Teaching Health as a Human Right in the Undergraduate Context: Challenges and Opportunities

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Abstract

This paper explores the possibility of a pedagogy about health and human rights that is understandable and persuasive to undergraduate students yet does not succumb to a reductive dualism of optimism and pessimism. In 2014, we presented the topic of health and human rights in an introductory undergraduate global health course in conjunction with the exhibit "Health is a Human Right: Race and Place in America" at the Centers for Disease Control in Atlanta, Georgia. The exhibition highlighted the United States' complicated legacy and failures of health and human rights, with an emphasis on ongoing racial and socioeconomic inequities. In conjunction with class lectures, students viewed the exhibit and submitted a survey and a reflective essay about human rights abuses, as well as possibilities for realizing the right to health in the United States. Contrary to our expectations, the human rights issues surrounding the AIDS epidemic raised very little interest among our students, for whom AIDS is a preventable and treatable chronic disease. Instead, students were most interested in exhibits on eugenics and forced sterilization, deficits in water and sanitation, racism, and contradictions of American exceptionalism. We conclude that an emphasis on the violations of human rights and their health effects using domestic examples from relatively recent history can be an effective pedagogical strategy. This approach represents an opportunity to counter students' presumptions that the United States exists outside of the human rights discourse. Moreover, this approach may reinforce the idea that the domestic race- and class-based inequalities can and should be understood as human rights violations.

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Introduction

The idea of health as a human right was codified in Article 25 of the 1948 Universal Declaration of Human Rights (UDHR) and reiterated in many subsequent treaties and declarations. The "human right to health" is now a well-established platform within global health policy, action, and research.[1] While this right has galvanized successful health activist movements across the world, it has not gained as much popular traction in the United States. Political discussion of the right to health is often conflated with access to and financing of "health care," so that the discourse focuses on promoting "cost-effective" and "value-driven" health services and products.[2] At the same time, discussion of human rights violations and their health consequences often harkens images of starving children or political conflicts in distant parts of the world. Dispelling the myth that human rights violations happen "over there" often proves difficult. The undergraduate classroom is an important place to sustain engagement with students about the human right to health and to unsettle assumptions about these violations. In 2014, we taught an introductory undergraduate global health course to 168 undergraduate students, most of whom were in their first or second year of enrollment. Our course was required for the global health minor but was also open to all undergraduates at Emory University.

Many undergraduates in the United States are drawn to human rights-based activism in an idealistic fervor to help alleviate extreme poverty and suffering in the Global South. Students sincerely want to help "save the world." This passion, however, often stands in tension with unfamiliarity, misunderstanding, and skepticism. Global health courses are an ideal place to explore these tensions and to temper idealistic fervor with humility and a realistic understanding of the complexities of health inequalities.[3] This requires formal cultivation and grounding in both historical and contemporary evidence. Indeed, few undergraduates have more than a cursory understanding of health and human rights, and fewer still have more than an abstract notion of what the violation of such rights entails. Few fully appreciate the fundamental premise of international human rights treaties, namely the claim that basic human rights are owed to every human being, regardless of the sociopolitical context into which an individual may be born.[4] These rights include both protection from harm as well as access to material goods necessary for a meaningful life. The rights are both aspirational and legally codified in international law—but they are violated with regularity and impunity in the United States.

Despite many students' dedication to social justice and health equity, there is a tendency to normalize health inequities and violations of human rights that are happening in neighborhoods, cities, and reservations across the United States. Students tend to attribute these injustices to "just the way things are" or to justify poverty in the United States as a condition that is "not as bad" as that in the Global South. Such misconceptions are pervasive in the United States and, as has been demonstrated in other contexts, students throughout the world are themselves entangled within political and historical contexts that shape their preconceptions and their own emotional responses to pervasive human rights violations around them.[5] This disconnect is especially pronounced for undergraduate college students, particularly those enrolled at elite universities, most of whom never lacked or even worried about access to basic necessities and whose health and well-being has been invisibly subsidized by social and institutional networks. Even as racial injustice and economic inequality have gained long-overdue attention in American popular media, these have rarely been linked to the human right to health. Further, even when students are made aware of these pervasive and ongoing violations, it is difficult to break their ideological barriers and engage them in transformative possibilities.[6] To address these difficulties, scholars have called for pedagogical approaches that critically examine human rights violations in nations with ostensibly strong commitments to human rights, with the goal of linking these pedagogical approaches to ongoing struggles for social justice.[7]

In this paper, we apply this approach to a US context and present our experiences teaching undergraduate students about the inextricability

of racism, poverty, inequality, and health using the Center for Disease Control and Prevention's (CDC) Smithsonian-affiliated Sencer Museum exhibition "Health is a Human Right: Race and Place in America." A version of the exhibition is available online via Georgia State University: https://exhibits.library.gsu.edu/exhibits/show/health-is-a-human-right. The exhibition was designed to commemorate the 25th anniversary of the Office of Minority Health and Health Equity (OMHHE) at CDC.[8] It ran from September 28, 2013 to April 25, 2014, drawing a record of nearly 50,000 visitors, and used video and still images, as well as historical artifacts and digital renderings of epidemiological findings, to show how institutionalized racism, colonialist logic, and structural violence have shaped American health policy and interventions, harmed the health of Americans, and contributed to the egregious health inequities that persist in the United States today. The exhibition was a powerful new way to engage our students with history, and to convey what we otherwise could not—namely the immeasurable and ongoing suffering brought on by human rights abuses, as well of the historical evidence that activism organized around a human rights framework had made a difference.[9] The exhibition covered a range of historical episodes and themes, thereby challenging current biomedical conceptualizations that consider "health" solely within the individual body. It included images of injustices such as the forced relocation of Native Americans, the involuntary sterilization of Chicana women, and the internment of Japanese-Americans. It also challenged simplistic narratives of exploitation by highlighting signature moments of collective resistance, mobilization, and activist fervor: the 1968 Memphis Sanitation Strike and the Poor People's March in the same year; the Safeway agricultural boycott of the 1970s; and the 1991 ACT UP campaign to pressure Dr. James Curran, then-head of the CDC's HIV/AIDS Task Force, to expand the AIDS case definition by sending him 20,000 postcards showing his own face marked with a red and white bull's eye.

This visual imagery provided us, as teachers, with a way to engage our students in the concrete, meaningful, and human experiences in the struggle for health and human rights in the United States. It was also an important way to transcend the limits of traditional methods (such as lectures, statistics, graphs, and international declarations by United Nations agencies) and draw our students' attention to the realities of both historical and ongoing struggles for human rights throughout the world, but especially in the United States.[10] By incorporating the CDC exhibition into our syllabus, we hoped to develop our students' interest in pressing contemporary inequalities, while empowering them to believe that their future actions can contribute to the struggle for human rights in the United States.

Our students' responses to the information and imagery presented in the exhibition was revelatory. We were surprised to learn that material which had resonated with all of us as teachers seemed outdated or irrelevant to our students. Conversely, our students found case studies from the exhibit compelling that we would not have considered incorporating into our classroom. Reflecting on this experience, this paper illuminates how the right to health is interpreted across generations. In what follows, we discuss the challenges we faced teaching health as a human right to undergraduates. We then describe our experience with assigning the CDC exhibition and incorporating its contents into the classroom. Next, we present results from a thematic analysis or our students' responses that revealed the four themes that resonated most with the students. Finally, we consider the challenges and opportunities in using this approach to teach health and human rights.

Background

Like many American colleges, Emory University has embraced global health as part of its liberal arts curriculum, and now offers an undergraduate minor concentration in global health.[11] Our class served as an introduction to global health within this curriculum, spanning issues such as principles of population health, social and physical determinants of health, the history of global health, and contemporary global health interventions.[12] We

sought to incorporate health and human rights in a way that neither advanced a two-dimensional triumphalist narrative, nor focused exclusively on violations, thereby casting doubt on the transformative potential of human rights-based activism. Our approach to health and human rights was incorporated into a traditional lecture-based format.

We began with definitions of human rights, and provided a historical background on the United Nations' (UN) 1948 Universal Declaration of Human Rights (UDHR), which in Article 25 lists health along with 30 other human rights.[13] We also introduced the World Health Organization (WHO) constitution and the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR) Article 12.[14] Drawing on WHO's holistic definition of health, we elaborated on the synergy between health and human rights by stressing the indivisibility of human rights; that is, their inextricability from political, economic, and social rights.[15] As anthropologists, we incorporated into our teaching the critique that human rights are imbued with moral claims derived from principles of liberal law.[16]

Rather than focusing exclusively on violations, which we feared could make our students disengaged and/or cynical, we took a positive approach to teaching health and human rights. We provided a detailed description of the notable successes of the health and human rights movement. Specifically, we focused on the accomplishments of Jonathan Mann and his work in HIV/AIDS activism, and the legal struggles to provide access to antiretroviral therapy in South Africa.[17] The positive teaching strategy complemented topics that had been previously discussed, such as structural violence, the complexity of global health problems, and severe health inequalities.

Although our students were highly engaged in most of the course material throughout the semester, they seemed simply disinterested in the topic of health as a human right. They were unexcited by the examples presented and seemed disconnected from the transformative potential we sought to relate to them. The lectures fell flat. We theorized that their disinterest was, in part, because the legalistic emphasis of human rights lent itself to the confusion of human rights and civil rights—an issue that dates back to the post-Second World War era, when American politicians maintained that atrocities within the United States should be exempt from external scrutiny.[18] Our students, for example, regularly conflated violations of human rights with violations of legal or constitutional rights. This may have been exacerbated by the fact that the United States has no formal commitment to a right to health for all citizens. Students thought that this topic was aspirational, and perhaps naïve; they had difficulty imagining successes built around the claims of the human right to health. Similarly, it was difficult to decenter the peculiarly American political struggle with health insurance and the Affordable Care Act (ACA), which was a major national issue at the time we integrated the CDC exhibition into our teaching. The prominence of the ACA in contemporary discourse reinforced our students' conflation of health with access to medical technologies; this detracted from the larger points we were attempting to convey and made health as a human right not about social justice and social welfare.[19]

When we had the unique opportunity to coordinate the course with the CDC exhibit, we were optimistic. In the current age of social media, the exhibition had the potential to immerse our students in a way that traditional lectures could not. Furthermore, we hoped that the exhibit's exclusive focus on the United States would both challenge the conflation of health and health care and reiterate the import of structural violence to ongoing human rights abuses in the United States.

Methods

Emory University is physically adjacent to the CDC, and the exhibition was free to the public, so our 168 students were able to take a self-guided tour. In addition to submitting notes from the field trip, we asked them to write a series of short essays to reflect on the legacy of the human rights abuses addressed in the exhibition and to generate ideas for realizing the right to health in the United States. For the purposes of this paper, we focus on students' responses

to the following prompt: "Which exhibition [display] did you find most surprising and why? Don't say you 'never knew about this,' instead perhaps reflect on why this is not widely known."

We analyzed our students' responses thematically. Our methodological approach consisted of the following procedure: 1) familiarizing ourselves with the data; 2) generating initial codes; 3) searching for themes; 4) reviewing the themes; 5) defining and naming the themes.[20] Both authors reviewed all student responses multiple times and independently identified key themes. When there was a disagreement about the themes or the interpretation of the content of the data, the authors discussed and resolved it. This method is appropriate for the qualitative description we offer below. Our analysis revealed four major themes from our students' responses: 1) eugenics and forced sterilization; 2) racism and health disparities; 3) poverty—living without the basics; and 4) grappling with American exceptionalism.

We recognize that our students' responses were generated in the context of a graded assignment, which may have led them to exaggerate or tailor their responses in anticipation of our expectations. Nevertheless, the exhibition provided a wide-ranging overview of human rights violations in the United States, and we believe that the themes with which students chose to engage provide important insight into their perspective. For example, the exhibits on HIV/AIDS—a topic that inspired much of the health and human rights movement—did not pique students' interest; less than 1% of students chose to engage with this topic.

We elaborate on the themes generated from our students' responses to the exhibition in the following section.

Theme 1: Eugenics and forced sterilization

The most popular theme expressed in our students' responses was shock at the compulsory sterilization programs that were practiced throughout the United States. Nearly a third (31%) of the class wrote about this topic. The Supreme court upheld the legality of forced sterilization in 1927, with 32 states allowing the practice in 1937. Although this practice began to decline in the 1960s, in some areas it continued through the 1980s and the laws remained on the books until the 21st century. In these programs, women of predominately ethnic minorities, as well as women with "mental defects" were sterilized against their will or without their knowledge in many states.[21] The coercion sometimes came in the form of threats to their welfare benefits, but often it was without their knowledge and while they were in the hospital for unrelated reasons. At the same time, the eugenics movement, which advocated controlled reproduction to increase the occurrence of desirable heritable characteristics and "improve" the human population, gained widespread acceptance in the United States.[22] Some students expressed outright disbelief and indignation after seeing this portion of the exhibit. "I couldn't believe that there was actually a eugenics movement in the United States, and actual laws passed that supported sterilization," one student said. Another echoed this sentiment: "The practice of forced sterilization goes against every value and moral that the United States claims to represent." Many students did not realize that eugenic policies were widespread in the United States. Others appealed to a human rights narrative in expressing their opposition to this practice. "Being able to give birth is a right that all women should have," proclaimed one student. Yet another proclaimed the practice "unconstitutional." And while the US Constitution does not guarantee all citizens the right to give birth, the UDHR does contain provisions related to the right to family and family planning (Article 12b). Our students therefore displayed an intuitive sense of—and support for—certain human rights without the vocabulary or framework to anchor these sentiments. Yet they were unaware that human rights are dynamic legal tools and principles that apply in regional, national, and international spheres.

The eugenics movement was in severe violation of UDHR principles. The Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination against Women (CEDAW) have both declared that women's right

to health includes their sexual and reproductive health.[23] However, there is room for disagreement in how governments should realize the rights to family and family planning. Empowering women to take control over their reproductive health is much more divisive and contentious than recognizing that women have been robbed of these rights in these egregious violations. These complexities highlight a broader difficulty with teaching health and human rights: the fact that human rights are easiest to recognize in their negation. Thus, mobilizing social protests against violations is easier and more feasible than mobilizing activism *for* change.[24] A human rights frame can help explain situations of grave health inequities and injustices, but this does not make human rights the preferred "idiom of social justice mobilization."[25] Ultimately, the absence of a human rights approach from key US struggles leaves students confused, and perhaps unconvinced, about its value.

Theme 2: Racism and health disparities

A similar problem exists in linking racism and health disparities. Structural violence, racism, and social inequalities in health had been significant topics in earlier sections of our course and were not new to our students. Therefore, it was a surprise to us that another large portion of students (27%) seemed astonished to connect the effects of structural racism to health disparities in the United States. Perhaps the museum's tangible exhibits documenting the links between racial discrimination and health forced them to confront these travesties while they seemed vague and distant before. One student commented:

> *I found the exhibit about structural racism the most surprising. I have always thought about racism as a distant idea that is very political. I have never really thought about how racism can bleed into every aspect of life and influence health. The exhibit talks about how private institutions like banks, schools, and transportation systems can have such an impact on the health of minority populations. When groups of people are not given the same access to transportation, education, and financing, it can take a toll on their health and the opportunities they have for improving health and living conditions.*

Another student was drawn to a video entitled *Excerpts from All My Babies: A Midwife's Own Story,* about an African-American "granny" midwife from rural Georgia in 1953. The student wrote:

> *The video compelled [sic] me because it showed in vivid detail the disparity in living conditions among Americans in different socioeconomic standings. In a scene in which a poor African-American woman was in labor, I could see flies flying and sitting on the mother. No one attempted to swat the flies because everyone seemed to be accustomed to the unsanitary living conditions. If the video was muted and shown today, people may think it was filmed in poor countries, such as certain African countries.*

Others pointed to the sordid history of medical experimentation, using examples from the Tuskegee syphilis study and the use of Henrietta Lacks' cells in ongoing medical and pharmaceutical research. In the Tuskegee Study, researchers sought to observe the natural history untreated syphilis in African-American men, which involved withholding treatment even after the advent of penicillin. Henrietta Lacks was an African-American cancer patient at Johns Hopkins University and the unwitting donor of the HeLa cell line, one of the most important and widely used cell lines in medical research. One student noted, "In fact, I use HeLa-derived cells in my HIV research in the Emory Vaccine Center. However, Lacks' family has not benefited financially from her legacy and did not know for decades that her cells were being used."

The ways in which these individual cases reflect broader processes of racism and inequality are commonly discussed in medical anthropology, social medicine, and human rights, having been articulated over a century ago by Rudolf Virchow and W.E.B. Dubois, among others.[26] Yet these ideas remain foreign to many undergraduate students, many of whom are accustomed thinking about health as the sum total of genetics and personal choice, and the practice of medicine as a purely technocratic endeavor. As a result, they conceptu-

alize health as a depoliticized matter, divorced from issues such as racism and structural violence.[27] When health is linked to a range of pervasive human indignities, students are intimidated and confused by such "big questions." This confusion is compounded when these pervasive social inequities are juxtaposed with the questions: Should there be a minimum guaranteed right to health? What basic minimum would the right to health require? The realization of rights necessarily involves conflict, the clash of interests, and divergent ideals.[28] Often, human rights claims signify the beginning, rather than the resolution of these conflicts. Of course, attention to these specificities may lead to short-term gains, but may ultimately divert from full realization of political and economic rights that is a prerequisite for health. Put another way, the difficulty is this: is it possible to take immediate steps towards public health goals without reinforcing and legitimating preexistent inequality, discrimination and inequality? This question is born of students' frustration and struggle to understand and apply human rights principles to the world around them.

Theme 3: Living without the basics of water and sanitation

As an answer to this conundrum, many of our students (20%) referenced the 639,000 American households without indoor plumbing, shown in the section of the exhibition entitled "Living Without the Basics." One student wrote:

> *[This exhibit] showed a corroded pipe and stated that in 2011, safe drinking water and sanitary sewage disposal is still unavailable for 13% of American Indian and Alaskan native homes on reservations, compared to 1% of the total population. This shocked me because as a developed country, I expected all citizens to have access to water and sanitation.*

Another remarked, "It's hard to believe that waterborne diseases still exist in some communities in the US… These people are mostly the poorest in the country, living in rural and urban communities." This assignment predated the public outcry over the Flint water crisis, but our students were pondering these issues at precisely the same time that Flint switched its water supply to the Flint River, prompting residents to complain about the water's color, taste, and odor, and to report rashes and concerns about heavy metal toxicity and bacterial contamination.

Students also invoked the trope of the "developed" vs. the "developing" nation in expressing their surprise about inequalities in access to essentials like clean water. One student observed,

> *The work on delivering safe and clean water is focused on developing countries. However, I failed to realize that many households in America also lack indoor plumbing and access to sanitation services. The corroded water pipe with the bottle of filthy water made an impression on me because I would not have imagined that it was the water used by someone in the United States.*

Another student stated, "Poverty in a wealthy country often goes unnoticed, and the consequences of poverty go beyond simply lacking basic necessities." The exhibit included information on water and health in several US regions, including the Central Valley of California, where residents struggle to access clean drinking water; Warren County, North Carolina, where toxic chemicals from a nearby factory polluted the water and soil; and "Cancer Alley," an 85-mile stretch of actively polluting factories between Baton Rouge and New Orleans, Louisiana. Throughout the United States, growing racial and socioeconomic divisions are reinforced and reproduced in the differential enforcement of civil and economic rights, and manifested in stark health disparities.[29] These processes are neither new nor isolated in our history. Our Global Health course had already considered water and health issues in low- and middle-income countries, but the exhibition demonstrated that global health also refers to health inequalities at home.

Some students focused on the successes and potential of human rights activism. Some, for example, expressed hope that successful litigation would either stop hazardous waste dumping or move polluting factories away from residential communities.

Others cited the Bucket Brigade Program, in which citizens organized themselves and received funding from the Environmental Protection Agency (EPA) to build low-cost, innovative monitors to measure and publicize toxic release from a nearby refinery and provide data for later lawsuits.

This example highlights the community achievements and transformative potential of health and human rights activism. It highlights the inextricability of local and national politics. More importantly, this case illustrates how the CDC exhibition used visual imagery to illustrate important "wins" and "losses" in the struggle for human rights. These cases may seem mundane and small if described in other contexts (e.g., a lecture or in an assigned reading), but the images employed in the exhibit showed how these so-called small battles can have profound and lasting effects across generations. This was a pedagogical lesson we had hoped to instill in our students.

Theme 4: Grappling with American exceptionalism

Although some students readily accepted the role of human rights violations within American history, many others (20%) expressed some discomfort and difficulty reconciling the tangible evidence of human rights violations with their ideological beliefs and assumptions of "American ideals." As they struggled to come to terms with the consequences of the eugenics movement, growing inequalities, and widespread poverty, our students expressed their surprise that these human rights violations were both recent and ongoing. Several, for example, were shocked that the final remaining eugenics law was repealed in 2008 in Mississippi. Again, viewing the exhibition over a year before the publicization of the Flint water crisis, others had dismissed the struggle for clean air or water as struggles of previous generations, or battles that had already been fought and won on behalf of the American people.[30] One student wrote, for example, that the United States is a country that "prides itself on equality, civility and protection of its people and their rights." Surely, such violations could only happen in China or Nazi Germany, others remarked. Many of our students mused that such atrocities are not publicized due to the embarrassment or shame of those involved. We were pleased that a few students explicitly noted that discrimination and inequality are embedded in the fabric of American history and society, and that this reality has palpable effects on human suffering and health. One student observed:

> *The exhibition has one central message; [sic] American history has been fully of inequality… In general, it was clear that the US has not been successful in the past in promoting equality in health because of the social factors that influence health. Most of the exhibits showed some form of poverty that influenced the health of each class.*

Indeed, this structural inequality is the foundation upon which American society is built. Ironically, this is the very thing that simultaneously undermines health and human rights and precludes their widespread recognition.

Students' comments within this theme demonstrate the presence of ideological and experiential barriers to meaningful engagement with health and human rights concepts and approaches. Such meaningful engagement requires that students first address their preconceived notions of the world they live in, by recognizing the grave injustices that regularly go unnoticed and unacknowledged. This is no small feat, for it requires an awareness of mundane injustices and the ability to recognize one's entanglement in these injustices and to situate them within broader historical and political frameworks.[31] Second, students must recognize their own position of privilege and the ways in which they are implicated (even passively) in the suffering and exclusion of others. We recognize, of course, that privilege is relative and that undergraduate students in the United States (and across the world) may come from disenfranchised backgrounds. Nevertheless, an undergraduate education, especially from an elite university, affords a level of privilege that must be recognized and confronted in order to understand the complexities of inequality in a meaningful way. These realizations are necessary for any resistance to the status quo.[32]

For undergraduates to recognize the connection between their own privilege in relation to violations of the rights of others, it requires unlearning their unquestioned and widely believed narratives about themselves and the world around them. In the following section, we reflect further on the challenges in teaching health and human rights to undergraduates in the United States, and propose some tangible suggestions to overcoming these challenges.

Conclusion

Although not all topics engaged our students equally, the CDC's exhibition helped us highlight the ways in which ongoing struggles with racism and structural inequality in the United States are embodied in the lives of individuals and communities. Situating these violations within a historical framework and linking them to human rights discourse and activism may help students see progress and possibilities for change in their own lives. Moreover, the exhibition illustrated the myriad possibilities within the struggle for human rights—the conflicting discourses and the possibilities for success.[33] In doing so, it helped illustrate the ways in which human rights laws are constantly translated into tangible collective activism.

While the exhibition helped our students recognize the immense scope of human rights violations in the United States, it is difficult to teach undergraduates the complexities of health and human rights on a global scale. It is a struggle to avoid a narrow focus on terrible atrocities or heroic narratives of sociopolitical action. Further, it is difficult to teach this topic without seeming to proselytize our belief in the right to health or take advantage of the power asymmetry that exists between teacher and student. In response to such difficulties, some educators have called for the use of an online or distance learning approach to balance this power differential and to engage students from a variety of backgrounds.[34] Despite the advantages of such an approach, it does not address the fact that the right to health refers not to an existing entitlement, but to an aspirational claim with normative and moral dimensions: people do not have the material prerequisites to achieve their highest levels of health, but they *should*. These claims have inspired ongoing political struggles and achieved tangible gains, some which now seem mundane and are taken for granted.

Perhaps this is why the exhibits on HIV/AIDS and the grievous injustices visited upon gay men and people of color caught so few students' interest. The fact that our students were not compelled by this historic example was surprising to us. Although it is difficult to conjecture on the absence of findings, it is worth noting that most of our students ranged from 18 to 22 years in age—born long after the peak of the AIDS epidemic in the United States, and political struggle, policy shifts, and biomedical advances has since helped transform HIV/AIDS from a rapidly fatal condition to a preventable and manageable chronic disease. Acceptance and stigma of the LGBTQ community has changed dramatically in their lifetime. Students in high school and universities have been a common target of successful interventions to reduce HIV-related stigma.[35] Oral HIV pre-exposure prophylaxis (PrEP) is gaining availability and acceptability in the United States, especially among university students.[36] These advancements were borne of the activism of Jonathan Mann, who successfully deployed the human rights framework to destigmatize people and communities stricken by HIV and to prioritize HIV-related research and treatment. Ironically, we believe that it was the very *success* of health and human rights activism that made the suffering associated with HIV/AIDS seem like a historical relic or a lackluster example for most of our students.

In contrast, the examination of the intersection of racism, reproductive rights, and structural violence was successfully illustrated with the example of the eugenics movement and forced sterilization. This example may have been more salient because it directly challenged the discourse of American rectitude, which many of our students had not questioned. Although we have discussed human rights violations in the context of United States history and American exceptionalism, we believe that this applies in other settings. Confronting local human rights violations allows students to grapple with the

ways in which societies fall short of their espoused ideals and to learn about the health consequences of these violations. Our students were able to draw direct parallels between some of the historical case studies presented in the exhibition and contemporary issues and ongoing rights violations in the United States. For instance, our student's observation that "racism can bleed into every aspect of life and influence health" is a prevalent theme throughout US history, one that can be linked to contemporary debates such as mass incarceration and income inequality. Less emphasized in popular discourse, and what we can illustrate to our students, is the way in which these structural inequalities are reflected in health disparities.

This, we believe, represents the most promising opportunity to demonstrate the salience of the human rights discourse to undergraduate students in the United States. Our students vacillated between normalizing discrimination and inequality as inherent to the human condition, and wanting to *do something.* Helping them to realize that discrimination and marginality are constantly produced and reproduced by human actors and are therefore always evolving and contested was the most fruitful part of the course and the CDC exhibition. We would therefore recommend the use of the online version of the exhibit, along with case studies that they could link to ongoing human rights violations in the United States. For instance, students may be given a contemporary case study of a human rights violation in the United States and assigned to research the historical and political conditions that enabled the violation and the effects of such violations on population health. To highlight the possibilities for the human rights framework to affect social change, students may also be assigned to research the efforts of activists to resist such violations at the local, national, and international levels. Finally, students may be asked to compare and contrast their case study with other examples presented in the online exhibition. There is no shortage of these contemporary case studies, but examples include: the Flint water crisis; the detention of children and separation of families in immigration detention centers; the use of solitary confinement in US prisons; and racially targeted referrals of drug-addicted pregnant women for arrest and prosecution for child abuse (see, for example, *Ferguson v. City of Charleston*).

Challenges remain in conveying the complexities of health and human rights and its possibilities as a tool of social change and political transformation. Although our students recognized important "wins" in the struggle for health and human rights in the United States, they expressed confusion and ambivalence towards a human rights-based approach to health. Rather than conveying this ambivalence as a weakness or as something indicative of irreconcilable internal contradictions, we seek to highlight the mutability of the human rights discourse, activism, and social change as sources of dynamism that fuels the transformative possibilities that underlie claims of the human right to health. By illustrating the ways in which different people with divergent backgrounds and worldviews across time and space can ground themselves within a human rights discourse, we can challenge structurally based rights violations in the United States and demonstrate to our students the richness and possibilities of a human rights-based approach to health. This, we believe, will not influence students' worldviews, but will give them tools to understand and engage with the world around them as they progress in their education and in their careers.

References

1. A.R. Chapman and B.J.H.R.Q. Carbonetti, "Human rights protections for vulnerable and disadvantaged groups: The contributions of the UN Committee on Economic, Social and Cultural Rights," *Human Rights Quarterly* 33/3 (2011), pp. 682-732; A.E. Yamin, "Will we take suffering seriously? Reflections on what applying a human rights framework to health means and why we should care," *Health and Human Rights* 10/1(2008), pp. 45-63.

2. G. MacNaughton, "Untangling equality and non-discrimination to promote the right to health care for all." *Health and Human Rights* 11/2 (2009), pp. 47-63; NESRI (National Economic and Social Right Initiative). Available at https://www.nesri.org/programs/what-is-the-human-right-to-health-and-health-care.

3. T. Bul et al., *Reflection in global health* (San Francisco: Global Health Collaborations Press, 2016); B. Astle et al, Global Health Education Competencies Tool-Kit. Available

at https://www.cugh.org/sites/default/files/CUGH%20Global%20Health%20Toolkit%20Web%20Version.pdf.

4. J. Donnelly, *Universal human rights in theory and practice*. (New York: Cornell University Press, 2013); B. Oomen, Barbara. *Rights for others: The slow home-coming of human rights in the Netherlands* (Cambridge University Press, 2014).

5. S. Khoja-Moolji, "Producing neoliberal citizens: critical reflections on human rights education in Pakistan," *Gender and Education* 26/2 (2014), pp. 103-118; S. Khoja-Moolji, "The making of humans and their others in and throughout transnational human rights advocacy: exploring the cases of Mukhtar Mai and Malala Yousafzai," *Signs: Journal of Women in Culture and Society* 42/2, pp. 377-402; A. Osler, "Human rights education, postcolonial scholarship, and action for social justice," *Theory and Research in Social Education* 43/2 (2015), pp. 244-274.

6. M. Zembylas, "Critical pedagogy and emotion: working through 'troubled knowledge' in posttraumatic contexts," *Critical Studies in Education,* 54/2 (2013), p. 176-189; L. Worsham, "Going postal: Pedagogic violence and the schooling of emotion." In *Beyond the corporate university,* edited by H. Giroux and K. Myroides, pp. 229-265 (New York: Rowman and Littlefield, 2001).

7. A. Osler, "Human Rights Education, Postcolonial Scholarship, and Action for Social Justice," *theory and research in social education,* 43/2 (2015), pp. 244-274; F. Tibbitts and HS.R. Katz, "Dilemmas and hopes for human rights education: Curriculum and learning in international contexts," *Prospects,* 74/1-2 (2017), pp. 31-40; K.W. Yang, "Afterword: will human rights education be decolonising?" In *Bringing Human Rights Education to US Classrooms: Exemplary Modesls from Elementary Grades to University,* edited by S.R. Katz and A. McEvoy Spero, p. 225-235 (New York: Palgrave Macmillan, 2015); A.E.C. Struthers, "Teaching British values in our schools: but why not human rights values?" *Social and Legal Studies* 26/1 (2017), pp. 89-110; M. Zembylas, "Re-contextualising human rights education: Some decolonial strategies and pedagogical/curricular possibilities," *Pedagogy, Culture and Society* 25/4 (2017), pp. 487-499; M. Zembylas and A. Keet, *Critical human rights, citizenship, and democracy education: Entanglements and regenerations* (New York: Bloomsbury Critical Education, 2018).

8. Centers for Disease Control and Prevention, *Health Is a Human Right: Race and Place in America*, L.E. Shaw, Editor (2013), Centers for Disease Control and Prevention David J. Sencer Museum: Atlanta, Georgia.

9. R. Burnham and E. Kai-Kee, *Teaching in the art museum: Interpretation as experience.* (New York: Getty Publications, 2011); R. Burnham and E.J.J.o.A.E. Kai-Kee, "The art of teaching in the museum," *The Journal of Aesthetic Education* 39/1 (2005), pp. 65-76.

10. See also: The National Library of Medicine, "Against All Odds: Making a Difference in Global Health (2008-2010). Available at https://www.nlm.nih.gov/exhibition/againsttheodds/exhibit/index.html; The Advocates for Human Rights, "The Right to Health: Equal Access to Health Care in the United States." Available at https://www.theadvocatesforhumanrights.org/uploads/right_to_health_care_lesson_plan.pdf.

11. D.R. Hill, R.M. Ainsworth, and U. Partap, "Teaching global public health in the undergraduate liberal arts: A survey of 50 colleges," *American Journal of Tropical Medicine and Hygiene* 87/1 (2012), pp. 11-15; J.P. Koplan, and R.L. Baggett, "The Emory Global Health Institute: developing partnerships to improve health through research, training, and service," *Academic Medicine* 83/2 (2008), pp. 128-133; L. Hanson, "Global citizenship, global health, and the internationalization of curriculum: A study of transformative potential," *Journal of Studies in International Education* 14/1 (2008), pp. 70-88.

12. P. Brown, and S. Closser, *Foundations of global health: An interdisciplinary reader* (New York: Oxford University Press, 2018).

13. United Nations General Assembly, *International Declaration of Human Rights*. 1948, United Nations General Assembly: New York.

14. Ibid.

15. J. Mann, "Human rights and the new public health," *Health and Human Rights* 1/3 (1995), pp. 229-233; P. Farmer, "Pathologies of power: Rethinking health and human rights," *American Journal of Public Health* 89/10 (1999), pp. 1486-1496.

16. S. Gruskin, E.J. Mills, and D. Tarantola, "History, principles, and practice of health and human rights," *The Lancet*, 370/9585 (2007), p. 449-455; P. Rosenblum, "Teaching human rights: ambivalent activism, multiple discourses, and lingering dilemmas," *Harvard Human Rights Journal* 15 (2002), pp. 301-308; S.E. Merry, "Measuring the world indicators, human rights, and global governance," *Current Anthropology* 52/S3 (2011), pp. S83-S95; S.E. Merry, "Human rights law and the demonization of culture (and anthropology along the way)," *Political and Legal Anthropology Review* 11/2, pp. 47-63.

17. P. Farmer, "Pathologies of power: rethinking health and human rights," *American Journal of Public Health* 89/10 (1999), pp. 1486-1496; E. Fee, and M. Parry, "Jonathan Mann, HIV/AIDS, and Human Rights," *Journal of Public Health Policy*, 29/1 (2008), p. 54-71; H. Hestermeyer, Human rights and the WTO: the case of patents and access to medicines (New York/Oxford: Oxford University Press, 2007); M. Heywood, "South Africa's treatment action campaign: combining law and social mobilization to realize the right to health," *Journal of Human Rights Practice* 1/1 (2009), pp. 14-36.

18. C.E. Anderson, Eyes off the prize: the United Nations and the African American struggle for human rights, 1944–1955 (Cambridge: Cambridge University Press, 2003).

19. L. Gable, "The Patient Protection and Affordable Care Act, public health, and the elusive target of human rights." *The Journal of Law, Medicine, and Ethics* 39/3 (2011), pp. 340-354.

20. H.R. Bernard, Research methods in anthropology: qualitative and quantitative approaches. (New York: Rowan and Littlefield Publishers, 2017).

21. E. Black, *War against the weak: Eugenics and America's campaign to create a master race*. (New York: Four Walls Eight Windows, 2003); C.P. Kendregan, "Sixty years of compulsory eugenic sterilization: three generations of imbeciles and the constitution of the United States." Chicago-Kent Law Review 43/2 (1966), pp. 123-143.

22. E. Black, *War against the weak: Eugenics and America's campaign to create a master race*. (New York: Four Walls Eight Windows, 2003).

23. Office of the United Nations High Commissioner for Human Rights, *Sexual and Reproductive Health and Rights*. Available at http://www.ohchr.org/EN/Issues/Women/WRGS/Pages/HealthRights.aspx.

24. A.M. Stern, *Eugenic nation: faults and frontiers of better breeding in modern America*. (Berkeley: University of California Press, 2015); L. Ko, *Unwanted sterilization and eugenics programs in the United States*. Independent Lens 2016. Available at http://www.pbs.org/independentlens/blog/unwanted-sterilization-and-eugenics-programs-in-the-united-states/.

25. S.S. Willen et al., "Syndemic vulnerability and the right to health," *The Lancet* 389/10072 (2017), pp. 964-977; S. Gloppen, "Litigation as a strategy to hold governments accountable for implementing the right to health," *Health and Human Rights* 10/2 (2008), pp. 21-36.

26. B. Salhi and P. Brown. "Rudolf Virchow," *International Encyclopedia of Anthropology 2018.* Available at https://onlinelibrary.wiley.com/doi/full/10.1002/9781118924396.wbiea1568 DOI: 10.1002/9781118924396.wbiea1568; W.E.B. DuBois, *Souls of black folk*. (Hayes Barton Press, 1965).

27. G. Oppenheimer et al. "Health and human rights: Old wine in new bottles?" *The Journal of Law, Medicine & Ethics* 30/4 (2002), pp. 522-532; A. Keet, "It is time: Critical Human Rights Education in an age of counter-hegemonic distrust," *Education as Change* 19/3 (2015), pp. 46-64.

28. C.E. Easley, S.P. Marks, and R.E. Morgan, Jr., "The challenge and place of international human rights in public health," *American Journal of Public Health* 91/12 (2001), pp. 1922-1925.

29. C. De Albuquerque, Realising the human rights to water and sanitation: A Handbook by the UN Special Rapporteur. Available at https://unhabitat.org/books/realising-the-human-rights-to-water-and-sanitation-a-handbook-by-the-un-special-rapporteur-catarina-de-albuquerque/

30. N. Gaber, "Mobilizing health metrics for the human right to water in Flint and Detroit, Michigan," *Health and Human Rights* 21/1 (2019), pp. 179-189.

31. M. Zembylas, "Critical pedagogy and emotion: working through 'troubled knowledge' in posttraumatic contexts," *Critical Studies in Education,* 54/2 (2013), p. 176-189; L. Worsham. "Going Postal: Pedagogic Violence and the Schooling of Emotion." In *Beyond the Corporate University,* edited by H. Giroux and K. Myroides, pp. 229-265 (New York: Rowman and Littlefield, 2001).

32. A.E. Yamin, "Shades of dignity: exploring the demands of equality in applying human rights frameworks to health," *Health and Human Rights* 11/2 (2009), pp. 1-18; A.E. Yamin. *Power, Suffering, and the Struggle for Dignity: Human Rights Frameworks for Health and Why They Matter.* (Philadelphia: University of Pennsylvania Press, 2017).

33. S. Willen, "Health is a human right—at CDC?" *Health and Human Rights* 21/1 (2019), pp. 163-177.

34. M. Bajaj, "Human rights education: ideology, location, and approaches," *Human Rights Quarterly,* 33/2 (2011), pp. 481-508; F. Tibbitts, "Evolution of Human Rights Education Models," in *Human Rights Education: Theory, Research, Praxis,* edited by M. Bajaj, pp. 69-95 (Philadelphia: University of Pennsylvania Press, 2017).

35. A.L. Stangl, J.K. Lloyd, L.M. Brady, C.E. Holland, and S. Baral, "A systematic review of interventions to reduce HIV-related stigma and discrimination from 2002 to 2013: how far have we come?" *Journal of the International AIDS Society*, 16/S2 (2013), pp. 18,734-18,748.

36. A.E. Petroll, J.L. Walsh, J.L. Owczarzak, T.L. McAuliffe, L.M. Bogart, and J.A. Kelly. "PrEP awareness, familiarity, comfort, and prescribing experience among US primary care providers and HIV specialists," *AIDS and Behavior* 21/5 (2017), pp. 1256-67; T. Arnold, C.E. Sims-Gomillia, K. Portz, E. Bologna, and B. Williams, "Preliminary investigation evaluating college students' willingness and need to take pre-exposure prophylaxis (PrEP) for HIV," *HIV & AIDS Review. International Journal of HIV-Related Problems* 17/2 (2018), pp. 98-102.