various counties in the transitional region. She expressed interest in learning whether any comparative studies have been done on issues, such as enabling factors, etc. She noted that change is less likely to occur as a result of one-off trainings. She spoke in favor of structuring a training so that it is set up as trying to achieve certain types of changes and so that it allows people to identify the goals themselves.

Millie cited the work of Scott Fritzen[9] on professionalism conditions in resource poor settings. The purpose of interventions should not be preaching about human rights, but about identifying and addressing the barriers and enablers to get people to act with the best professionalism. Barriers should be identified and can then be used as outcome measures. Organisers can bring examples of what these changes can be: ethics programs, ombudsmen's programs – patient advocacy positions, etc.

It was also said that one of the critical decisions to be made is whether human rights should be mentioned explicitly. It is less threatening and less divisive in some countries to frame interventions as a quality improvement effort because being explicit about human rights may be counterproductive.

The need to promote better adherence to the professional codes of conduct was also discussed. Many professional associations, especially in Africa, have elaborate mechanisms for enforcing professional conduct among members; however these mechanisms are not always upheld.

The issue of using appropriate training methodology was raised. Although the participatory approach is considered to be most effective, it was noted that it is often compromised due to lack of resources. When in-services training classes are attended by two or three hundred participants, there is a shortage of educators. There is also resistance to fully accepting participatory training culture.

The participants discussed the advantages of participatory learning and agreed that although there is still a role for the educator-led didactic framing, e.g. shorter lecture, use of visual media or a concluding summary, promoting small group discussions and peer enriched learning should be encouraged. Faculty should also be well-trained and comfortable using adult learning methodology.

Complicated dual loyalty issues were also mentioned during the discussion.

The panel presentation and discussion concluded with the following main comments:

- Design trainings keeping in mind the desired outcomes;
- Adopt a systems approach in both taking a diagnostic and implementation;
- Utilize the richness of experience among participants and facilitate an exchange of views;

[9] Assistant Professor, Lee Kuan Yew School of Public Policy, National University of Singapore.

- Create a mechanism for institutionalising sustained sharing (e.g. internet databases for accessing and depositing materials);
- Promote a culture of participatory learning, which is a widely recognized rights-based approach in its own right.

Break-out Session on Mapping "Trainings" by Audience and Training Type

The goal of this session was to produce a collection of successful models for training of health providers, according to two categories: (1) the **audience** being trained (health workers or health managers), and (2) the **type of training** (awareness-raising/changing attitudes, skills-building, or knowledge-development). Using a grid, participants discussed good models in break-out groups and then presented them in a plenary session.

For each model, participants discussed the following questions:

- Where on the grid is this training best situated?
- What was the goal of the training?
- Who was the audience for the training, and why?
- What were the learning objectives? Did the training focus on raising awareness, imparting knowledge, or teaching skills?
- What was the training methodology? What materials did the training use?
- What if any were the measurements of success for this training?

The participants were divided into four groups and below are summaries of the groups' report-back discussions mediated by Joanna Erdman. Please also find a grid detailing groups' recommendations in the Appendix.

Group 1 Summary Report-back[10]

Group one reported on a regional human rights training organized in Ukraine by the Vinnytsya Human Rights Group for approximately 30 participants. In Ukraine, training participants were identified by the agency granting its staff permission to attend trainings. The fact that people in the audience did not always know each other particularly well necessitated the use of well-thought-through icebreakers. The audience can often be mixed and include both health managers and providers of care.

The described training was focused on human rights and started with an introduction to human rights issues, followed by information sharing about patients' rights (general and specialised), a review of legislation, and work with case studies.

Materials included a presentation on human rights, printouts, a bibliography, and participants' contact information. In terms of learning objectives, the training was a mixture of sharing knowledge and raising awareness. The methodology included a role playing exercise (good and bad cop), which in the feedback questionnaires was rated as the most interesting by the attendants.

The importance of engaging instructors with both medical and legal background was highlighted.

[10] Group 1 included Olga Baraulia, Joanna Erdman, Tamar Ezer, Dmytro Groisman, and Mariya Vynnytska.

Another version of this training was also described. It involved a less formal meeting with approximately 20-30 medical students, invited to attend a training and a discussion through the distribution of leaflets. The training is aimed at future leaders and entails a presentation followed by an informal discussion on how to reorganise the system in order to make it more respective of rights. Usually, participants offer many suggestions. One of the desired outcomes is the identification of like-minded individuals for future collaboration.

Group 2 Summary Report-back[11]

Group two described two training examples in Georgia.

Example 1 was concerned with trainings for doctors in Georgia, which started in 1995 and were focused on the patients rights provision of the law on health care. At first, the goal of the trainings was to raise awareness about the new chapter of the law and the notions of doctor-patient relationship, informed consent, etc. covered by the new law.

The training was intended for doctors with an academic background, and it was later adapted for penitentiary doctors (following a case when prison doctors force-fed inmates during a hunger strike, thus violating the requirement for respecting patients' autonomy and consent).

The training materials included presentations on each topic, excerpts from the law, and case studies. The discussions covered professional ethics and legal protections of health care providers, novel issues at the time. The course was required by the health care system, however, participants were selected on a voluntary basis. The requirement of continued medical education was also used.

The group shared that it may often be counterproductive to make only patients' rights a topic for trainings, especially in settings where doctors are forced to work under very difficult conditions. The group recommended that rather than blatantly confronting providers with the need for upholding the human rights of their patients, it may be better to first initiate a dialogue-- for example, by circulating a questionnaire among prospective participants and then using the responses during the training.

In 2000, Georgia passed a law on patients' rights, which made it easier to speak about and work on patients' rights issues.

Example 2 was related to a two day workshop specifically focusing on patients' rights issues. Unlike in example 1, these trainings were structured not around the concepts of law, but rather around human and patients' rights as an ethical concept.

The main purpose of these trainings was knowledge transfer. The trainings were intended for all medical staff and were designed as multi-professional trainings. The methodology included discussions, case studies, and pre- and post-training tests. Evaluation focused on assessing levels 1-3 of the Miller's pyramid[12]. Level 4, related to behaviour changes in

[11] Group 2 included Jonathan Cohen, Givi Javashvili, Nina Kiknadze, and Judy Overall.

[12] In 1990, psychologist George Miller proposed a framework for assessing clinical competence. In the model, Miller distinguishes between knowledge, competence, performance, and action; or knowing, knowing how, showing how, and doing.

day-to-day work activities, was outside the training's reach. It was noted that follow up requests can be considered as indicators of success.

The notion of the environmental level in Miller's pyramid was further unpacked, and it was stated that although environment is something that cannot be controlled, it, nevertheless, can undo the impact of the entire training. It was recommended to include considerations of the issues that need to be changed in the system while planning particular trainings.

Group two concluded the presentation with an account of the recent changes in the country, where health care is being privatised and continued education for doctors has been abolished. The aspiration is that privatizing medical institutions will result in higher quality of care (care institutions will be forcing doctors to apply best practices). Given the new conditions, a need for training for health managers should be seriously considered.

The group underlined the importance of environment analysis and value of understanding and forecasting political and socioeconomic developments in a specific country.

Group 3 Summary Report-back[13]

This group focused on multidisciplinary trainings organized by the Uganda National Human Rights Commission (UNHCO) on the district and sub-district levels. Thanks to UNHCO's good working relationship with the Ministry of Health, the organization was able to receive assistance in selecting districts for conducting trainings. Interested facilities were identified, and participants among community advocates and care providers were nominated by the health workers' organizations and community directly.

The described training was a combination of skills building and knowledge development. It was a 2 day event funded by DFID. The focus of the training was policy environment; specific issues of care provision, namely rights and responsibilities of patients; feedback mechanisms around monitoring and follow up regarding the impact on the populations and their ability to seek services.

The training used participatory methodology, brief presentations and work in small groups, as well as brainstorming and flash cards. Each training was assessed, and quarterly follow up took place with the UNHCO secretariat and local consumer advocates based on jointly devised activity plans and indicators. Follow up was community initiated due to the broader context of the advocacy component of the project. Since the project is dependent on external funding, sustainability was raised and the need to get the community to take ownership of the project.

The group stated the importance of being aware that policy, entitlements and responsibilities are of great concern to the health workers whose responsibilities inevitably impact their rights. Knowledge of these issues is instrumental in supporting health workers' advocacy capacity.

To strengthen work on patients' rights, Robinah Kaitiritimba, a representative of the UNHCO, recommended mobilising patients' groups to combine efforts with the health workers' groups; exploring issues of accountability and making sure that patients'

[13] Group 3 included Cynthia Eyakuze, Anne Gathumbi, Robinah Kaitiritimba, and Sarah Kalloch.

organizations get allocations of funding from donors like the Global Fund; utilising the CCM mechanism, as the members of the CCM have the right to question relevant policies and have an MoU with the Ministry of Health.

One of the questions asked during the discussion was about pros and cons of having a relationship with the MoH. On the one hand, such a relationship can lend sustainability to projects; however, it may also undermine credibility and independence.

Group 4 Summary Report-back[14]

Group four reported on examples of both successful and unsuccessful pre- and post-test HIV counselling trainings held in South Africa. In South Africa, there is an urgent need to train HIV councillors on confidentiality and disclosure issues. The country is experiencing acute lack of personnel, and health provider's capacity is limited. Under such circumstances, it is necessary to incorporate human rights into specific trainings on clinical issues and use such trainings as entry points infusing content laterally on different subjects.

The described training was aimed at values clarification, building empathy, helping understand feelings about context around clients' and providers' own concerns. The training was conducted for a small group of people taken from various hospitals. The methodology combined experiential and didactic elements, it included role play and videotaping with subsequent peer discussion and self viewing. Participant evaluation was also part of the process.

The group discussed the question of what objectives should be made explicit to the group and which should be left unspecified. It was noted that HIV cannot be effectively addressed without dealing with such complex subjects as gender, sexuality, and rights and, therefore, these issues must be brought up. Identifying the current level of providers can help decide how explicit the exercise should be in order to best meet the end goal. Clinical examples can provide ample opportunities to explore rights through the prism of care issues. An outcome of the meeting can be identifying those areas in clinical care where most violations occur. This information can be used as a starting point.

The group also recommended the following steps and components to help strengthen training outcomes: choose participants who can take issues forward (advocacy; ToT); conduct evaluation; solicit feedback (e.g. by giving people observation sheets to watch and identify violations in the workplace); check back with the participants; and make it fun.

Group 5 Summary Report-back[15]

Group five discussed the example of a pilot human rights course for medical students in Armenia implemented under the aegis of the National Institute of Health (NIH). The duration of the training was five days and it consisted of a mixture of presentations about the existing legislative framework, followed by discussions on case studies. The participants were also invited to identify cases relevant to them.

[14] Group 4 included Virginia Chambers, Delme Cupido, Liesl Gerntholtz, and Vicci Tallis.
[15] Group 5 included David Amiryan, Suren Krmoyan, Anahit Papikyan, and Millie Solomon.

The described pilot training is expected to be institutionalised by medical universities as a compulsory course for medical professionals and the examination component to be integrated into the evaluation of medical graduates.

The pilot course helped identify numerous lessons, including but not limited to:

- Need to adapt content to make it more applicable to specific areas.
- Need to introduce courses in the workplace (e.g. hospitals), not only at the NIH.
- Develop course for health managers.
- Develop institution-specific courses (e.g. in the context of mental health).
- Identify ways to reach to the penitentiary and military health care systems, which are independent from the MoH.
- Courses should make human rights practical and relevant to the specific audience and use plenty of examples.

The group also singled out the need to identify and target champions trying to change attitudes at levels where they can effect change. An interesting way to reach out to the audience can be a discussion on what can the participants can do to support each other in effecting change.

Thus, the session on mapping trainings by audience and training type provided a valuable opportunity to focus more closely on the components of particular initiatives that were referred to in the panel discussion on training methodology. The participants shared specific examples of trainings and courses and compared general versus specific approaches. The examples from Georgia, Uganda and Ukraine were on general patients' rights initiatives implemented by the civil society organizations. The example from South Africa was specific to clinical interaction. In the example from Armenia, where civil society's capacity is limited, a pilot university course for students was described. An interesting conversation about the focus of the trainings and feasibility of structuring trainings either around the law or specific patients' rights issues (e.g. consent, confidentiality, etc.) also took place.

Session on Group Review of Sample Proposal

The goal of this session was to develop and apply a framework for evaluating funding proposals for human rights training of health providers. In two groups, participants evaluated a sample proposal according to the questions below.

- Does the proposal identify a clear goal? If so, what is the purpose behind the training?
- What if any are the learning objectives? Does the training focus on raising awareness, imparting knowledge, or teaching skills?
- What if any is the training methodology? What materials does the training use?
- What if any are the measurements of success for this training?
- What are the strengths of the proposal?
- What are the weaknesses of the proposal?
- Would you recommend funding this proposal? Why or why not?

The groups compared their evaluations in plenary discussion.

Group 1 Summary Report-back:

The discussion in this group focused on efforts getting a more succinct and clear proposal; the questions of how much detail and what guidelines grantees should be given; how can a checklist with the pertinent OSI questions be developed; and ensuring that sustainability is taken into account.

The group stated a need for clear guidelines for constructing and reviewing proposals. The guidelines should solicit:

- Statement of needs;
- Goals objectives and specific activities under each section;
- Selection of trainees delineated;
- Analysis of beneficiaries and better justification of funding;
- More info on evaluation.

The group recommended that a longer vision of the proposal be developed and advised to offer funding for phase one hoping the grantee would return for the next phases. It was suggested to also request a capacity statement for the organization and description of partners, as well as an annex with an evaluation framework laying out measurements of success and indicators by activity.

The group concluded the assessment by stating that the proposal would be funded, but only as phase one of a more long-term initiative.

Group 2 Summary Report-back:

Group two observed that the proposal contains a multitude of issues (it starts with a process goal of developing a program for training, goes on to raising awareness and changing attitudes and also creating a ToT) and methodologies (creating a booklet, trainings, a manual; and conducting a national training on stigma), which can be overwhelming for one year.

Although the proposal mentioned changing attitudes as one of the objectives, there was no indication of a pre-evaluation component, which would be needed for measuring the outcomes.

The group also noted that getting buy-in from the institution management is essential for the proposed institutionalised training to transform the environment in Ukraine and achieve the stated objectives. Given the situation in Ukraine in this type of institution, it seemed the resources were not sufficient. The group recommended limiting the scope of the project to more intensive work with fewer focus groups.

General Discussion

The discussion touched upon the issues of providing technical assistance to grantees implementing human rights training of health care providers and the value of facilitating collaborations with education consultants in certain cases (especially when grantees are not professional educators themselves). Such an approach is believed to improve outcomes and

help ensure that the designed training is more likely to effect behavior change among the target group.

Another model of providing such technical assistance can take form of a joint seminar for grantees. In such a 'controlled' environment, it is possible to ensure quality and facilitate cross-learning among the participants.

LAHI coordinators expressed a concern regarding the feasibility of tightening the requirements for submitting proposals. The level of scrutiny and requirements should be commensurable with the project budget and goal. Coordinators are often faced with the need to identify better proposals among those of lower quality circulating in the donor circuit for years.

Background on PHP efforts in streamlining capacity building initiatives was also provided. It was noted that the program engages in TA, including capacity building grant-making, and funds organizational development initiatives. There is a specialised task team working on centralising the PHP strategies and developing recommendations and identifying TA opportunities. It was also highlighted that PHP often provides additional support to grantees by engaging consultants on specific issues. The group also agreed that technical support is a challenging category and should be approach with care.

Given limited availability of resources, it was recommended that when planning interventions efforts should be made to ensure that change leaders are targeted. OSI can support others to effect change and collaborate with other funders to leverage resources.

The challenge of balancing conflicting stakeholder interests was mentioned. Indeed, what is strategic for a funder may not be strategic for the grantee and alignment is desirable, but not always possible.

It was stated that the funding decision should not be based solely on the received proposal, but also on a multifaceted assessment whether a grantee has the capacity to achieve the project goals and objectives.

Training was described as only one of many ways to achieve the desired change in the quality of health care. Training is necessary, but it should be a part of a larger set of strategies.

Designing the Annual Law and Health Salzburg Seminar

The goal of this session was to practice designing a human rights training for health providers by working in small groups to develop three options for LAHI's future Salzburg Seminar focusing on this subject.

Overview and description of Salzburg Seminar series (by Tamar Ezer)
For over a decade, the Salzburg Seminar Series has provided a forum for educational exchange between leading medical practitioners from around the world and their colleagues from countries in transition. The Salzburg Law and Health Seminar builds on this legacy by offering instruction in legal and human rights concepts applicable to patient care. The week long seminar is held at the Schloss Arenberg Center for Arts and Sciences, a fully equipped conference center, and brings together up to 35 participants and 5 faculty

members. Previous LAHI Salzburg seminars focused on law and health courses design and on Practitioner Guides for lawyers interested in taking up patients' rights cases.

Focus of the group discussion on the Salzburg Seminar concept for the identified training goal:

- What audience might you target for the Salzburg Seminar? What health providers would you involve?
- What might be the learning objectives?
- What methodologies might you use? What materials might be necessary?
- What might be the follow up?
- What might be the measurements of success?

Summary Report-backs:

Group 1 – improving compliance with the legal frameworks on patients' rights

This group developed suggestions on convening professionals to explore ways to better implement the existing legal requirements on patients' rights. Outcomes would be to share experiences for successful compliance in the participants' countries and internationally and develop action plans for respective countries and guidelines to improve compliance.

As a starting point, the group recommended conducting a rapid assessment exercise on the status and scale of the problem and identifying movers and shakers who can become change agents. Among the selection criteria should be: non-divisive personalities with consensus building capabilities. It should be recognized that not all areas of health should be represented, but civil society should be included. Each country should have several persons representing it.

As the event would be framed as an experts meeting, the main task would be to look at the training needs. Instead of being a training, this working meeting will rather serve as an action base or an advisory committee. There will be a need for the participants to get on the same page on definitions, share lessons learnt, and come to an agreement regarding specific issues.

The group noted that devising an effective evaluation strategy for measuring outcomes could be a challenge. Among the necessary materials, the rapid assessment tool and an action plan to implement patients' rights were mentioned. It was also suggested that participants form each country should design a strategy to improve the patients' rights situation and an action plan on mobilizing the community they represent. These action plans, along with analysis of the current situation and future strategies, can be used not only for OSI funded programs, but for other donors as well.

The international convening held in Salzburg can be followed up in home countries to galvanize a more in-depth country-level discussion. Media and web-based components can help raise awareness and provide a forum for engaging civil society and individuals in the discussion.

Group 2 - "Do you have a rights-based system?"

This group developed an idea of a multi-year training program for future leaders among the medical students. It was suggested that initially training should, however, focus on policymakers in order to facilitate a favourable environment change and later shift to the emerging leaders in health care. Such an approach could prevent loss of human capital and help reduce the frustrations young professionals may experience when trying to implement the acquired knowledge in the workplace. The participants can be selected through informal mechanisms and should include persons in positions of power and with capacity to change. This group also advocated for a multi-sectoral approach and recommended additionally targeting NGOs and service organizations.

It was suggested that the training could start with a question "Do you have a rights-based system in your country?" Presumably, many of the participants would initially answer in the affirmative. The training can go on to explore the real situation by looking at the law, its implementation and other evidence and comparing the perceived and real situations.

Additionally, the training can use Paul Hunt's[16] overview of 17 points consistent with a rights-based system as one of the tools. The desired outcome of this training would be a better understanding of the patients' rights, rights-based health care systems among the participants and readiness to implement these ideas in their respective countries. During the seminar, small group discussions can work cases demonstrating specific human rights health issues as they relate to OSI target groups.

The group seriously considered using a training institution for conducting the training.

Post-training follow up could include assistance with developing plans for implementing rights-based policies in the participants' areas of responsibility.

Group 3 – focus on human rights abuses in reproductive rights context.

This group discussed a training for health care professionals working with women with HIV in the context of maternal health; clinical trials with women with HIV or women who got infected in the course of trials) in countries with anecdotal evidence of abuse[17] (e.g. Namibia, Botswana, Ukraine, Kenya).

The goals of this training would include protecting sexual and reproductive rights of women with HIV; raising awareness regarding policies and other related frameworks (e.g. negotiated agreements such as Cairo Program of Action[18]); providing guidance regarding the due care and policy frameworks. There should also be an advocacy component.

Participants could include health policymakers from the government structures, Ministry of Health, public health representatives and HIV focal point at the ministry; HIV advocates (to ensure that the activists' voices are heard); academics (e.g. to provide input on public health epidemiological situation/statistics). Participants must be from the regions and bring local expertise with them. The location of the training should be prestigious to ensure that the policy makers show up.

[16] UN Special Rapporteur on the right to the highest attainable standard of health (from 2003 to 2008).
[17] For example, forced sterilization.
[18] The twenty year "Cairo Programme of Action" was adopted in 1994 at the International Conference on Population and Development (ICPD) in Cairo.

The training should be interactive, with participants actively involved as facilitators. Materials should include documents synthesizing evidence around abuses; analysis of policy frameworks on international and local level. The discussions should be both topic-specific and generalised.

Following the training, participants will be better equipped to "shake" the situation on the ground and develop action plans within their specific mandate. It may be unrealistic to expect them to develop a joint task force, but they may further policy discussions among high level officials, e.g. African Union. Follow up could include a monitoring strategy and the possibility of grants on advocacy and monitoring going to CS participants. Regional seminars/trainings can also be organized with the idea of creating space for emerging issues (e.g. male circumcision).

Concluding comments on the Expert Consultation and next steps:

The meeting came a long way from a discussion about training methodologies to concrete recommendations and identification of effective and ineffective elements of trainings (please see the training "Dos and Don'ts" in the appendix). The meeting also provided participants with an opportunity to put the lessons and recommendations into practice by designing a potential LAHI Salzburg Seminar.

Building on the meeting's input, LAHI Team will continue working on the plan for a Salzburg seminar and the following criteria will be used to guide the process:

- Relevance to other parts of OSI and PHP community, including SFs;
- Availability of faculty members to lead the seminar;
- Whether it can be multi-year initiative;
- Coordinators input with regard to strategic pertinence and feasibility.

The meeting also helped expand the network of resource people, both internal and external, that can assist with efforts at human rights training for health providers. A special section was developed on KARL[19] (OSI's Knowledge and Resource Locator) to provide a forum to share materials and continue discussions on these efforts.

[19] If you would like to join the community, please contact Olga Baraulia at vbaraulia@sorosny.org

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Dos

- Plan a training as a component of a broader intervention.
- Training should be framed as a process, rather than an event. It necessitates action when participants go back to their work.
- Training should be action-oriented and combined with the development of advocacy.
- Set out ambitious, but well-defined and narrow goals.
- The training can also serve as a leadership development workshop, increasing impact.
- Create prestige around an issue.

Who

- Identify leaders at different levels in the health system who can create incentives and mobilize people for change.
- Involve local opinion leaders.
- Provide key people a sense of public visibility as a leader on an issue.
- Use both a top-down and bottom-up strategy.
- Focus on faculty for systemic impact.
- Aim to create a culture of respect by influencing younger generations.
- Look across the continuum of care.
- Engage with family care physicians.
- Use a systems approach to change and harness multiple audiences on behalf of common goals.
- From alliances with NGOs, professional organizations, and the medical and judicial establishment.

How

- Tailor strategies to the target audience.
- Recognize local peculiarities.
- Use peer-led trainings.
- Human rights should be made concrete. Trainings could be combined with an audit or rapid assessment.
- Bring the voices of patients and people whose rights have been violated into the room though guests, case studies, and film.
- Include marginalized groups as an integrated part of training.
- Doctors are also patients so it is possible to tap into their own experiences as patients.
- Connect to the reasons health providers decided to enter the health care profession.

- Cross role boundaries and disciplines. People do not work in a vacuum, but rather in relation to one another.
- Use interactive, participatory adult methodology.
- A technique that will work well in a large group is to show a film clip and then ask participants to discuss with their neighbour.
- Provide a brief introduction to the legal framework, followed by many practical examples.
- Include didactic framing at the beginning of the training and a didactic pulling out of key lessons at the end.
- Start the workshop with provider rights so that health workers feel invested and their concerns are addressed.
- Engage in values clarification. Recognize the difficult situations of health professionals and that human rights answers are not easy.
- Provide health workers a space to talk about their challenges.
- Identify needs, desired behaviours, and the reality.
- Tap into people's highest aspirations.
- Start with an assumption of alignment, and empower participants and mobilize them to effect change.
- Encourage participants to focus on their own sphere of influence so that they can make a difference.
- Respect participants as agents of their own destiny.

Evaluation and Impact

- May want to have pulse checks during the workshop and an independent exit interview of participants after a training.
- Always plan for follow up.
- Post-training, use checklists and "reminders" or visual re-enforcements, such as posters to integrate ideas in practice.
- Identify "enablers" to people acting in the best professional sense. These can then become outcome measures for evaluation.
- Training is about the actions afterwards. These actions can then become outcome measures.
- Benchmarks could be developing clinical guidelines and observational studies to measure adherence.
- Use both short term process indicators and measure long term impact through observational audits.
- Employ annual audits to check how participants are doing.
- Provide encouragement and award good behaviour.

Don'ts

- Do not engage in training with no buy-in from senior leaders. This will only lead to frustration.
- Do not proceed with training without the gatekeepers' buy-in and buy-in at all levels.
- Avoid one-offs and training with no follow-up.
- Do not hold trainings for health providers that are only led by lawyers.

- Do not rely on lectures and didactic learning.
- Do not envision training as the "pouring of expertise" from trainer to participants. Rather, training is an interactive process of mutual learning.
- Do not relay human rights as abstract principles.
- Do not preach about human rights, while not listening to health providers and paying attention to the barriers they encounter in their work.
- Do not attack participants.
- Do not take a confrontational approach and rely solely on external motivations, such as the avoidance of malpractice suits. This can lead to the practice of defensive medicine.

Questions to Consider

- When is it appropriate to train?
- What can training do or not do on an untouchable problem in a country?
- Who is best placed to train?
- If we train enough health managers, will this have an impact on policy?
- What is the role of medical students and professional associations?
- How general or specific should a training be?
- How do we make human rights practical and relevant to health providers?
- How explicit do we want to be about human rights? Do we want to use the quality and ethics approach?
- How can we monitor and know we achieved results?

Mapping Grip on "Trainings" by Audience and Training Type

	Awareness Raising	Skills Building	Knowledge Developing
Workers	Training for doctors around new law on medical activity (e.g. new patients' rights law in Georgia): – 1 day workshop – Adapted for penitentiary doctors – Presentations, not didactic lectures – Used language of rights	Training for nurses in South Africa – pre and post test HIV counseling – shaping disclosure and confidentiality around human rights framework: – 10 day residential training (need at least 3-5 days in out of work environment) – Values clarification pieces – Some didactic parts, but mostly experiential adult education – Role play and peer feedback – Participant evaluation after each training – Challenges : previous methodology, 'them + us' dynamic; ability of health workers to see violations – <u>Recommendations:</u> link to further training or advocacy efforts; make it fun	Armenia course for health physicians and medical students by MOH-NIH – 5 days – Presentations on law – Case based discussions; invite participants to share cases from their experiences – Course ultimately to be integrated as part of national exam – Nature of international human rights conventions, health legislation in Armenia – Themes around confidentiality and informed consent – <u>Recommendations:</u> engage champions within MoH, those in positions of power; bring together for a workshop as change agents <u>Lessons learned/ future plans:</u> – Evaluating knowledge pre and post training event – Would need to adapt to different medical professions – Want to offer courses within hospitals – Separate courses for health managers

	Awareness Raising	Skills Building	Knowledge Developing
Workers		UNHCO knowledge development and skills building (Uganda): – Trained health workers and community advocates on policy environment – Discussed provider needs and rights and responsibilities of patients – Very participatory – small group work, flash cards, presentations – Feedback mechanisms – how to monitor and follow up on trainings – Quarterly basis follow up w/facilities and local consumer advocates – Health workers and community advocates would put together a work plan and establish indicators (e.g. use of suggestions collection boxes) – Follow up initiated by community, but funding-dependent – Perhaps need to develop a separate curriculum specifically targeting health workers?	
Managers	Ukraine training of health managers, department heads, nurses: – Regional 1 day training – Legal provisions on patient rights – Case studies – Q&A – PP + presentations on human rights – Bibliography materials – Referrals of patients – Follow up calls by providers – Awareness on both patient rights and existence of human rights groups – Good cop/bad cop – Good for trainer to be both a doctor and lawyer; both know medical terminology and take actual cases against providers		Training in Georgia for doctors, nurses and managers on concept of patient rights: – Materials included parts of law and ethical codes – Used case studies – Used Pre and post training tests – 30 people from 1 institution – Some levels of knowledge are environmental and beyond the training's control, but perhaps can specifically design a workshop to address this – Positive outcome – participants requested assistance in developing informed consent forms – Key indicator of impact - follow-up requests

List of Papers Outlining Training Methodologies and Outcomes and Country Contexts

1. Background Paper on Citizens Rights in the Field of Health Care and Biomedicine: Legal Framework, Ways of Implementation in Georgia (by Givi Javashvili and Guram Kiknadze)

2. Developing human rights competencies for South African health professional graduates (by Leslie London et.al.)

3. Experience with Human Rights Training in Medical and Nursing Schools in Latin America (by M. Virginia Chambers)

4. Health and Human Rights Training by Physicians for Human Rights (by Sarah Kalloch)

5. Health Workers for Change: developing the initiative (by Sharon Fonn and Makhosazana Xaba)

6. Health Workers for Change as a Health Systems Management and Development Tool (by Carol Vlassoff and Sharon Fonn)

7. Human rights and health: challenges for training nurses in South Africa (by Leslie London et.al.)

8. Human Rights in Health Care Settings in Uganda (by Robinah Kaitiritibma)

9. Human rights in the Field of Health Care: Legal Framework in Armenia (by Suren Krmoyan)

10. Human rights in the system of health protection of Ukraine (by Dmytro Groisman)

11. Incorporating Human Rights Concepts within in-Service and pre-Service Training of Health Professionals: Reflections on training content and methodologies (by TK Sundari Ravindran)

12. Promoting Human Rights in Health Care Settings: Strategies for Aligning Organizational Culture and Professional Practice with Ethical Norms (by Mildred Z. Solomon)

Open Society Institute
Law and Health Initiative
Expert Consultation:
How Can Training of Health Providers Be Effectively Used to Promote Human Rights in Patient Care?

Mercure Hotel
Váci str. 20, 1052 Budapest, Hungary
Tel : (+36)1/4853100
October 22 - 23, 2008

Meeting Agenda

October 21, 2008

Afternoon	Registration and welcome at the Mercure hotel lobby
18:00 – 21:00	Optional dinner for participants already in town at the Mercure Hotel restaurant

Day 1: October 22, 2008

9:00 – 9:15 **Registration**

9:15 – 9:30 **Introductions**

9:30 – 10:30 **Situating this meeting** (Jonathan Cohen)

- LAHI has a history of training lawyers and human rights advocates on specific health issues, and on strategies such as human rights documentation and strategic litigation
- Examples include: Practitioners' Guide project; work with law clinics; Health and Human Rights Resource Guide; integrating health and legal services; etc.
- There is increasing demand to provide human rights training to **health providers** as a complement to this strategy
- However, LAHI lacks the experience or expertise with reaching out to this audience or evaluating proposals to do so
- For LAHI, the ultimate goal of such training must be a reduction of human rights abuses against specific patient groups, i.e. people living with HIV, people needing palliative care, LGBT communities, sex workers, IDUs, and Roma

Goals of the meeting

1. To be better prepared to evaluate funding proposals for human rights trainings of health providers and to design our own initiatives in this area

2. To expand our network of external experts who can assist us in these efforts

Overview of the agenda (Tamar Ezer)

- Plenary discussion: Can Training Change Practice?
- Break-out groups: Mapping different approaches to "training"
- Exercise I: Practicing evaluating a sample proposal
- Exercise II: Designing the 2009 LAHI Salzburg Seminar

10:30 – 11:00 Coffee Break

11:00 – 12:45 **Plenary Panel: Can Training Change Practice? (**Moderator: Jonathan Cohen)

Session description: The goal of this session is to identify **do's and don'ts** for ensuring that human-rights training actually changes the behavior and practice of health providers. Panelists will answer the following questions in relation to human rights trainings they have conducted:

- What change in behavior or practice did you seek through training?
- How did you set about accomplishing this?
- What sustained or derailed this effort?
- If it did not work, why not?
- What would you have done differently?
- Any indications of success?

12:45 – 14:00 Lunch

14:00 – 14:30 **Introduction to afternoon exercise** (Jonathan Cohen)

14:30 – 16:00 **Break-outs: Mapping "trainings" by audience and training type**

Session description: The goal of this session is to produce a collection of **successful models** for training of health providers, according to two categories: (1) the **audience** being trained (health workers or health managers), and the **type** of training (awareness-raising, skills-building, or knowledge-development). Using a grid, participants will discuss good models in break-out groups and then present them in plenary. For each model, participants will discuss the following questions:

- Where on the grid is this training best situated?
- What was the goal of the training?
- Who was the audience for the training, and why?
- What were the learning objectives? Did the training focus on raising awareness, imparting knowledge, or teaching skills?
- What was the training methodology? What materials did the training use?
- What if any were the measurements of success for this training?

16:00 – 16:30 Coffee break

16:30 – 17:30 **Reports back and discussion** (Joanna Erdman)

17:30 – 17:45 **Introduction to next day's sample proposal exercise** (Tamar Ezer)

18:30 **Group dinner** (Gerloczy Café, Budapest, Gerloczy st.1.)

Day 2: October 23, 2008

9:00 – 9:15 **Overview of the Day** (Jonathan Cohen, Tamar Ezer)

9:15 – 9:45 **Exercise I: Group review of sample proposal**

Session description: The goal of this session is to develop and apply a framework for evaluating funding proposals for human rights training of health providers. In two groups, participants will evaluate a sample proposal according to the questions below. They will then compare their evaluations in plenary discussion.

- Does the proposal identify a clear goal? If so, what is the purpose behind the training?
- What if any are the learning objectives? Does the training focus on raising awareness, imparting knowledge, or teaching skills?
- What if any is the training methodology? What materials does the training use?
- What if any are the measurements of success for this training?
- What are the strengths of the proposal?
- What are the weaknesses of the proposal?
- Would you recommend funding this proposal? Why or why not?

9:45– 10:30 **Report backs and discussion** (Liesl Gerntholtz)

10:30 – 10:45 Coffee break

10:45 – 11:00 **Exercise II: Designing the 2009 LAHI Salzburg Seminar**

Session description: The goal of this session is to practice designing a human rights training for health providers by designing, in small groups, three options for LAHI's 2009 Salzburg Seminar.

Overview and description of Salzburg Seminar (Tamar Ezer)

- March 23-27, 2009 in Salzburg, Austria
- Can have up to 35 participants: 5 country teams of up to 7 people

11:00 – 12:00 **Groups to develop each Salzburg Seminar concept**
For the identified training goal:

- What audience might you target for the Salzburg Seminar? What health providers would you involve?
- What might be the learning objectives?
- What methodologies might you use? What materials might be necessary?
- What might be the follow up?
- What might be the measurements of success?

12:00 – 12:45 **Report backs and discussion** (Tamar Ezer)

12:00 – 13:00 **Closing remarks** (Jonathan Cohen)

13:00 – 14:00 Optional lunch at the Mercure Hotel restaurant

18:00 – 21:00 Optional buffet dinner at the Mercure Hotel restaurant

Law and Health Initiative
Expert Consultation:
How Can Training of Health Providers Be Effectively Used to Promote Human Rights in Patient Care?
October 22-23, 2008

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