Teaching Human Rights in Graduate Health Education

Vincent Iacopino, MD, PhD
Senior Medical Consultant, Physicians for Human Rights and
Instructor, Health and Medical Sciences Department, University of California, Berkeley

January 10, 2002

Commissioned by:
Health and Human Rights Curriculum Project

American Public Health Association
François-Xavier Bagnoud Center for Health and Human Rights

I. Introduction

The purpose of this paper is to outline the current state of human rights teaching in schools of public health, medicine and nursing and to provide a framework for discussions on the future development of health and human rights curricula in graduate health education. The paper includes a review of the need for human rights education in health professional schools, the relationship between human rights and bioethics, a profile of current instructors, a summary of content and methodology of present human rights education initiatives and considerations for discussions among Health and Human Rights Curriculum Project participants.

Several sources of background information were used in the preparation of this paper: 1) Medline literature searches on health and human rights education topics, 2) review of relevant human rights course syllabi, 3) interviews with 9 instructors teaching human rights[1] in schools of public health, medicine and nursing, and 4) one interview with a representative of the American Nurses Association. A list of relevant human rights courses was compiled using data files of course syllabi provided by the François-Xavier Bagnoud Center for Health and Human Rights (including a total of 36 courses located at 23 different institutions and 3 additional web-based courses) and a listing of 60 additional undergraduate course syllabi available through the Institute of International Studies at the University of California Berkeley.[2] See Appendix A for a summary of courses included in these data files. Appendix B includes course descriptions and syllabi for most of the courses.[3] Since such information has not been centralized in the past, the summary of courses listed should be considered a work in progress.

II. The Need for Human Right Education in Health Professional Schools

[1] The institutions represented include: Boston University School of Public Health and School of Medicine, Columbia University The Joseph L. Mailman School of Public Health, Emory University Rollins School of Public Health, Harvard School of Public Health, Johns Hopkins University School of Hygiene and Public Health, University of California Berkeley School of Public Health, Yale University Department of Epidemiology and Public Health, NYU School of Medicine May Chinn Society for Bioethics and Human Rights, Princeton University Council for Science and Technology, University of Minnesota Center for Spirituality and Healing.

[2] See International Studies at the University of California Berkeley website: http://globetrotter.berkeley.edu/AIUSA-syl/toc.html.

[3] Though several international course are listed in Appendix A and B, there was no systematic effort to include international health and human rights courses.

The Intrinsic Value of Human Rights in the Health Professions

The need for human rights education in the health professions stems from its intrinsic value in alleviating human suffering and promoting health and well-being. These values operate on both moral and practical levels. The health and human rights discourse not only serves as a unifying framework to understand the role of health practitioners in society; it provides practical tools for effective and socially relevant health policy and practice. While the goals of alleviating human suffering and promoting health and well-being may seem self-evident to some, there is no formal mandate, *per se*, in medical ethics to designate these concerns as responsibilities of physicians and other health professionals.[4] In fact, the assertion of a need for human rights education in health professional schools represents a powerful critique of normative health practices and the current state of medical ethics. Since 1978, World Health Organization (WHO) has defined health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity;"[5] however, health concerns in the twentieth century have focused almost exclusively on the diagnosis, treatment and prevention of disease. It may be argued that, by reducing suffering to disease concerns health practitioners fail to recognize the relationship between health and human rights and consequently marginalize their role in promoting health in society.

In the absence of a formal mandate to protect and promote human rights, social causes of suffering and health promotion have been neglected. Perhaps one of the most disturbing examples of such neglect of human rights concerns is that of "Apartheid medicine" in South Africa.[6] Under Apartheid, the vast majority of health practitioners failed to document human rights violations, delivered health services on a highly discriminatory basis, remained silent in the face of widespread torture of political detainees and the forced displacement of more than 3 million Africans, and neglected the health consequences of extreme racial disparities in poverty, illiteracy, unemployment, and other social determinants of health.

The Significance of Linking Health and Human Rights:

The acceptance of conceptual linkages between health and human rights, in most cases, requires practitioners to re-examine their definitions of health and the scope of their professional responsibilities. The ways in which health practitioners link health and human rights matters and have significant implications for the development and integration of human rights into graduate health education.

---

[4] A code of ethics is currently in the process of being drafted by the American Public Health association. For details see: http://www.apha.org/codeofethics/ethics.pdf for the draft code and http://www.apha.org/codeofethics/background.pdf for relevant background information.

[5] World Health Organization. *Declaration of Alma Ata*. Geneva, Switzerland: World Health Organization, 1978:1-3.

[6] Chapman AR, Rubenstein LS, Iacopino V, *et al*. *Human Rights and Health: The Legacy of Apartheid*. Washington, DC: American Association for the Advancement of Science, 1998.

Relationships between health and human rights may be conceptualized as either “instrumental” or “intrinsic.” What distinguish these conceptualizations most are their implicit definitions of health. Instrumental relationships generally define health in terms of morbidity and mortality, while the intrinsic relationship focuses on the inherent dignity and the worth of individuals as primary outcomes rather than death and disease.

Instrumental Linkages:

One of the most compelling arguments for the inclusion human rights concerns among health practitioners is that violations of human rights and humanitarian law have extraordinary health consequences. In the past century, the world has witnessed ongoing epidemics of armed conflicts and violations of international human rights, epidemics that have devastated and continue to devastate the health and well-being of humanity.[7] Armed conflicts have claimed the lives of more than one hundred million people in the twentieth century, and increasingly, civilians have become the victims of war and internal conflicts. Today, ninety percent of war related deaths are civilians. Twenty-six major conflicts occurred in 1995. Torture, forced disappearance and political killings are systematically practiced in dozens of countries, and more than 100 million landmines threaten the lives and limbs of non-combatants. In 1995, one in every 200 persons in the world was displaced as a result of war or political repression.

Despite a century of technological progress, poverty, hunger, illiteracy, and disease continue to plague the health of the world community.[8] Today, 1.3 billion people live in absolute poverty, and over eighty-five percent of the world's income is concentrated in the richest twenty percent of the world's people. 750 million people go hungry every day. 900 million adults are illiterate; two-thirds of who are women. More than one billion people have no access to health care or safe drinking water. Each day 40,000 children die from malnutrition and preventable diseases, lack of clean water and inadequate sanitation.[9] That is the equivalent of 100 jumbo jets loaded with passengers-mostly children-crashing each day with no survivors. It is as many people as died in Hiroshima, every three days, and three times as many people, in the last five years, as died in all the wars, revolutions and murders in the past 150 years.

Human rights violations, whether they are civil, political, economic, social or cultural in character, may have profound effects on morbidity and mortality. The effects of war, torture, famine, forced migration, etc. on morbidity and mortality are not difficult for health practitioners to understand. Perhaps

---

[7] Sivard RL. *World Military and Social Expenditures, 1996*. Washington, DC: World Priorities, 1996:1-53.
[8] Id.
[9] United Nations Children’s Fund. *World Declaration on the Survival, Protection and Development of Children*. New York, New York: UNICEF, 1990.

the health consequences of other rights violations may not be so apparent; for example freedom of speech or the right marry and found a family. However, restrictions on freedom of speech have been linked to the large-scale famines that occurred in China between 1958 and 1961 and claimed the lives of close to 30 million people.[10] Also, the right to marry and found a family was developed to prevent forced sterilization practices such as those that preceded Nazi "euthanasia" programs and later genocide.[11]

Instrumental relationships between social conditions and both morbidity and mortality have been recognized for a long time. Throughout the 20th century in European countries and North America, a marked decline in morbidity and mortality was associated with a combination of far-reaching socio-economic changes. These included improvements in safe water supply, sanitation and nutrition, personal hygiene, income from regular employment, social security, education, and preventive measures in public health. More recently, studies on "social determinants of health" have demonstrated that disadvantaged social and economic circumstances increase the risk of serious illness and of dying prematurely.[12] Although the association between social conditions and health status has not been expressed in terms of rights, the health consequences of unrealized economic and social rights are readily apparent.

Another important instrumental relationship between health and human rights is that of health policy and human rights. According to Mann, Gostin, Gruskin, et. al, "health policies and programs should be considered discriminatory and burdensome on human rights until proven otherwise."[13] Despite principles of beneficence and nonmaleficence in medicine, health policies often have been developed without consideration to human rights concerns.[14] Under such circumstances, health policies have the potential to be ineffective or even harm the populations they are intend to serve.[15] Therefore, new health policies should be evaluated with regard to both positive and negative effects on human rights. Toward

---

[10] Sen A. Freedoms and needs, *The New Republic* 1994;(Jan):31-37.

[11] Forced sterilization was practiced extensively in the United States as well. See:

[12] See Kunst AE, Mackenbach JP. The size of mortality differences associated with educational level: a comparison of nine industrialized countries, *American Journal of Public Health* 1994;84:932-7; Fox AJ, Aldershot H, eds. *Health Inequalities in European Countries*. Brookfield, Vermont: Gower Publishing Company, 1989; and Davey Smith G, Hart C, Blane D, *et al*. Lifetime socioeconomic position and mortality: prospective observational study, *British Medical Journal* 1997;314:547-552.

[13] Mann, J, Gostin L, Gruskin S et al. Health and human rights, *Health and Human Rights* 1994;1(1):7-23.

[14] Gostin LO, Lazzarini Z. *Human Rights and Public Health in the AIDS Pandemic*. New York, New York: Oxford University Press, 1997:12-32, 49-55

[15] See Gostin LO, Lazzarini Z. *Human Rights and Public Health in the AIDS Pandemic*. New York, New York: Oxford University Press, 1997:12-32, 49-55; Ziv TA, Lo B. Denial of care to illegal immigrants: proposition 187 in California. *The New England Journal of Medicine* 1995;332(16):1095-1098; Barry M. The Influence of the U.S. tobacco industry on the health , economy, and environment of developing countries. *The New England Journal of Medicine* 1991;324(13):917-919; and Neufeldt AH, Mathieson R. Empirical dimensions of discrimination against disabled people, *Health and Human Rights* 1995;1(2):174-189.

this end, human rights impact assessments represent essential and practical tools in attaining the best possible public health outcomes while protecting the human rights of individuals and populations.[16]

Intrinsic Linkages:

The need for human rights education in health professional schools can also be argued on the basis of an intrinsic relationship between health and human rights. The intrinsic conceptualization asserts that human rights are essential qualities of health[17] and need not be justified solely on the basis of morbidity and mortality concerns. Human rights provisions essentially prescribe the conditions for health as defined by the WHO. Therefore, human rights are health outcomes in and of themselves because they are intrinsic to the state of well-being outlined in the WHO definition of health. Education and work opportunities are health ends in and of themselves regardless of their associations with reduced morbidity and mortality. Similarly, freedom of thought, speech, movement and association are components of health and well-being independent of their instrumental relationships to death and disease.

The intrinsic perspective focuses on the inherent dignity and the worth of individuals as primary outcomes rather than death and disease. Torture, for example, is a concern of health practitioners because it represents an assault on the dignity and worth of individuals and humanity as a whole, and not solely because of its adverse effects on the bodies and minds of individuals. Consequently, remedial interventions call for the protection and promotion of human dignity and not merely improvements in the morbidity and mortality associated with torture. Respect for human dignity is a concern that all members of the human family can share. Therefore, the intrinsic perspective has the potential of bridging our humanity with professional health practices.

Implications for Health and Human Rights Education: Principled vs. Strategic Approaches

Whether conceptualized in terms of morbidity and mortality or from an intrinsic perspective, human rights concerns represent a significant departure from the normative conceptualization of health as the presence or absence of disease. In the past ten years, associations between health status (morbidity and mortality) and social determinants of health have gained considerable acceptance among health practitioners. However, such formulations refer to a limited number of social factors (income or income disparity, education, race, etc.) and neglect the wide range of human rights considerations that may affect health status.

---

[16] Gostin L, Mann J. Towards the development of a human rights impact assessment for the formulation and evaluation of public health policies, *Human Rights and Health* 1994;1(1):58-80.

[17] See Mann, J, Gostin L, Gruskin S et al. Health and human rights, *Health and Human Rights* 1994;1(1):7-23; and Iacopino V. Human rights: health concerns for the twenty-first century. In: Majumdar SK, Rosenfeld LM, Nash DB, Audet AM, eds. *Medicine and Health Care Into the Twenty-First Century*. Philadelphia, Pennsylvania: Pennsylvania Academy of Science, 1995:376-392.

Instrumental and intrinsic conceptualizations of health and human rights have different implications for the integration of human rights in graduate health education. The instrumental perspective has the strategic advantage of relying on traditional concerns of morbidity and mortality. Health practitioners are simply challenged to recognize causes of morbidity and mortality other than disease, injury or environmental exposure. Also, the concept of “social justice” in public health adds credibility and support to instrumental conceptualizations of health and human rights. Despite the relative ease of understanding instrumental relationships between health and human rights, it is often difficult for practitioners to recognize practical applications of human rights in their everyday work and to accept interrelations that have been heretofore unrecognized. One of the most significant disadvantages of the instrumental perspective is the risk that practitioners will selectively focus on a limited number of human rights concerns and fail to recognize the interdependence of human rights and their combined effect on health status. For example, social determinants of health such as poverty, education and race may not be effectively addressed if rights to free speech, association, and representation in government are not ensured. Similarly, efforts to end torture or to institute effective and fair health policies depend on these and other human rights as well.

The intrinsic perspective of health and human rights is a more principled approach that requires health practitioners to recognize rights as conditions for human dignity and essential constituents of health and well-being, independent of morbidity and mortality considerations. It has the advantage of creating a consistent and unified framework for health concerns. Though widely accepted among health and human rights educators, the intrinsic perspective is likely to be met with more ideological resistance than instrumental perspectives and, in some cases, hinder or slow the development of health and human rights curricula in graduate health education. For this reason, the inherent tension between these strategic and principled approaches should be discussed further among project participants.

Objectives of Health and Human Rights Education

The need for human rights education may also be considered in terms of more immediate objectives. The 9 health and human rights educators who were interviewed for this paper identified the following objectives:

1. Awareness and Engagement: Health practitioners, by and large, have not been exposed to human rights concepts. Most students have little or no knowledge of human rights principles or familiarity with international human rights instruments; they have not viewed health within a human rights framework and are unaware of the ways in which the protection and promotion of human rights relate to health promotion. Even in the schools where health and human rights courses are offered, such courses are typically elective in nature and therefore reach only a small proportion of students. Efforts to improve awareness and engage students have been facilitated by the following:

- Interdepartmental collaborations for teaching and other program activities.
- Program activities for student involvement
  - summer research fellowships
  - visiting human rights lecture series
  - facilitating human right related internships
  - interactions with local human rights non-governmental organizations
- A combination of both required course material and elective courses
- Exposure at multiple points in time in the course of graduate education
- Certificate programs and course concentrations in health and human rights
- Institutional support (i.e. deans, department chairs, senior faculty, curriculum boards)
- Financial support
- Student initiatives
  - health and human rights caucuses
  - local NGO chapters, i.e. Physicians for Human Rights, Amnesty International
  - film series on human rights topics
- Human rights issues and research in medical and health journals
- Exposure to human rights and health policy research, training and advocacy

2. Core Knowledge and Skills: Another important objective of health and human rights education that is related to raising awareness among health practitioners and engaging them in human rights the human rights discourse is identifying basic knowledge and skills that apply to all health professional. If human rights concerns are, indeed, essential to health promotion, then health practitioners should be required to develop capacities in the core knowledge and skills of health and human rights.[18] The strategies of requiring health and human rights course material and mandating health and human rights competency through associations for health professional schools are discussed below.

3. Development of Practical Applications: Virtually all health and human rights educators interviewed for this paper indicated that developing practical applications to health and human rights concerns is of critical importance. It is not uncommon that students and faculty sometimes view human rights as irrelevant to their daily clinical or health practice. This issue has been addressed by health and human rights instructors in a variety of ways:

   - Using group discussion of case examples that relate to local health practices and problems
   - Facilitating local field experiences that are human rights related
   - Include readings that are relevant to local, as well as international, human rights concerns

[18] The development of core knowledge and skills may differ somewhat in schools of public health, medicine and nursing.

- For students to write their required papers on practical human rights concerns
- Providing summer internship and/or research programs for students
- Using human rights impact assessment tools (especially in school of public health)

4. Address the Social Context of Health: Health practitioners need to develop knowledge and skills that enable them to address the social context of health. Human rights studies in graduate health education should prepare health practitioners to act in a social and political context to protect and promote human rights. This implies the need to integrate human rights concerns into the ethics health practitioners.

5. Breakdown Barriers Between Human Rights and Health (and other) Discourses: Several health and human rights educators indicated that the language of human rights sometimes has the effect of insulating it from other discourses. It is therefore important to find ways of establishing a common language and agenda. In recent years, there has been significant progress in overcoming such barriers, for example, rights-based programming in the provision of humanitarian assistance, and interdisciplinary approaches to anthropology and human rights.

Human Rights and Bioethics: The Need for a Common Agenda

The relationship between human rights and bioethics is an important consideration in the development of health and human rights curricula in graduate health education for several reasons: 1) human rights and bioethics share the common interest of respecting human dignity; 2) though human rights are considered by some to be essential to health practices, bioethical principles do not formally recognize the protection and promotion of human rights as responsibilities of health practitioners; 3) bioethics courses are one of several primary targets for the inclusion of human rights in graduate health education. Before discussing the possibility of a common agenda for human rights and bioethics, it is important to understand some significant differences between human rights and bioethics.

Although the idea of human rights can be traced to the Magna Carta (1215) and later the English Bill of Rights (1689), the French Declaration of the Rights of Man and the American Declaration of Independence, the justification of human rights was rhetorical, not philosophical. Such rights were expressions of moral identity in the context of the Holocaust and the Second World War; they were self-evident and derived from common societal goals of peace and justice and individual goals of human dignity, happiness and fulfillment. Human rights are social claims or values, which simultaneously impose limits on the power of the state (i.e. civil and political rights) and require the state to use its power to promote equity (i.e. economic, social and cultural rights). The realization of such claims or rights is, in effect, a means of achieving the conditions for health and well-being in a global, civil society. The legitimacy of human rights is based on the process of consensus among States.

Bioethical principles such as beneficence, non-maleficence, confidentiality, autonomy and informed consent, are codes of conduct that regulate clinical encounters with individual patients. These principles do not attempt to define health and well-being, nor do they indicate possible causes of human suffering. In fact, it is fair to state that the discipline of bioethics was born out of the misconduct by physicians and other health practitioners. Historically, the discipline has evolved more in response to increasing ethical dilemmas that arise from the practice of clinical medicine, than it has from an active agenda for health promotion. Also, while public health practitioners have defined health to include a wide range of social factors,[19] normative public health practices focus primarily on the diagnosis, treatment and prevention of diseases.[20] In addition, public health does not have a strong tradition of bioethics. During the past year, the APHA released a memo on human right and is currently in the process of drafting a code of conduct.[21]

Differences between human rights and bioethics underscore the importance of parallel initiatives to develop international consensus on the linkages between health and human rights and to formally articulate the responsibilities of health practitioners' in protecting and promoting human rights. In the past year, the FXB Center for Health and Human Rights and Physicians for Human Rights launched an international effort to develop a Declaration on Human Rights and Health Practice to formally conceptualize linkages between health and human rights and articulate ethical responsibilities regarding human rights. Thus far, 75 participants from 40 different countries have contributed to the initial drafting of the Declaration.

Despite such efforts to establish a common agenda for human rights and bioethics, human rights educators and bioethicists often disagree on the relative importance of the two discourses (i.e. that one discipline subsumes the other). Bioethicists sometime criticize human rights as lacking a principled approach and those in human rights fields criticize bioethics for the lack of an active agenda to address social causes of human suffering and health promotion. Therefore, it seems that clear that outlining a common agenda for human rights and bioethics agenda, and the process by which this may be attained, requires further discussion among project participants.

Student's Interest in Human Rights Education

---

[19] See World Health Organization. *Declaration of Alma Ata*. Geneva, Switzerland: World Health Organization, 1978:1-3; and World Health Organization. *Ottawa Charter for Health Promotion*, Geneva, Switzerland: World Health Organization, 1986:1-3.

[20] World Health Organization. *Health For All in the Twenty-First Century*. Geneva, Switzerland: World Health Organization, 1998.

[21] For details see: http://www.apha.org/codeofethics/ethics.pdf for the draft code and http://www.apha.org/codeofethics/background.pdf for relevant background information.

Interest in health and human rights among students may depend on a number of key factors: 1) whether the material is required or elective, 2) time constraints within the student's schedule, especially medical students, 3) opportunities for human rights experiences outside the classroom, 4) opportunities for multiple exposures to human rights, i.e. at multiple points in time and across study disciplines, 5) the perceived importance of human rights by senior faculty, 6) the degree to which instructors are perceived as role models, and 7) the presence of student-led human rights initiatives on campus.

It is clear from discussions with health and human rights instructors that health and human rights courses have been received with great interest and enthusiasm. This is true from both subjective assessments and feedback from objective course evaluations. Increasing class size, the demand for additional health and human rights courses and the successful expansion of extra-curricular human rights program activities also serve as measures of student interest in human rights. Moreover, student interest in human rights is greatly enhanced by many of the factors discussed above, especially opportunities for multiple curricular and extra-curricular exposures to human rights.

Since most health and human rights courses are offered as electives, it is not surprising that students choose courses in which they have considerable interest. Also, health and human rights studies in graduate health education have evolved organically (without a formal competency mandate) and in the hands of instructors who often possess unique human experiences and perspectives and are regarded by students as role models. These factors have undoubtedly contributed to the success of present health and human rights initiatives. Currently, human rights material has been included in required course in two medical school programs (Boston University School of Medicine and Griffin Hospital, Yale School of Medicine). The material has been well received by students and the success of these initiatives is largely due to one or more of the following factors: 1) the use of case examples that relate to local health practices and problems, and 2) opportunities for extra-curricular human rights experiences such as clinical encounters with refugees.

It is worth noting that exposure to human rights concerns can be traumatic in nature, for example, learning about torture, genocide, and the profound effects of poverty, child labor, the complicity of health practitioners in human rights violations. Students often exhibit signs of secondary trauma in class such as helplessness, hopelessness, anger, avoidance, guilt, and depression that may, indeed, interfere with effective processing of the information and constructive responses to human rights challenges. Lack of interest in human rights should not be confused with normal responses to traumatic subjects. Health and human rights instructors should be aware of these distinctions and facilitate the processing of emotions that are inherent to human rights work.

In addition, it should be noted that the development of a human rights perspective among students often represents more than the acquisition of a critical framework for the conceptualization health and health practice; it can be a transforming life-experience. That is, recognizing respect for

human dignity as a foundation for human interactions often changes individuals' sense of who they are and their relation to the world.

Mandatory Requirements versus Elective Courses: Complementary Strategies

The vast majority of health and human rights courses are currently offered as electives and at a limited number of institutions (see Table 1). Twenty-three percent of accredited schools of public health currently offer health and human rights courses compared to 2% of medical schools and less than 1% or nursing schools.

Table 1. Institutions Offering Health and Human Rights Courses in Schools of Public Health, Medicine and Nursing

Schools*	Health and Human Rights Courses	Institutions Offering Courses	Proportion of Institutions Offering Courses %
Public Health (N=31)†	8	7	23
Public Health (N=37)‡	8	7	19
Medicine (N=125)	4	3	2
Nursing (N=556)	1	1	0.2

* The schools are those listed by the American Association of Schools of Public Health, the American Association of American Medical Colleges (US listings), and the American Association of Colleges of Nursing.

† Includes 31 accredited schools of public health.

‡ Includes 31 accredited schools of public health and 6 member programs.

In addition to courses on health and human rights, there are at least 11 other courses offered in schools of pubic health on selected human rights topics. The course are offered by a total of 4 institutions: Harvard University School of Public Health, Columbia University The Joseph L. Mailman School of Public Health, Emory University Rollins School of Public Health, Harvard School of Public Health, and the University of California Berkeley School of Public Health. See Table 2 for specific course topics and Appendix A and B.

Table 2. Courses on Selected Human Rights Topics Offered in Schools of Public Health

Selected Topics in Health and Human Rights	# Institutions offering courses
Refugees and Humanitarian Intervention	3

Women, Gender and Sexuality	2
Right to Health Care	1
Health as Social Justice	1
Human Rights and Development	1
Health, Human Rights and the International System	1
Science and Human Rights	1
Rights of Children	1
TOTAL	11

Since nearly all of these courses are offered as electives, many health and human rights educators describe their teaching efforts as "preaching to the converted." If human rights knowledge and skills are essential to effective health practice, it stands to reason that health practitioners should be exposed, on some level, to human rights concerns in their education. Most health and human rights educators support a complementary strategy of integrating human rights material into required courses while continuing to offer a range of elective human rights courses, ideally leading to certificates or minor concentrations.

The inclusion of human rights in required course studies has the potential to raise awareness and engage many more health practitioners in the human rights discourse. It should enable them to incorporate human rights principles in their daily health practice and help to foster a culture of human rights in the health sector over time. At the same time, there are formidable barriers to human rights curricular requirements and potential negative consequences to consider. The health and human rights educators that were interviewed identified the following:

Barriers

- Competition for time in students' schedules, especially medical students
- Conflicting conceptualizations of health and the ethical responsibilities of health practitioners
- Skepticism regarding the relevance of human rights to daily medical and health practices
- The lack of human rights understanding and support among deans, senior faculty and curriculum boards
- Perception that health and human rights educators operate on the fringe of mainstream health concerns
- The lack of funding sources for health and human rights education initiatives

Potential Negative Consequences

- Negative reactions on behalf of requirement-weary students
- Decline in the quality assurance for course content and instruction

- Consumption of resources for human rights exposure will limit the development of substantive human rights work by committed individuals.

Perhaps the most critical element of successfully integrating human rights in required components of graduate health education is the need firmly grounding its content to the very real problems that health practitioners face on a daily basis. This, in no way, discount s the importance of international health and human rights concerns.

Potential targets for required human rights education suggested by the interviewees included the following:

- A modular component in bioethics courses
- A modular component in public health courses:
  - health policy
  - international health
  - cross-teaching in required courses, i.e. epidemiology, humanitarian crises, etc.
- A modular component in medical and nursing schools:
  - introduction to the patient
  - community and social medicine
  - or replace current topics
- Identify health and human rights as a core competency
- Develop continuing health education courses that fulfill licensing requirements, i.e. ethics for physicians
  - web-based courses
  - short courses

III. Profiles of Human Rights Instructors

General observations on the profile of instructors in various settings

Human rights educators are generally familiar with one another since they belong to a small community of individuals and share a number of common interests. In addition to sharing common health perspectives, they have developed strong commitments to issues of social justice in the course of profound life experiences. These may include direct and indirect exposure to human rights violations, working with disadvantaged individuals and populations, being exposed to the suffering that stems from human rights abuses and unrealized human needs, and witnessing gross discrepancies in morbidity and mortality, to name a few. Such experiences are often gained in working with non-governmental human rights and other organizations. Continuing to work with such NGOs typically enables human rights educators to relate real-life, human rights experiences to their students. Human rights educators also

tend to have cross-disciplinary experiences and capabilities including law, health, medicine, science, social sciences and advocacy among others that enrich their perspectives and teaching capabilities.

Human rights educators often believe that the failure of public health to achieve its stated goals is strongly related to neglect of human rights concerns. The frustration that may result from such a perspective refers not only to the understanding of human rights as conceptual framework to guide health practice; it refers to the understanding of rights as a rhetorical statements of moral identity, an idea that was evident in the development of the Universal Declaration of Human Rights in the aftermath of WWII.[22] It is not surprising, therefore, that human rights educators and activists generally exhibit extraordinary commitment to their work.

Another important observation of the profile of human rights instructors is that they often view their teaching efforts as "up-stream" activities that contribute to the development of a culture of human rights as opposed to "downstream" activities, such as documentation of human rights violations or caring for survivors of torture, that are employed only after abuses have occurred.

The implications of the current situation for development of a curriculum

The somewhat unique experiences of human rights educators are of critical importance in teaching health and human rights in graduate health education. The experiences of human rights educators are the motivating force for teaching human rights and, at the same time, serve as critical examples of practical applications of human rights concerns to students. Such experiences often convey to students the value of human rights perspectives in real and practical terms. The experiences of human rights educators also seem to be related to the perceived credibility of instructors by both students and faculty and serve as models for students' careen interests and choices.

This review of instructor profiles indicates that human rights experiences are of critical importance to effective educational initiatives. Human rights include a wide range of human interests, a range that exceeds any one individual educator's experiences. Therefore, gaps in relevant human rights experience or cross-disciplinary expertise underscores the need for collaboration with educators with a wide range of domestic and international experiences and cross-disciplinary expertise.

IV. What is taught in courses on human rights and related subjects?

Content of Health and Human Rights Courses

Using available health and human rights course syllabi (see Appendix B), a systematic review of course content and required readings was conducted. Only course that focused specifically on health and human rights were included in the analysis. A total of 18 course syllabi were available from a total of 21 course listings in Schools of public health (n=8), medicine (n=2), nursing (n=1), law (n=3), and undergraduate programs (n=4). A total of 14 health and human rights courses were offered at a total of 12 different graduate health institutions. All 18 courses (100%) included a review of two core subjects: 1) human rights law, principles and/or instruments and conceptual linkages between health and human rights.[23] The courses included a range of 7 to 15 sessions and each course contained a variety specific topics. The most common topics are listed in Table 3.

Table 3. Content Analysis of Health and Human Rights Courses in Graduate Health Education

Session Subjects	Public Health (N=8)	Medical & Residency (N=2)	Nursing (N=1)	Law (N=3)	Undergrad (N=4)	TOTAL (N=18)
HR Law/Instruments	8	2	1	3	4	18
Health and HR Linkages	8	2	1	3	4	18
Women	8	2	1	2	4	17
Health Policy	7	2	1	2	2	14
War & Refugees	7	2	1	0	3	13
Ethics	4	0	0	3	4	11
Children	4	2	1	2	4	9
Torture	3	1	1	1	3	9
Economic /Social Rights	4	0	0	2	2	8
Universality	4	0	0	2	1	7
Multinational Corporations	3	0	0	2	1	6
Access to Care	1	1	0	1	2	5
Violations/Documentation	2	0	0	0	2	4
Environment	2	0	0	0	2	4
Disabilities	1	0	0	2	1	4
Others*	4	3	0	0	6	13

* Included a total of two courses on each of the topics of race, genocide or sexual identity and one course on each of the following: health practices, human rights violations in the United States, rights of indigenous persons, human rights education, truth and reconciliation, structural violence and terrorism.

---

[22] Henkin L. Introduction: The human rights idea. In: *The Age of Rights*. New York: Columbia University Press, 1990:1-10.

[23] The most common references included the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, and the International Covenant on Economic, Social and Cultural Rights.

This analysis provides some insight into the topics that are commonly covered in health and human rights courses. Of course, statistical comparisons are not possible given the small number of courses in each group. In addition, the value of this information is limited by a number of factors: 1) overlap between subject headings, 2) topics were limited to those listed as session subjects and not individual readings within sessions, and 3) several course syllabi were not available at the time of the analysis.

A summary of required readings for health and human rights courses is listed in Table 4.

Table 4. Readings for Health and Human Rights Course

Readings*	Public Health (N=8)	Medical & Residency (N=2)	Nursing (N=1)	Law (N=3)	Undergrad (N=4)	TOTAL (N=18)
25 HR Documents*	4	1	0	1	2	8
Local Readers	2	4 (N=5)	1	0	1	8 (N=21)
Mann et. al. Reader†	5	0	0	1	1	7
Handouts	1	1	1	2	1	6
Amnesty Ethics Book‡	2	1	0	0	1	4
Steiner§	1	0	0	1	1	3
Others*	3	0	1	2	4	10

* Twenty-five Human Rights Documents. New York: Center for the Study of Human Rights, Columbia University, 1994.
† Mann J, Gruskin S, Grodin M, Annas G. Health and Human Rights: A Reader Routledge, New York 1999 ISBN 0-415-92102-3
‡ Amnesty International, Ethical Codes and Declarations Relevant to the Health Professions, 3rd edition. London: Amnesty International, 1994.
§ Steiner, HJ and Alston P. International Human Rights in Context: Law, Politics, Morals 2nd Edition, Oxford University Press, ISBN 0-19-829849-8

Human Rights Relevant Content of Course on Ethics

Presently, the status of human rights teaching in ethics courses is unclear. This study did not include a systematic assessment of ethics courses in graduate health education. Human rights relevant content was evident in only 2 of the medical/residency training courses. The only study to assess human right content in schools of medicine was conducted in 1996 by Sonis et. al.[24] The study included bioethics course directors and bioethics section directors of 125 US medical schools. The extent of

[24] Sonis J, Gorenflo DW, Jha P, Williams C. Teaching human rights in US Medical Schools. *JAMA*. 1996;276(20):1676-1678.

human rights teaching at each school was measured as the percentage of 16 human rights issues. Course directors at 113 (90%) of the 125 US medical schools responded to the survey. Medical schools included about half (45%; 95% confidence interval, 41%-49%) of 16 human rights issues in their required bioethics curricula. Domestic human rights issues, such as discrimination in the provision of health care to minorities (82% of medical schools), were covered much more frequently than international human rights issues, such as physician participation in torture (17% of schools). However, the study did not measure the amount of curriculum time devoted to any or all of the human rights issues, or attempt to verify the information reported. The course directors may have over-reported inclusion of human rights issues due to perceived social desirability. Also, the study instrument did not assess whether courses included any reference to human rights law or instruments or conceptual linkages between health and human rights.

Assessing the extent to which human rights relevant content exists in courses on ethics seems to warrant further research given the importance of outlining a common agenda for human rights and bioethics agenda.

Human Rights Relevant Content of Courses on Social Justice, Societal Issues and Similar Topics

A review of relevant content of courses on social justice, societal issues and similar topics is beyond the scope of this paper. For the purposes of this paper, it is important to understand that a great number of courses exist on these and other topics in graduate health education. For example, courses on social determinants of health, poverty, gender, violence, environmental justice, hunger, reproductive health policies, HIV/AIDS, the health of vulnerable populations, humanism, and bioethics may be included in the curriculum, but it appears that they are not presented within any overarching conceptual framework such as health and human rights.

V. Teaching Methods

Teaching methods for health and human rights courses in graduate health education often depend on whether the course is offered as an elective or a requirement, the school and department in which it is offered, and who teaches the course. In general, health and human rights courses in graduate health education are elective seminars that employ a combination of lectures and group discussions. In most cases, the lecture component is minimized to allow for extensive discussions.[25] Dividing the class into working groups that focus on specific problems or case studies typically enhances the quality of discussion. Discussions also may take the form of student-led reviews of class readings, or assignments

---

[25] This tends to be more problematic in medical education where course time is critical and in undergraduate programs because of larger class size.

for debate on specific human rights issues. Regardless of the way in which discussions are conducted, human rights instructors agree that they should be grounded in examples that are relevant to the future health practices of the students.

Many instructors suggest that human rights material be presented in a variety of formats. Articles and textbooks are the most common, but it is worth mentioning that these readings tend to be more interesting to students when they reflect a range of perspectives, i.e. scientific, analytical, human rights reports, literary, opinion, etc. In some cases, articles may be selected to highlights controversies in human rights to help students sort through polarized or oversimplified points of view. Audiovisual material that is well chosen is often one of the most compelling formats to present human rights information. For example, some courses uses a audiotape of a torture survivor's account of her torture experiences in Guatemala. The format enables instructors to covey the meaning of such experiences in a way that cannot be accomplished through written material.

Guest speakers are commonly used in health and human rights classes. Typically, they provide expertise and experience on human rights issues that the instructor(s) may not have. Such guests may be colleagues in other areas of health study, human rights advocates and experts, clinical patients, survivors of human rights abuses, government representatives, and others. A series of guests may be invited to present in a panel format as well to offer a variety of perspectives on a specific human rights concern. The inclusion of guest speakers throughout the course, however, may interrupt the continuity of class discussions.

As mentioned earlier formal methods of teaching human rights in graduate health education are most effective when they are complemented by informal and participatory forms of education. For example:

Informal

- Human rights lecture series
- Exposure to human rights issues and research in medical and health journals
- Student film series

Participatory

- Student research fellowships and Internships
- Student caucuses and social meetings
- Opportunities to interact/volunteer with local NGOs and service organizations
- Student health and human rights caucuses and informal meetings
- Human rights symposia on campus

Knowledge assessment is an important component of teaching methods as well. In most health and human rights courses in graduate health education, knowledge is assessed through participation in discussion and written papers on health and human rights topics. Health and human rights educators generally used these tools to assess the student's ability to engage in critical thinking and develop original ideas on human rights.

VI. Conclusions and Future Considerations

For health practitioners to effectively respond to social causes of human suffering in the next century, human rights concerns should be integrated into curricular studies of graduate health education. Academic discourse on human rights may be facilitated by undergraduate and graduate courses in schools of medicine, public health and nursing, fellowship and graduate research programs in human rights, and greater emphasis on human rights-related experiences. The degree to which human rights concerns are actively supported by health practitioners will have far-reaching and long lasting effects on students conceptualizations of health and human suffering, and thus the scope of their professional interests in society.

The health and human rights discourse that has developed during the past 10 years has the potential to serve as comprehensive framework in understanding health and human suffering and in providing practical tools for health promotion. For this reason, the Health and Human Rights Curriculum Project's goal of integrating human rights into graduate health education represents an important goal in the realization of health and well-being in the world today.

Considerations for Discussions, Working Group A
Health and Human Rights Curriculum Project

1. What are the immediate and short-term goals of health and human rights studies in graduate health education and how should these be prioritized?

2. Should our conceptualizations of the linkages between health and human rights reflect a strategic or a principled approach, or some combination of both?

3. How do we best resolve the tension between human rights and bioethics discourses and engage bioethicists in a common agenda for health and human rights?

4. What should be the primary and secondary products of the Health and Human Rights Curriculum Project? Consider the following:

- Course material or modules for required and elective courses
- Health and human rights competency policies for schools of public health, medicine and nursing
- Continuing health education courses
- Web-based courses
- Web-based compilations of:
    - human rights courses and syllabi
    - international human rights instruments
    - Principles of bioethics and codes of conduct for health practitioners

5. What are the specific targets for health and human rights education in the health sector,

6. What should be included in the core content of required health and human rights courses/modules?

7. What strategies are most effective in engaging leaders in the health sector to support health and human rights education in schools of public health, medicine and nursing?

8. What parallel activities within and outside of the health sector would help to facilitate the integration of health and human rights into graduate health education?

9. What steps, if any, should be taken to make the Curriculum Project international?