Incorporating human rights into reproductive health care provider education programs in Nicaragua and El Salvador

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Suggested citation Reyes HLM, Padilla Zuniga K, Billings DL, Blandon MM. Incorporating human rights into reproductive health care provider education programs in Nicaragua and El Salvador. Rev Panam Salud Publica. 2013;34(1):54–9.

ABSTRACT *Health care providers play a central role in the promotion and protection of human rights in patient care. Consequently, the World Medical Association, among others, has called on medical and nursing schools to incorporate human rights education into their training programs. This report describes the efforts of one Central American nongovernmental organization to include human rights–related content into reproductive health care provider training programs in Nicaragua and El Salvador. Baseline findings suggest that health care providers are not being adequately prepared to fulfill their duty to protect and promote human rights in patient care. Medical and nursing school administrators, faculty, and students recognize the need to strengthen training in this area and are enthusiastic about incorporating human rights content into their education programs. Evaluation findings suggest that exposure to educational materials and methodologies that emphasize the relationship between human rights and reproductive health may lead to changes in health care provider attitudes and behaviors that help promote and safeguard human rights in patient care.*

Key words Human rights; reproductive health; education, medical; Nicaragua; El Salvador.

Global recognition of the human right to health has increased significantly over the past two decades as every country in the world has become party to at least one human rights treaty that addresses health-related rights (1). As the primary interface between patients and health systems, health care providers, including doctors, nurses and medical paraprofessionals, have an important role in promoting and protecting human rights in their daily practice. Indeed, it has been noted that "there is perhaps no better place to begin to impart an awareness of human rights and human dignity than in the small world of the doctor-patient relationship" (2, 3). Health care providers who are literate in human rights principles and laws may invoke them to advocate for better services on behalf of their patients and may be better prepared to navigate challenging ethical patient-care dilemmas that may also be human rights issues, such as decisions concerning confidentiality and reproductive decision-making (4). In addition, a better understanding and awareness of the linkages between health and human rights may motivate health care providers to deliver and advocate for patient care that reflects a "broader health promotion model (concern for prevention of disease and promotion of the health of the population as a whole) rather than the biomedical model (intervention to treat a patient)" (4, p. 21). Recognizing this, several medical professional organizations, including the World Medical Association (5) and the International Council of Nurses (6), have acknowledged health care providers' role in safeguarding human rights and have recommended that medical and nursing schools integrate human rights–related content into their training programs. However, few studies have examined whether or how medical and nursing schools have responded to this recom-

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mendation (7, 8). This report describes an initiative to incorporate human rights concepts and principles into reproductive health provider education programs housed in medical and nursing schools in two Central American countries, Nicaragua and El Salvador. The authors present the results of two pilot studies that evaluated the impact of a workshop and training course that included human rights content on health care provider attitudes and behaviors.

HUMAN RIGHTS IN REPRODUCTIVE HEALTH EDUCATION (HRHE) INITIATIVE

The Human Rights in Reproductive Health Education (HRHE) initiative was established in 2006 by Ipas Central America, a nongovernmental organization (NGO) in Managua, Nicaragua, that promotes reproductive health and rights in collaboration with medical and nursing schools in the Central American region. The overall goal of the initiative is to ensure that health care provider education programs in Central America prepare students to fulfill their role in protecting and promoting human rights in reproductive health care. Specific aims of the initiative are to 1) increase administrator, faculty, and student awareness and motivation to learn about the relationship between human rights and health; 2) identify gaps in training program content where human rights perspectives may be integrated into established curricula; 3) develop, pilot-test, and disseminate educational materials that address human rights in reproductive health care; and 4) provide technical assistance and support to faculty who are interested in incorporating HRHE materials into their courses.

The HRHE initiative was launched after formative research, conducted by Ipas Central America, with medical and nursing school administrators, faculty, and students from the University of El Salvador (UES) and the National Autonomous University of Nicaragua in Managua (UNAN), indicated a strong interest in incorporating human rights into training programs and suggested that schools were not adequately preparing students to fulfill their role in safeguarding patients' rights. For example, a baseline needs assessment survey of 183 medical and nursing students from Nicaragua and El Salvador found that less than half of the students expressed confidence in their ability to 1) identify human rights violations in the delivery of health care services (37%); 2) take action if rights violations are detected (40%); or 3) advocate for their rights as health care providers to supervisors (33%) (K. Padilla, 2007, unpublished data). Faculty and administrators at both the UES and the UNAN expressed interest in collaborating on the HRHE initiative, and formal partnerships were established with each school in 2007.

Conceptual model

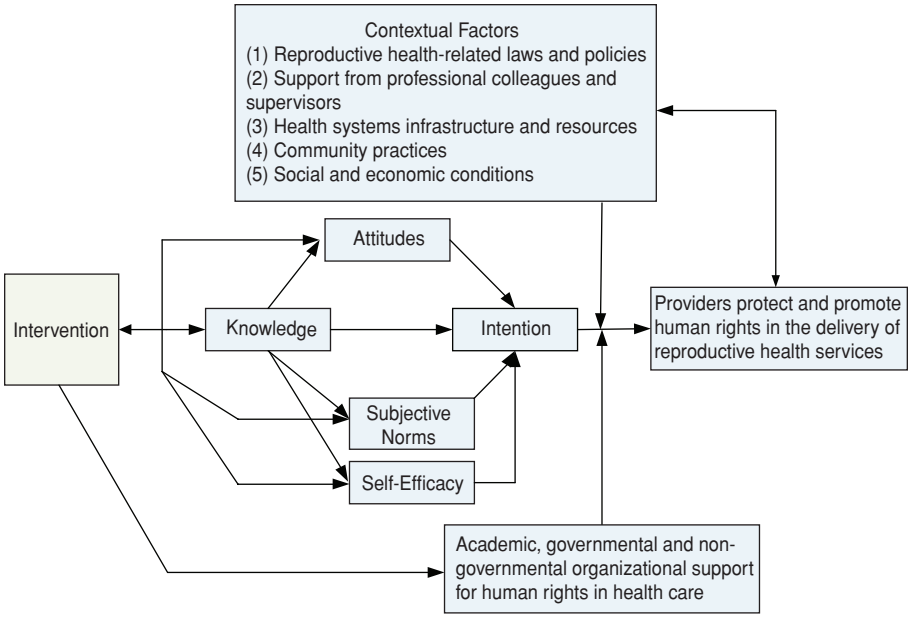
A theory-based conceptual model was developed to guide the design and evaluation of the HRHE initiative. Depicted in Figure 1, the model was informed by two leading theories of health behavior, the theory of planned behavior (9) and social learning theory (10), and puts forth that exposure to rights-based educational materials and training (the intervention) is expected to 1) increase health care provider knowledge about health and human rights; 2) lead to the adoption of attitudes and norms that support the fulfillment of human rights in patient care; and 3) strengthen students' self-efficacy beliefs (their beliefs in their ability to perform tasks related to the protection and promotion of human rights in health care). Favorable attitudes, norms, and increased self-efficacy will lead to increased motivation to protect human rights (intention) and, in turn, lead providers to protect and promote human rights in patient care.

The conceptual model also posits that contextual factors will influence the likelihood that increased motivation (intention) to protect and promote human rights will translate into behavior change. In particular, prevailing social and economic conditions; national policies; health systems infrastructure; support for human rights in both the proximal environment (e.g., supervisors and colleagues) and the distal environment (e.g., medical professional societies); and cultural attitudes and practices may moderate the efficacy of the intervention. For example, participants who are exposed to human rights materials and training may enter into practice with high levels of intention to ensure that women seeking post-abortion care be examined in a private place, but then may be confronted with a lack of resources (e.g., infrastructure) and environmental conditions (e.g., crowding) that prevent them from acting on that intention.

Educational materials development

As part of the HRHE initiative, project staff and faculty collaborators developed teaching tools and educational materials that use a rights-based approach to

FIGURE 1. Conceptual model of the Human Rights in Reproductive Health Education (HRHE) Initiative (HRHE) established by NGO Ipas Central America, Managua, Nicaragua, 2006



address reproductive health topics. This was particularly challenging because there were few existing materials that fit the needs the authors had identified, and the materials that were found tended to be available only in English. Consequently, significant project resources were dedicated to the development and piloting of new educational materials. In particular, teaching tools (e.g., presentations and skills-building activities) were developed that 1) address the relationship between human rights and reproductive health; 2) define providers' role in safeguarding human rights; 3) present information on reproductive health–related laws and policies; and 4) increase providers' motivation and ability to safeguard human rights. The materials also aimed to improve specific rights-related service-delivery skills, including providers' ability to 1) protect patient confidentiality (right to privacy); 2) provide comprehensive information and counseling (right to non-discrimination, information, and education); 3) respect patient privacy during examination and counseling (right to privacy and dignity); 4) respect patients' autonomy in making decisions about their health care (right to non-discrimination, and freedom of thought, religion, and conscience); 5) monitor and report violations of patients' and providers' rights; and 6) advocate for the resources necessary to fulfill various rights (e.g., rights to the benefits of scientific progress, access to available resources, and their fair allocation).

HRHE PILOT STUDIES IN NICARAGUA

At the invitation of UNAN and Ministry of Health (MINSA) partners in Nicaragua, HRHE project staff and university collaborators developed and conducted a workshop and training course for nursing students and medical school graduates on different reproductive health and human rights topics. These training events provided the opportunity to pilot-test, evaluate, and refine the HRHE educational materials and methodologies. Key evaluation findings from two pilot studies, both of which were conducted in Nicaragua, are presented below.

Pilot Study 1

In April 2008, in collaboration with the UNAN nursing school, project staff developed, conducted, and evaluated a five-day (40-hour) health and human rights workshop for second-year nursing students in Nicaragua. The overall objective was to increase participants' ability to protect and promote human rights in reproductive health care. The workshop comprised four sessions, each covering one of the following topics: 1) the relationship between health, human rights, and medical ethics; 2) the relationship between human rights and reproductive health; 3) specific ways that providers can safeguard human rights in the service delivery context; and 4) the legal processes involved in reporting a human rights violation.

Methods. The workshop material was evaluated using a pre-/post-test quasi-experimental study design. The intervention group included 25 second-year nursing students attending courses at the UNAN nursing school's campus in Managua. A comparison (control) group was composed of second-year students attending courses at a school campus in a nearby province ($n = 30$). Students at both campuses received the same academic training and were similar in terms of their demographic profiles but were not in direct contact with each other because they lived in different areas of the country. All second-year nursing students attending courses at the two campuses were eligible and consented to participate. Baseline data were collected from both groups immediately prior to delivery of the workshop to the intervention group, and post-test data were collected from both groups three months after workshop delivery. The data collection protocols were reviewed and approved by the UNAN nursing school.

Outcome measures consisted of four items assessing participants' self-efficacy beliefs. Respondents were asked to report their level of confidence in their ability to 1) make ethical decisions in difficult situations; 2) identify human rights violations in health services; 3) take action to change health services if human rights are being violated; and 4) advocate for their rights as health care providers to supervisors. Response options for each outcome were assessed on a four-point scale ranging from "not confident" to "very confident." Linear regression analysis was used to assess the effects of the intervention condition on each of the four outcome measures (four separate models), controlling for pre-test scores.

Results. Results are presented in Table 1. The workshop had a significant effect on participants' confidence in their abilities to take action to change health services if human rights were being violated ($b = 0.59$, $P = 0.04$) and a marginally significant effect on participants' confidence in their ability to advocate for their rights as health care providers to supervisors ($b = 0.22$, $P = 0.05$) but had no significant effect on participants' confidence in their ability to 1) make ethical decisions in difficult situations or 2) identify human rights violations in health services. The workshop also influenced providers' knowledge of where to report rights violations (various institutions; results not shown). In particular, workshop participants were more likely than control group members to know that patients can report rights violations to health center administrators ($P = 0.03$) and nongovernmental human rights organizations ($P < 0.001$).

Pilot Study 2

In collaboration with MINSA and the UNAN Medical School in Managua,

TABLE 1. Effects of a health and human rights workshop for nursing students on self-efficacy outcomes at three-month follow-up, Managua, Nicaragua, April 2008[a,b]

Self-efficacy outcome measure	Intervention group ($n = 25$) M (SD)	Control group ($n = 30$) M (SD)	*b* (SE)	*P*
Ability to make ethical decisions in difficult situations	3.33 (0.65)	3.22 (0.58)	0.12 (0.21)	0.58
Ability to identify human rights violations in health services	3.11 (0.60)	3.27 (0.72)	–0.09 (0.27)	0.75
Ability to take action to change health services if human rights are being violated	3.44 (0.53)	3.12 (0.88)	0.59 (0.27)	0.04
Ability to advocate for their rights as health care providers to supervisors	3.78 (0.44)	3.26 (0.76)	0.22 (0.18)	0.05

[a] Mean (M) values and standard deviations (SDs) are from data collected three months after intervention group workshop exposure.

[b] Parameter estimates (beta coefficient, *b*); standard errors (SEs); and *P* values for the effect of treatment on each self-efficacy outcome are from linear regression models that control for baseline levels of the outcome.

project staff delivered a three-day (24-hour) training course to doctors who had just graduated from medical school and were about to enter into a year of social service practice, which is mandated by Nicaraguan law. The course was delivered in July 2008 and focused on providing information and developing skills related to the delivery of post-abortion care, sexual violence health care services, emergency contraception, pre- and postnatal care for adolescents, and family planning counseling. The role of health care providers in the protection and promotion of human rights was a cross-cutting theme.

Methods. To evaluate the training course, semi-structured interviews were conducted with selected participants (n = 18) approximately three to six months after the course had finished. A purposive sampling strategy was used to select a sample that included doctors who had been assigned to social service posts in each of the six different regions of the country. All training course attendees selected to participate in the evaluation study agreed to participate and gave informed consent. Six of the participants were male and 12 were female. Participant interviews were conducted by HRHE staff in a private location convenient to the participant and normally lasted about one hour. The interviews focused on 1) clarifying the role of contextual factors on participants' use of knowledge and skills acquired in the course; 2) documenting the impact of participation in the course on provider practice; and 3) eliciting participant perceptions of which aspects of the course were most and least relevant in the practice setting. Digital recordings of the interviews were transcribed and analyzed using a text-coding structure developed in the analysis package NVivo 8 (QSR International, Melbourne, Australia).

At the time of the interview, most of the doctors participating in the study were working in small health centers in rural areas and almost half (n = 7) reported being the only doctors at their health center. Results indicated the predominant services delivered to patients seeking care at study participants' health centers were those related to family planning, sexually transmitted infections (STIs), and prenatal care.

Results. The doctors identified several contextual factors that influenced their ability to fulfill their role in protecting and promoting patients' rights. These contextual factors included support from colleagues and supervisors, availability of material and human resources, and cultural issues related to gender inequality. Results indicated that support from colleagues (i.e., other providers working in the same facility) was a key factor determining the success of efforts to advocate for changes to service delivery (e.g., requests for more secluded spaces for counseling and examination to protect patients' privacy). When colleagues did not support changes in services, supervisors were less likely to respond to complaints. A predominant narrative with respect to resource availability was that of being overworked and understaffed, which limited the time the doctors had to offer counseling and support to their patients. Some study participants reported that they felt bad providing comprehensive counseling on family planning methods when shortages in supply meant that they could not offer all of the options described. Finally, the doctors' narratives revealed substantial frustration with issues of gender inequality that arose when talking about contraceptive decision-making and intimate partner violence. For example, some study participants described investing time and energy providing family planning counseling to female patients whose family planning decisions ultimately were made by their husbands. Several study participants said they feared negative consequences for themselves if they involved themselves in counseling patients on intimate partner violence, as shown in the statement below:

> *Sometimes you want to get involved—get in the middle of the fight—and—this is really horrible to say—you feel like your hands are tied; you can say to the woman "do this and do that" but here [rural areas in Nicaragua] the woman will tell her man and it is a problem; the population here has a machete in hand; it's really better not to get involved in counseling about [violence].*

All study participants felt that the content of the training course was directly applicable to their daily practice, and the majority reported that the course content related to adolescent pregnancy and family planning methods and counseling was particularly relevant. The transcripts suggest that although doctors all received training in these areas during medical school, some concepts covered in the training course, such as the provision of comprehensive information, respect for patients' privacy and decision-making autonomy, and emotional support, were either not covered or not emphasized in their medical school training. Several study participants reported changes in how they approached communicating with their patients that demonstrated increased respect for their patients' dignity and integrity, as shown in the statement below.

> *I got out [of medical school] and I thought I could tell the patient what I wanted, and the workshop helped me a lot to make the decision that I am not the boss; how can I say this—just because a patient comes to me I am not God, or his mother or father to judge him. . . .*

In addition, some study participants reported increased motivation to fulfill their role as guarantors of patients' rights even when under enormous strain due to working in under-resourced settings. In some cases, as shown in the statements below, this increased motivation was attributed to an increased empathy for patients based on a better understanding of the social determinants that underlie reproductive health conditions and/or an expanded notion of their role as providers obliged to protect and promote patients' rights.

> *. . . [the workshop] has made me reflect more on putting emphasis on family-planning counseling, because really the population is very poor and I live it and I see that it really is the poorest who have more children, and it is for lack of opportunities, because really men don't let women control their fertility. . . .*

> *. . . and maybe I have a stack of charts like this [gestures with her hands], and maybe I have seen this patient before and the patient really wants to see me, so I can't take away her right to see me, so what I say is, "someone else take this other patient and I will take her," because it's not like I can just keep on taking more patients either, but yes, above all else I have learned to really see what the patient wants. . . .*

DISCUSSION

The current findings highlight the need to further develop, evaluate, and refine educational materials and methodologies that focus on preparing providers to protect and promote human rights in reproductive health care. The results of Pilot Study 1 suggest that while the workshop content increased participants' confidence in their abil-

ity to take action if rights were being violated, it did not influence study participants' confidence in their ability to identify rights violations in health care.[4] The results of Pilot Study 2 suggest that contextual factors (e.g., workload, resource limitations, health systems infrastructure, support from colleagues and supervisors) influence providers' ability to protect and promote rights. Overall, the findings suggest that future training should include information on how to identify rights violations and provide strategies for addressing contextual barriers to rights protection and promotion. For example, educational materials could be developed that 1) provide students with guided "real-world" opportunities to identify rights violations in health care services (e.g., through a services "audit" or by critiquing videotaped service-delivery scenarios); 2) equip students to navigate contextual barriers to human rights protection and promotion that they may face in practice; and 3) provide opportunities for students to gain awareness of and develop skills for addressing these barriers (e.g., through role-play and modeling). Educational materials that seek to enable providers to protect and promote human rights in patient care should also address the frustration providers may feel as a result of their lack of power to address complex structural barriers such as health system infrastructure and resource limitations that limit their ability to practice in the best ways possible (11). To further inform the development of these types of training materials and methodologies, further research should be conducted to elaborate the types of contextual barriers health care providers face and test practical strategies for addressing them.

The current findings are consistent with those of other studies that suggest the importance of developing and implementing multilevel interventions designed to not only improve provider motivation and preparedness to provide high-quality care that protects and promotes human rights but also directly address the contextual factors that influence providers' ability to fulfill their role as human rights guarantors (e.g., through policy development, the organization of support networks, and the use of human resource management tools) (12, 13). More broadly, the current findings suggest that current health care provider training programs may need to put more emphasis on building skills related to health promotion, including counseling and communication with patients about family planning, intimate partner violence, and adolescent pregnancy. The findings of Pilot Study 2 clearly indicate that providers were surprised at the level of demand for these types of services and generally felt underprepared by their training programs to deliver them.

[4] The small sample size of Pilot Study 1 limited the ability to make strong conclusions based on the findings because the power to detect effect size was quite limited.

Conclusions

It has been noted that the field of reproductive health differs from other fields of health care in that health care providers deal primarily with healthy people embedded in societies that are polarized with respect to issues of human reproduction (2). Reproductive health care providers must therefore be specially prepared to engage patients in preventive care, facilitate medical decision-making, and invoke human rights and ethical principles to navigate situations in which the interests of patients, intimate partners, and family members conflict (2). The experience recounted in this report suggests that efforts to incorporate human rights content into reproductive health care provider education programs are needed and may be well received by medical and nursing schools in Latin America. Although education and training interventions may not fully counteract the degrading influence of contextual factors such as resource limitations that hinder health care providers' ability to effectively safeguard human rights, training programs may increase providers' motivation and ability to protect and promote human rights, confront contextual barriers, and cultivate a sense of pride in their responsibility as "frontline" defenders of human rights. Changes in health care provider attitudes and abilities may, in turn, lead to improved human rights protection and promotion in patient care. Ultimately, these same providers may be the decision-makers of the future, able to influence important changes needed in education and practice so that human rights are fully respected.

Acknowledgments. The authors wish to thank the administrators, faculty, and students from the National Autonomous University of Nicaragua and the University of El Salvador who participated in the HRHE initiative for their collaboration in this study.

Financing. Financial support for the Human Rights in Reproductive Health Education Initiative was provided by the Ford Foundation (Mexico City, Mexico) and the Interchurch Organization for Development Cooperation (ICCO) (Utrecht, Netherlands).

Conflict of interest. None.

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Manuscript received on 20 June 2012. Revised version accepted for publication on 17 December 2012.

RESUMEN

Incorporación de los derechos humanos a los programas de formación de los proveedores de atención de salud reproductiva en Nicaragua y El Salvador

Los proveedores de atención sanitaria desempeñan una función esencial en la promoción y la protección de los derechos humanos en la atención al paciente. En consecuencia, la Asociación Médica Mundial, entre otras instituciones, ha exhortado a las facultades de medicina y de enfermería a incorporar la formación en materia de derechos humanos en sus programas de capacitación. Este informe describe las iniciativas de una organización no gubernamental centroamericana para que se introduzcan contenidos relacionados con los derechos humanos en los programas de capacitación de los proveedores de atención de salud reproductiva en Nicaragua y El Salvador. Las conclusiones iniciales indican que no se prepara adecuadamente a los proveedores de atención de salud para cumplir su responsabilidad de proteger y promover los derechos humanos en la atención al paciente. Los administradores de las facultades de medicina y de enfermería, el profesorado y los estudiantes reconocen la necesidad de fortalecer la capacitación en esta área y son entusiastas acerca de incorporar contenidos relacionados con los derechos humanos en sus programas de formación. Los resultados de la evaluación indican que la exposición a materiales y métodos didácticos que subrayen la relación entre los derechos humanos y la salud reproductiva puede conducir a cambios en las actitudes y los comportamientos de los proveedores de atención de salud que contribuyan a promover y proteger los derechos humanos en la atención al paciente.

Palabras clave Derechos humanos; salud reproductiva; educación médica; Nicaragua; El Salvador.