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# Needs Assessment for a Training in Health and Human Rights among Centers for Disease Control and Prevention Locally Employed Staff: A Study of Knowledge, Attitudes, and Practices Related to Human Rights

By

Izraelle McKinnon

MPH

Hubert Department of Global Health

_____

Dabney Evans

Committee Chair

_____

Aun Lor

Committee Member

_____

Basia Tomczyk

Committee Member

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By

Izraelle McKinnon

B.A., Brown University, 2011

Thesis Committee Chair:

Dabney P. Evans, PhD, MPH – Hubert Department of Global Health, Emory University

Thesis Committee Members:

Aun Lor, MPH, MA, PhD – Center for Global Health, Centers for Disease Control and Prevention

Basia Tomczyk, RN, MS, PMH, DrPH – Center for Global Health, Centers for Disease Control and Prevention

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# Abstract

Needs Assessment for a Training in Health and Human Rights among Centers for Disease Control and Prevention Locally Employed Staff: A Study of Knowledge, Attitudes, and Practices Related to Human Rights

By Izraelle McKinnon

**Objective:** To determine the need for a training in Health and Human Rights (HHR) among CDC Locally Employed (LE) staff.
**Research Design and Methods:** We conducted this needs assessment through in-depth interviews and an electronic survey. Interviews of eight LE staff members took place June 9 and June 10, 2016 which the interviewer recorded, transcribed, and analyzed through MaxQDA software. We made the electronic survey available to all CDC staff from September 4, 2015 to December 1, 2015 and analyzed data for only LE staff respondents for the purpose of this study. Of the approximately 1,546 LE staff members, 104 took part in the survey.
**Results:** Sixty-three percent of survey respondent were African LE staff, 26% Asian, and the remainder Caribbean and Latin American. Survey results indicated that 86% of respondents believed that public health could benefit from an HHR framework. However, 72% of respondents did not feel that they had enough knowledge to adequately address human rights in their work. Particular knowledge gaps related to HHR were the Siracusa Principles, although no more than 6% of LE staff were trained in any knowledge indicator. Few respondents indicated having skills related to human. Survey results also demonstrated preference for a combination of training methods (41%), the inclusion of local and international HHR experts (49% and 55% respectively), and HIV/AIDS as a content area of interest (54%). Qualitative results supported these findings. Participants revealed awareness that human rights violations impact universal access to health, a lack of knowledge in HHR, the need for a training in HHR, as well as a need for interactive training methods and a combination of facilitator types as a part of training.
**Conclusion**: This study confirmed that gaps exist in knowledge in HHR issues and the skills to address those issues among LE staff. We recommend the creation and implementation of a training for LE staff which addresses the use of data and programs to support human rights in public health practice, particularly in the context of Emergency Preparedness and Response and HIV/AIDS. Trainings must use interactive methods and local and international HHR experts.

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# Contents

## Table of Tables and Figures

## Abbreviations

| | |
|---|---|
| AAHR | Atlanta Alliance for Health and Human Rights |
| AIDS | Acquired Immune Deficiency Virus |
| CAT | Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment |
| CEDAW | Convention on the Elimination of all Forms of Discrimination Among Women |
| CERD | International Convention on the Elimination of all Forms of Racial Discrimination |
| CIO | Center, Institute, Office |
| CRC | Convention on the Rights of the Child |
| CDC | Centers for Disease Control and Prevention |
| DHHS | Department of Health and Human Services |
| EIS | Epidemic Intelligence Service |
| EPO | Epidemiology Program Office |
| ICCPR | International Covenant on Civil and Political Rights |
| ICESCR | International Covenant on Economic, Social and Cultural Rights |
| LE | Locally Employed |
| HHR | Health and Human Rights |
| HHRW | Health and Human Rights Workgroup |
| HIV | Human Immunodeficiency Virus |
| MCWA | Malaria Control in War Areas |
| NCHSTP | National Center for HIV, STD, and TB Prevention |
| PHS | United States Public Health Service |
| STD | Sexually Transmitted Disease |
| TB | Tuberculosis |
| UN | United Nations |

# Introduction

Despite the existing evidence of instrumental and intrinsic linkages between human rights and public health, the Centers for Disease Control and Prevention (CDC) has yet to create a formal training curriculum in a human rights-based approach to health for its staff members, including its overseas Locally Employed (LE) staff. Violations of human rights can cause physical, mental, and emotional traumas and harm, which is significant to people working to achieve population health (Mann et al., 1994). Moreover, by definition human rights are the norms necessary to achieve population well-being. Therefore, they are the essential conditions necessary to achieve "a complete state of physical, mental, and social well-being," the World Health Organization (WHO) definition of health. Without an approach to health which considers human rights, public health practitioners risk missing important intervening and underlying factors which they must address in order to improve population health. This also implies that their work has the potential to uncover and alleviate inadvertent or deliberate abuses of human rights. This potential requires that public health practitioners have the awareness, knowledge, and skills to address human rights through their work. It is therefore important for public health practitioners, including LE staff for the CDC, to have training in a human rights-based approach to health. A training which conveys practical skills and knowledge within the context of staff members' working conditions can improve the capacity and outcomes of training participants.

## Problem Statement

A human rights-based approach to health connects the complementary fields of international human rights and public health to provide a comprehensive approach to achieving the highest attainable standard of health. Through such an approach, human rights can provide a framework to guide the objectives and practices of work in public health. Although public health

and human rights scholars alike promote a human rights-based approach to health, the global leader in public health, the CDC, does not currently provide a formal training for its staff members in a human rights-based approach to health. An essential preliminary step in creating such a training is conducting a needs assessment among the potential training population, which for the purposes of this assessment is CDC LE staff. A needs assessment will reveal the training needs and desired educational components of a formal training curriculum. Through conducting this needs assessments, there is potential to create a training which provides the tools for a transformative approach to health among CDC LE staff.

### Purpose Statement

The purpose of this assessment was to determine the needs for training in a human rights-based approach to health among CDC LE staff. The objectives were to determine 1) the desire for a training in in a human rights-based approach to health, 2) the need for a training in a human rights-based approach to health, 3) the necessary objectives to include in such a training, and 4) the types of trainers and appropriate methods to include in such a training.

### Questions

1. Is there interest in a Health and Human Rights training among LE staff?
2. Is there a need for a Health and Human Rights training among LE staff?
3. What are the knowledge and skill objectives to include in a Health and Human Rights training among LE staff?
4. What are the appropriate methods to include in conducting a Health and Human Rights training among LE staff?

## Significance Statement

This needs assessment allows for evidence-based determination of whether there is a need for a human rights-based approach to public health practice among LE staff. In addition, this needs assessment informs the creation of objectives and educational methods for such a training. Providing LE staff with the knowledge and skills to approach health through a human rights-based framework may result in greater capacity of staff to monitor and address underlying determinants of health, which are often related to human rights violations. These underlying determinants of health often determine health outcomes. Moreover, creating a training which is appropriate for our study population can better equip staff to be more aware of the impact of their public health practices on the human rights of the populations they serve.

## Definitions

**Locally Employed Staff:** staff members employed by the Centers for Disease Control and Prevention who are citizens or residents of the country in which they are employed

**Health and Human Rights:** also known as a human rights-based approach to health, is manner of approaching health objectives within a framework that explicitly considers international human rights mechanisms

**Non-retrogression:** once a State has been made progress toward fulfilling a right within international human rights instruments, States must not retreat from that level of progress

**Progressive realization:** the duty of states engaging in international human rights instruments to work toward the fulfillment of rights when lack of resources or instability prevents full realization of rights

# Literature Review

## Introduction

The literature review provides background in well-established concepts and the key populations related to conducting a needs assessment for a Health and Human Rights (HHR) training among Centers for Disease Control and Prevention (CDC) Locally Employed (LE) Staff. An overview of human rights gives an understanding of what human rights are and mechanisms of international human rights law. Drawing from concepts and studies of experts well established in HHR reveals the utility of a human rights framework within health. A historical review of the CDC and LE staff describes the role of these populations within public health domestically and globally. Finally, education recommendations specific to human rights, adults, and professional development trainings guides the creation of tools to conduct a needs assessment and build an appropriate educational environment for our study population.

## An Overview of Human Rights

Human rights exist for protection from political and social abuses, and to provide freedoms and well-being to all people (Nickel, 2014). The source and justification for these rights has been debated. Some claim that human rights are "God-given" and inherent to all in accordance with religious doctrine; others claim that human rights are a part of the innate nature of man to live in harmony with others, or are the norms born from social relations among man; others too claim practiced law determines human rights, States having the authority to create those rights (Shestack, 1998). No matter the source of human rights, there are characteristics which all human rights share. Human rights, as the name would suggest, are the rights of all humans. They are universal to all people without discrimination. Human rights are also

inalienable, meaning that no entity can take them away, nor can any person given them up voluntarily. Moreover, they are rights – the holders of those rights, or all persons, have the protections, freedoms, and benefits of those rights. The duty-bearer of those rights, or all States, have the responsibility to uphold those rights.

The diversity of religions, cultures, and values which exist worldwide is an important consideration in the argument as to whether human rights should exist as moral or social norms, or within national or international law. Theorists of cultural relativism posit that country-specific beliefs and values shape the ethical, political, and legal standards of that country (Nickel, 2014). In order to build a moral consensus on human rights and to create the political power of these rights, standardized human rights exist within international human rights laws. The positioning of human rights within international law is not without push back based on cultural relativist argument. Some East Asian countries in particular deny the underlying assumption of the universalism of human rights. These countries emphasize the regional differences in value systems as contributing to their lack of participation in the development of international human rights legal systems (Sen, 1997). Nonetheless, international human rights laws allow for the practical application of human rights standards and justification of enforcement measures when they do not exist nationally.

Contemporary international human rights laws have historical origins in such systems as international humanitarian law and the League of Nations. However, no events were as consequential for these laws as World War II and the subsequent creation of the United Nations (Buergenthal, 2000). The United Nations (UN) assembled to prevent such atrocities as those which occurred in the Second World War through protecting the fundamental human rights of all people. The UN has contributed to this mission through creating the Universal Declaration of

Human Rights and associated human rights standards, and international human rights treaties – The International Covenant on Civil and Political Rights (ICCPR, 1966), the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966), the International Convention on the Elimination of all Forms of Racial Discrimination (CERD, 1966), the Convention on the Elimination of all Forms of Discrimination Among Women (CEDAW, 1979), the Convention on the Rights of the Child (CRC, 1989), and the Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (CAT, 1984).

Currently, 87 percent of States have ratified the ICCPR and 85 percent of States have ratified the ICESCR (UN, 2016a, 2016b). In doing so, these States have agreed to be legally bound to the obligations within this treaty, and to implement such obligations within their domestic law. Also, ratifying states agree to review of compliance with international standards and international scrutiny for non-compliance (Nickel, 2014). States willing to engage in treaties can also choose to be signatories to a treaty, not legally binding them to the treaty, but demonstrating their intent to act in the spirit of the treaty and refrain from acts which defeat the purpose of the treaty (UNICEF). There are States that have ratified treaties which, whether due to limited resources or instability, are unable to ensure the fulfillment of all human rights within that treaty, particularly social and economic rights. Such rights are then treated as goals with States having the duty of progressive realization of those rights – States must be working toward the fulfillment of those rights. Progressive realization also implies non-retrogression – once a State has made progress toward a goal, States must not retreat from that level of progress (Fukuda-Parr, Lawson-Remer, & Randolph, 2008).

There exist UN agencies which assist in the standards creation, monitoring, implementation, and enforcement of the previously mentioned treaties, including the Human

Rights Committee, the High Commissioner for Human Rights, and the Security Council, as well as bodies specific to each of the conventions. Moreover, there are regional human rights systems which exist outside of the UN. These regions include the European Union, the Organization of American States, the African Union, and the Arab League. Each regional system has its own charter and treaty system, along with monitoring bodies and courts. Some systems more effective and well-established – the European Union – and others less so by comparison – the African Union and Arab League (Forsythe, 2006).

## The Right to Health

The UN first mentioned the right to health in its foundational Universal Declaration of Human Rights standards. Article 25.1 of the declaration states "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security…" (Assembly, 1948). This right was first seen as an obligation within a legally binding international UN treaty in article 12 of the ICESCR:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
    a. The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
    b. The improvement of all aspects of environmental and industrial hygiene;
    c. The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

d. The creation of conditions which would assure to all medical service and medical attention in the event of sickness (Assembly, 1966).

The right to health is also found in several other international and regional human rights treaties, including those specific to vulnerable populations (Annex A). Consequentially, according to the UN High Commissioner for Human Rights and WHO Factsheet on the Right to Health (U. WHO, 2008), every State has ratified at least one – if not many – international human rights treaty addressing the right to health (p.1). As such, all States have the legal obligation to uphold this right for its citizens.

However, inherent within the ICESCR, as well as explicitly stated within article 2 of the treaty, is the condition of progressive realization of these social and economic rights (Assembly, 1966). According to Forman (Forman, 2015), this condition of progressive realization constrained the States' aspirations to achieve the right to health for all (p.92). Therefore, the UN body over the ICESCR – the UN Committee on Economic, Social and Cultural Rights – explained the scope, content, and obligations of article 12 in General Comment 14 (CESCR, 2000).

General Comment 14 provides an extensive interpretation of the right to health and the manner in which States must engage with the right. Included within this explanation is that all persons have the right to services necessary for the highest attainable standard of health, and that these services must be available in sufficient quantity, accessible to all, culturally acceptable to all, and of good quality. Importantly, General Comment 14 also makes clear that the right to health is inclusive of other rights. In other words, the right to health is dependent upon the realization of other social factors which are the underlying determinants of health, including food, housing, safe water and working conditions, and a healthy environment. This multifaceted

ideology of health is reminiscent of the WHO definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1964). In respect to this interrelation between rights, it is also recognized that achieving the highest attainable standard of health is fundamental for the exercise of other rights.

There are three realms of obligations which States have in accordance with the right to health. States must respect the right to health by not interfering, whether directly or indirectly, with the right to health; States must protect the right to health by preventing third parties from interfering with the right; and States must fulfill the right to health by adopting appropriate measures in order to fully realize the right to health (CESCR, 2000). Progressive realization of the right to health requires that States take immediate action to the full capacity of their resources and appropriate means, without discrimination, evidenced by concrete and targeted steps (U. WHO, 2008). Forman (2015) identified three mechanisms which are impactful in translating the right to health and other human rights norms into concrete practices with tangible benefits. These mechanisms include 1) having a domestic litigation system to enforce health rights in national courts, 2) the presence of rights-based advocacy groups which utilize international human rights laws as a framework to transform perceptions of health from a charitable privilege to a legally binding right, and 3) constructing and implementing rights-based programs, policies, and tools which incorporate human rights, focus on vulnerable groups, and explicitly refer to international human rights instruments (p.94-96).

### A Human Rights-Based Approach to Health

General Comment 14 explicitly discusses the nature of human rights as interdependent and interrelated – the violation or fulfillment of one right affecting the ability of individuals to achieve other rights (U. WHO, 2008). The first line in General Comment 14 is "Health is a

human right indispensable for the exercise of other human rights" (Article 1). As such, States which have ratified treaties have the obligation to protect, as well as to respect and fulfill, *all* human rights within that treaty, as well as those necessary for the realization of those rights, as these rights are indivisible for achieving the well-being of people everywhere.

In assessing the relationship between health and other human rights, on the one hand, violations of human rights can impact health through practices such as torture and inhumane treatment, lack of provision of underlying determinants of health, or discrimination to name a few (Mann et al., 1994). There are also significant mental effects associated with the potential trauma of human rights violations. Such abuses have significant impacts on physical, social and mental well-being, otherwise known as the health of individuals. On the other hand, the duties associated with health care workers have the potential to adversely affect the realization of other human rights. Public health professionals in particular have the potential to exercise discriminatory or coercive practices, or interfere with the privacy of individuals as a result of their investigation of health needs, as well as policy and program development (Mann et al., 1994). As an example, health professionals at times have the authority to use measures which restrict human rights, particularly in control and emergency situations. While there is understanding that health professionals should exhaust the least coercive measures before the use of measures which restrict civil liberties, the Siracusa Principles – a UN human rights document – provide the legally agreed upon guidelines for use of such measures and conditions to maintain in such situations (Upshur, 2002).

The links between public health and human rights become more apparent when considering the objectives of either field. Public health professionals work at the population-level, ensuring the *conditions* for the health and well-being of populations primarily through

preventative measures (J. M. Mann, 1997). Inherent in this charge is that there are basic conditions necessary to achieve health. Human rights offers the opportunity to define these basic conditions. The UN established human rights standards to prevent abuses which are detrimental to the well-being of populations (Sirkin et al., 1999). Therefore, Mann (1997) asserts that a human rights approach to public health offers the "framework for identifying and analyzing the essential societal factors that represent the 'conditions in which people can be healthy'" (p.8). Moreover, human rights instruments provide the political power and legal obligations to affect those conditions (Braveman & Gruskin, 2003b). The WHO definition of health specifies that well-being is an essential component of achieving health, implying that health is not achieved through a single tactic but through the concerted application of many interrelated tactics which provide a comprehensive, preventative solution to provide well-being (J. Mann, 1997). A human rights framework complements the practices of public health professionals in its pursuit of achieving population-wide well-being.

Public health often equates the underlying determinants of health with socioeconomic status (J. M. Mann, 1997). However, strategies which focus on poverty and health without consideration of intervening and underlying factors in this relationship – such as living standards, environmental exposures, and even more insidiously racism, gender discrimination, and homophobia – may often fail (Braveman & Gruskin, 2003b). It is often the underlying determinants of health which contribute to health inequality both between and within countries (Marmot et al., 2008). These underlying determinants, or social and economic rights, require mechanisms within public health to ensure that they are understood, measured, and considered in the development of effective policies and programs (Braveman & Gruskin, 2003a). According to Braveman (2003), "explicit adoption of equity and human rights approaches can ensure

systematic attention to social disadvantage, vulnerability, and discrimination in health policies and programmes" (p.540). Otherwise, public health action has the potential to neglect or even exacerbate health inequalities and discriminatory practices (Marmot et al., 2008). The highest attainable standard of health for all may not be progressively realized if there is not also progressive realization of the conditions which affect health. A human rights-based approach to health provides the conditions and equal opportunity necessary to achieve the highest standard of health for *all* (Braveman & Gruskin, 2003a).

As much as human rights benefits public health practice, incorporating a human rights approach into public health also benefits the realm of human rights. Through explicitly linking health and human rights, according to Mann (1994) "documentation of health impacts of rights violations may contribute to increased societal awareness of the importance of human rights promotion and protection" (p.19). Due to their training in data collection and analysis, advocacy, and treatment, public health professionals fulfill a unique role in human rights investigation and promotion (Sirkin et al., 1999). Farmer also notes the status of professionals in medicine and public health which affords them privileges in access to spaces to investigate human rights violations where human rights advocates may not have such access or skills (Farmer, 1999).

In consideration of their capacity in discovering and addressing human rights violations, some see a human rights-based approach as being essential to the duties of public health professionals as alleviators of human suffering (Sirkin et al., 1999). A human rights approach to health may be especially important to the duties of government public health professionals as State actors. As discussed in the right to health, State actors have an obligation to protect, respect, and fulfill the right to health. In line with these obligations, States must not interfere, whether directly or indirectly, with the ability of individuals to achieve the right to health. States

must adopt appropriate practices to fulfill the right to health for all, which is dependent upon realizing underlying rights (Comment, 2000).

## The Centers for Disease Control and Prevention

### *History*

The history of the Centers for Disease Control and Prevention traces back to 1940 malaria control of military camps in the midst of the Second World War (Parascandola, 1996). The U.S. Public Health Service (PHS) assigned Louis L. Williams, Jr. as chief malariologist in the spring of 1941. In early 1942, PHS established a malaria control program headed by Dr. Williams for several southeastern states and US territories. This program located in Atlanta, GA became Malaria Control in War Areas (MCWA). MCWA was part of the PHS division headed by Joseph Mountin whose approach to malaria control, which included concerted efforts of medicine, engineering, and entomology, guided the program practices (Parascandola, 1996). MCWA encouraged innovation as staff began to develop new materials and establish new procedures for killing mosquitos (Etheridge, 1992). At this time, the MCWA occupied one floor of a building and employed a few more than 400 employees (CDC, 2015b).

Over the course of the next twenty years, the scope of the role of MCWA expanded dramatically as well as its reach as it spread westward to California by 1945 (Etheridge, 1992). The malaria focus expanded to other diseases associated with the mosquito vector, included yellow fever and dengue. Tropical parasitic diseases also became a concern as troops were returning after World War II, and MCWA also began assisting states with infectious disease outbreaks.

With the war over, Mountin promoted the establishment of the organization as a center to continuously work in the control and eradication of communicable diseases, resulting in the creation of the Communicable Disease Center in 1946 (Parascandola, 1996). There was a continued focus in malaria control during the first years of the organization, however in 1947 the center added a veterinary division and took over the PHS Plague Laboratory which would become the Epidemiology Division. This division rapidly grew under Alexander Langmuir. Langmuir also established the first disease-surveillance program which would reveal the disappearance of malaria from the U.S (CDC, 1996). With the threat of biological warfare in the midst of the Cold War and Korean War, Langmuir launched the Epidemic Intelligence Service (EIS) in 1951, a program of epidemiologists trained to investigate disease outbreaks (CDC, 1996).

Increasingly, the Communicable Disease Center provided assistance with epidemics and disasters to local jurisdictions, pioneered biomedical research and epidemiological activities, and moved beyond communicable disease into the realms of nutrition, chronic disease, and environmental health. Successful immunization programs, the introduction of Public Health Advisors to ensure the effectiveness of disease-control programs, and it's role in the eradication of smallpox are a few of the important accomplishments which have attributed to the success and establishment of the Communicable Disease Center (CDC, 1996). Two events in particular solidified the value of surveillance and established the credibility of the Communicable Disease Center, including when live virus got into the Salk polio vaccine in 1955 and the Asian influenza epidemic in 1957 (Etheridge, 1992). The expansion of scope of the center's activities, as well as expansion in size as the center built and grew on land donated by Emory University, led to a series of name changes which would lead to its current designation as the Centers for Disease

Control and Prevention (CDC) (Parascandola, 1996). The CDC is now considered world-wide to be the global leader in public health practice (CDC, 2015b). With more than 15,000 employees in more than 170 occupations in over 50 countries, the roles of public health practitioners working at the CDC include public health advisors and analysts, epidemiologists, health scientists, behavioral scientists, medical officers, etc. (CDC, 2015a).

### *Locally Employed Staff*

The increasing capacity for travel, bioterrorism, and globalization has further spurred the CDC's development into an international global health leader (NIH, 2014). There is ever-growing potential for international disease and public health conditions to affect the health of U.S. citizens. The CDC has responded with global programs to improve the health of people around the world, respond quickly and effectively to global public health threats, and increase the capacity of public health work forces and technology abroad. In order to sustainably build local capacity abroad, the CDC, along with other organizations under the Department of Health and Human Services (DHHS) – the Food and Drug Administration, the National Institutes of Health, the Substance Abuse and Mental Health Services Administration, and the Office of Global Affairs – employ Locally Employed (LE) Staff in offices overseas (DHHS, 2014). These LE staff are experienced public health professionals, as well as citizens or residents of the countries in which they work. They offer a valuable perspective to CDC's global health activities (Mitchell, 2015). DHHS maintains over1,700 LE staff in all, with CDC employing 1,546 of those staff members in more than 50 countries world-wide (Mitchell, 2015).

Many of CDC's LE staff work closely with their respective national health ministries, or with WHO (NIH, 2014). With the goal of ensuring the minimum number of U.S. staff overseas, the CDC aligns LE staff with the their global health objectives, including 1) the President's

Emergency Fund for AIDS Relief (PEPFAR), 2) the President's Malaria Initiative, 3) establishment of Global Disease Detection Centers, 4) elimination of polio, 5) reduction of measles-related mortality, and 6) global migration and quarantine effort in their respective countries of residence (CDC, 2011). The CDC's Center for Global Health, created in January 2010, is responsible for overseas programs. LE staff positions include advisors, branch chiefs, and directors in order to ensure the long-term stability of programs abroad and capacities of overseas public health programs.

### *History of Human Rights at the CDC*

There is a long standing history of HHR at the CDC. Jonathan Mann, one of the most prominent pioneers in defining and advocating for the HHR movement, spent some of the earlier years in his career with the CDC. Jonathan Mann was an EIS Officer in New Mexico with the CDC from 1975-1977 (Tarantola, Gruskin, Brown, & Fee, 2006). Mann left the CDC after this period only to return during the rapid rise of the AIDS epidemic in 1984. Dr. James Curran, director of the CDC AIDS Program at the time, recruited Mann to be director of an international AIDS research group in Zaire (Ligon-Borden, 2003). In his two years there, Mann identified AIDS as not just any infectious disease, but one which is prominent in conditions of poverty, discrimination, and social violence (Ligon-Borden, 2003). This experience became the basis of the field of HHR – incorporating human rights knowledge and principles into public health strategy.

Mann's conviction that public health cannot achieve its without transforming the societal factors which adversely affect health in all forms did not end with his untimely death in 1998 (Gensheimer, 2003). In Atlanta, a student-initiated call for more education on HHR led to a collaboration between organizations such as the Carter Center, the CDC, Emory University,

CARE USA, and the American Cancer Society to create the Atlanta Alliance for Health and Human Rights (AAHHR) in 1996. The goal of AAHHR was to uphold a rights-based approach to health (Nijim, 2007). In 1997, the National Center for HIV, STD, and TB Prevention (NCHSTP), created the first Health and Human Rights Workgroup (HHRW) at the CDC (Nijim, 2007). Though dissolved in 1998, the workgroup was re-established initially as an Epidemiology Program Office (EPO) workgroup, but expanded into a CDC-wide, officially recognized workgroup in 2003 (Nijim, 2007). The HHRW seeks to incorporate HHR into public health practice through training public health professionals in the principles and methods of HHR. The objectives of the HHRW are the following:

1. Contribute to an ethical framework for public health;
2. Create a more educated, sensitive, and effective public health workforce;
3. Build a trusting relationship between public health professionals and the communities they serve; and
4. Improve public health research, programs, politics, and practices (Nijim, 2007).

The HHRW includes more than 185 members representing every Center, Institute, and Office (CIO) of the CDC. The workgroup champions a combination of expertise and ability to affect public health with a holistic perspective of health in order to achieve the highest attainable standard of health for all (Nellis, 2005). The HHRW collaborates with such partners as The Institute of Human Rights at Emory University, CARE USA, the human rights office of the Carter Center, Doctors for Global Health, the WHO, and the Public Health Ethics Committee at the CDC. Through its work and collaborations, the HHRW impacts awareness and education through its own bulletin, entitled “HHRW Bulletin”, seminars, workshops, and symposiums.

Such events as the 2005 Health and Human Rights Conference Lessons Learned from Rights Based Approach to Health continue the mission of Mann to promote human well-being through a rights-based approach to health (Nellis, 2005). Despite these achievements, the HHRW intends to address a training gap in HHR principles and practice among CDC staff in order to improve knowledge of HHR.

### Health and Human Rights Education

In 1993, the World Conference on Human Rights included "Education in Human Rights" as a priority area in the Vienna Declaration and Programme of Action (Assembly, 1993). The declaration deemed an education in human rights as essential for such objectives as "promotion and achievement of stable and harmonious relations among communities," "strengthening of respect for human rights and fundamental freedoms," and "strengthening universal commitment to human rights" (p. 20). Article 82 of the declaration in particular called for the government to take an active role in promoting human rights education, and addresses the health profession as a special group for participation in such an education. For this and many other reasons, education in human rights among health professionals is not only a professional obligation, but a necessity in keeping pace with the evolution of health sciences education (London & Baldwin-Ragaven, 2008).

The Truth and Reconciliation Commission of South Africa (TRC, 1998) has recommended:

> Training in human rights [must] be a fundamental and integral aspect of all curricula for health professionals. This training should address factors affecting human rights practice, such as knowledge, skills, attitudes, and ethical research practices. Knowledge of and competence and proficiency in the standards (both national and international) to which

> [health professionals] will be held accountable should be a requirement for qualification and registration (Volume 4, chapter 5).

The Commission also advised that health workers need opportunities for training in human rights throughout their education and continuing professional development.

London, a HHR program expert in Capetown, SA, identified some important steps and components of a training in HHR (London & Baldwin-Ragaven, 2008). An important preliminary step is identification of objectives and competencies to include in a training. London identified a list of potential knowledge, attitudes, and skills objectives and competencies (Annex B). Questioning potential participants in a training can establish the objectives of that training and ensure the relevance of the training (Chastonay, Klohn, Zesiger, Freigburghaus, & Mpinga, 2009). London also identified effective teaching methods as those which allow students to engage in experiential learning and critical thinking, such as "case studies, site visits, role plays…, small group discussion, debate, and other experiential exercises…" (p. 13). A pilot training conducted by Chastonay gave evidence of the motivating factor of such interactive training methods (Chastonay et al., 2009). Journaling and critical review of current events are also effective, as well as local field experiences and using human rights impact assessment tools (Iacopino, 2002). Moreover, trainers should develop materials to be locally relevant (London & Baldwin-Ragaven, 2008). Iacopino (2002) also claimed that trainers who have experience in approaching health through a human rights framework are critically important to "convey[ing] to students the value of human rights perspectives in real and practical terms" (p.561). Trainers should also have a wide range of domestic and international experiences.

Although human rights trainings do not seem to be a high priority in respect to the many other learning needs for health professionals, putting some of these learning needs into a human rights perspective allows for experience in both the challenges and advantages of working through with a human rights-based approach. The objectives and teaching practices if a HHR training should allow for the development of practical applications which will directly affect and inform the future work of health professionals (Iacopino, 2002).

## Adult Education Theory

In training adults and professionals, it is important to consider adult learning theory. Adult learning theory has implications on effective practices for training programs. While there is no single theory or practice for adult learning, there are various theories, principles, and models which form the current knowledge base of approaches to adult learning. Three of the most prevalent schools of thought on adult learning are andragogy, self-directed learning, and transformative learning.

### *Andragogy*

Research in the question of how adults learn began in the 1920s. Initial work in the field of adult education centered on questions of whether adults could learn. By 1968, theorists began considering adult education a unique practice separate from other forms of education. This began with Malcolm Knowles' theory of andragogy, or the study of helping adults learn, as opposed to the child equivalent of pedagogy (Knowles, 1989). Underlying his theory are the assumptions that adult learners (1) are independent and can direct their own learning, (2) have a variety of life experiences which are a resource for continued learning, (3) have learning needs related to a change in their social roles, (4) are problem centered and want to be able to immediately apply their knowledge, (5) and are intrinsically motivated to learn (Merriam, 2001). These assumptions

have implications on the methods and the culture of an adult learning setting; namely, adults must feel respected and equal to teachers, replacing the traditional power dynamic between "teacher" and "learner" with a cooperative learning environment. This requires that adults have a hand in planning and directing their own learning (Merriam, 2001). Therefore, the needs and interests of the learners should determine the objectives of the adult learning classroom. Moreover, adult learning must be an extension of and utilize the rich wealth of experience of adults. The adult learning classroom should consist of practical activities which the learner has had a hand in selecting and which can be immediately applied to the learner's life or work (Merriam, 2001).

Knowles' theory is not without debate and criticism. Critics claimed that andragogy is not a theory at all. In response, Knowles (1989) himself agreed that andragogy is not a theory so much as "a model of assumptions about learning or a conceptual framework that serves as a basis for an emerging theory" (p. 112). Critics also claimed that concepts of andragogy do not hold true for all adults, especially those more dependent on an instructor. The assumptions may be true for more independent and self-motivated children with experiences richer than some adults. Knowles then revised his andragogy versus pedagogy argument. He instead began to place the two on a spectrum of learning types, ranging from teacher-oriented to self-directed (Merriam, 2001).

A still discussed critique of andragogy is whether it takes context into account. According to Merriam (2001), "Critics have pointed out that there is little or no acknowledgement that every person has been shaped by his or her own culture and society, that every person has a history, and that social institutions and structures define, to a large extent, the learning transaction irrespective of the individual learner" (p.7). In other words, Knowles did not create

the enduring characterization of all adult learners. Rather, Knowles described adult learners within a society which values self-directed, experiential learning; a society which happens to be characteristic of 1960s North America when Knowles introduced his model. This is not a universal societal structure, especially when this structure is subject to change. Knowles has never answered the question of how adults learn so much as provided a structure for independent learners to thrive.

### *Self-Directed Learning*

Within the same time and context of Knowles' conceptual framework of andragogy, self-directed learning came about as a model to define and differentiate adult learning. Major actors in this work include Knowles, Cyril Houle, and most notably Allen Tough. The major goals of self-directed learning are to build the capacity of learners to be self-directed and promote critical reflection of learners. According to Mezirow (Mezirow, 1985), critical reflection by learners uncovers "the historical, cultural, and biographical reasons for one's needs, wants, and interests…Such self-knowledge is a pre-requisite for autonomy in self-directed learning" (p.27). Instructors must provide the appropriate instructional strategies to create a feeling of readiness and comfort in learners to direct their own learning (Merriam, 2001). Much like andragogy, however, critics felt self-directed learning theory does not accounting for the social and political context of adult learners, limiting its capacity to provide understanding of adults as learners.

### *Transformative Learning*

Foundational to adult learning theory is that learning is a lifelong process that is naturally additive. Each new idea learned builds on to what we already know (Baumgartner, 2001). We can add to our knowledge through informational learning, or using new information to change what we know (Kegan, 2009). On the other hand, through transformational learning powerful

experiences allow us to change how we view ourselves and the world, and therefore how we know (Baumgartner, 2001). Kegan (2009) summarized, "transformative learning puts the form itself at risk of change (and not just change but increased capacity)" (p.49).

There are four approaches to transformational learning theory. There is Freire's social justice approach. Freire's approach focuses on empowering learners through discussion and building consciousness rather than having learners passively listen to explanations by an authority figure (Baumgartner, 2001). Jack Mezirow, widely known to have significantly advanced transformational learning theory, takes a cognitive-rational approach. Mezirow's approach is similar to Freire's, both grounded in constructivist theory that knowledge and reality are not readily existing, but experiences and interpretations of those experiences create knowledge (Baumgartner, 2001). Adults develop lasting knowledge through making their own interpretations. Unlike Freire's, Mezirow's approach focuses on the importance of critical reflection and rational thought to lead to perspective transformation. Imel (Imel, 1998) explained meaning structures as "frames of reference that are based on the totality of individual's cultural and contextual experiences and that influence how they behave and interpret events" (p.2). People build these meaning structures over a lifetime, and Mezirow proposed a step-wise process of transforming them:

1. A 'disorienting dilemma' must occur, which is usually a sudden, powerful, personal experience, but can also occur gradually through a series of powerful events, such as learning through an educational course
2. People engage in critical reflection, which occurs when they purposefully consider the assumptions they hold concerning themselves and the world, and realize something is not consistent with what they hold to be true.

People engage in "reflective discourse," validating their new perspective through discussion with others

3. The final and solidifying step of this process is that people must then act on this new perspective, not just thinking, discussing, or seeing their new perspective, but living it (Imel, 1998).

Mezirow's proposal has been highly criticized by those who believe his approach relies too heavily on rational thought and discourse. In doing so, he ignores the role of emotional responses and thought and action outside of what is rational in the process of transforming meaning structures. A significant figure in this argument is Robert Boyd. Imel (1998) explained Boyd's process of discernment which allows a moving back and forth between the rational and the extrarational by utilizing "symbols, images, and archetypes to assist in creating a personal vision of what it means to be human" (p.3).

Other approaches to transformative learning include Larry Daloz's developmental approach. Daloz recognized that the adult learning process will be highly intuitive and contextually based (Baumgartner, 2001). Baumgartner described that the process of learning through this approach is highly humanized, as "a mentor guides students in a learning journey affected by the student's social environment" (p17). Finally, there is a fourth approach which considers spirituality. This approach minimizes the rational aspects of transformative learning, emphasizing the extrarational learning which occurs through feelings and images (Baumgartner, 2001).

According to Baumgartner (2001), transformative learning requires teachers to create a safe and trusting environment which fosters "participation, collaboration, exploration, critical reflection, and feedback" (p.20). He recommended the removal of traditional teacher-learner

power dynamics, consideration of learning styles of students, and focusing content around controversial topics (Baumgartner, 2001). Transformative learning is a complex process highlighting feelings and thoughts. Unlike andragogy and self-directed learning, it takes into account context and culture.

## Training Needs Assessment

### *What is a training needs assessment?*

A training needs assessment is the process, including the tools and tactics, of collecting information related to a perceived training need within an organization (Cekada, 2010). Job required knowledge or skill gaps and/or employee-determined needs define whether there is a need for training and what are the specific training needs. A training needs assessment also helps in estimating associated costs and resources associated with the training (Brown, 2002; Cekada, 2010).

Needs assessment can occur at three different levels: organizational, task, and individual (Brown, 2002). An assessment at the organizational level determines where in an organization there is a need for training. This assessment also determines when and under what conditions this training should occur. According to Brown (2002), the tools and tactics required for this level of assessment involve analysis of data from human resources, including "departments or divisions with high turnover, high rates of absenteeism...employee grievances, customer complaints, quality control issues, accident records, and so on" (p.572). It is important to consider future skills that employees may need as there are changes within the organization. Changes in the labor pool that may affect the needs of employees and changes in laws and regulations may require training to address new policies or standards (Brown, 2002).

At the task level, assessments evaluate employee knowledge and skills in comparison to those expected in the job description. Any discrepancies between the what, how, or when of job task expectations and how tasks are currently performed may indicate a need for training. Most often, this level of assessment requires analysis of job descriptions, as well as interviewing, testing, or observation of employees.

Finally, individual level analysis targets individual employees and their job performance or personal needs. Brown (2002) explains that performance reviews can determine training needs, or employees "can be surveyed, interviewed, or tested to determine their training needs. They can indicate problems they have or provide recommendations to solve problems" (p.573). At any level of assessment, information obtained is used to plan training that helps employees meet organizational, task, and performance standards.

*Why conduct a training needs assessment?*

According to Judith Brown, there are four main reasons for conducting a needs assessment prior to planning trainings (Brown, 2002).

1. Needs assessments specify problems and knowledge gaps. They ensure that trainings address the appropriate objectives;
2. Needs assessments provide evidence to managers and directors that a training is necessary to improve performance. This leads to investment and buy-in from those who may be providing the necessary resources to carry out the training;
3. Needs assessments provide information on where potential trainees are prior to the training. This allows for evaluation after the training to demonstrate the effectiveness of the training using the assessment as a point of comparison;

4. Needs assessments allow for cost of the training versus benefit of the training to assessed. This can further investment of managers.

Needs assessments provide the opportunity to shed light on current employee skills and mindsets. They also identify where discrepancies may lie between current skills and mindsets and what is necessary to effectively achieve the mission and goals of an organization. Moreover, needs assessments help to determine whether training is the appropriate tool for addressing problems or gaps, or if there is a better solution.

### *How to conduct a training needs assessment*

When planning and conducting a training needs assessment there are important factors to consider. To assist in exploring these considerations, there are various expert suggested models. Samuel McCleland suggested an 11-step approach:
1) Define assessment goals; 2) Determine assessment group; 3) Determine availability of qualified resources to conduct and oversee the project; 4) Gain senior management support for and commitment to the process; 5) Review and select assessment methods and instruments; 6) Determine critical time frames; 7) Schedule and implement; 8) Gather feedback; 9) Analyze feedback; 10) Draw conclusions; 11) Present findings and recommendations (Cekada, 2010).

Barbazette's (2006) model achieves a similar process through asking five questions. 1) Why is the training necessary? This question requires a cost-benefit analysis. 2) Who has the need? Answering this question helps to identify the target population and customize the training to their needs. 3) How can the need be addressed? This question identifies whether a training is necessary while also shedding light on other possible solutions. 4) What is the desired outcome

or expected performance? This question directs the creation of objectives and competencies which the training will achieve, and may help in fostering good quality data. 5) When can the assessment best be delivered? This consideration helps to ensure optimal impact and reach of the training (Barbazette, 2006).

Other important considerations include investigating how training organizers identified similar training needs in the past and the results of those assessments, the budget for the assessment, how those within the organization perceive the training needs, and indicators of a successful and meaningful training needs assessment.

There are a variety of assessment tools which training organizers can use depending on the level of the assessment and the information needed to inform the potential training [Annex C] (Brown, 2002).

### *Training Needs Assessment in Health and Human Rights*

A 2007 study conducted among French-speaking Africans aimed to implement a HHR training program appropriate to the African context. To do so, Chastonay, et al. conducted a needs assessment to determine relevant health and human rights issues, as well as learning needs. They also conducted a pilot test of the training. Chastonay, et al. (2009) conducted the needs assessment through four different approaches.

1. A review of data on HHR in target countries. This review consisted of health indicators and documented human rights circumstances. This helped to establish "a global framework of possible learning objectives for a Health and Human Rights course" (p.2).
2. Country visits and semi-structured interviews with board members of professional associations and representatives of the Ministries of Health and Education in target countries.

3. Focus group discussions with key informants from each country. Questions of the focus group focused on educational objectives in HHR. Key HHR issues were further discussed and prioritized in a second round of discussions.
4. A questionnaire which included items on public health competencies, knowledge, attitudes, and tasks in HHR, as well as educational approaches. International agencies discussed the surveys and health professionals and professionals taking a HHR course piloted the surveys.

The needs assessment yielded the following results:

1. Global Peace Index reveal that public health and human rights challenges exist within the target countries and inform an approach relevant to the local context.
2. Country visits show that professional associations wish to partner in planning, implementing, and evaluating the training program.
3. Focus group discussions show demand for "basic public health competencies for health professionals and human rights activists, such as needed assessment tools, project management methodology, project impact assessment methods, health and human rights lobbying strategies" (p.4).
4. Questionnaire results highlight "strong emphasis on public health challenges and human rights violations (>85%), but also on insight understanding (better knowledge) of risk factors of basic human rights abuse in the health system and of major health problems (>80%), as well as on appropriate attitudes to develop, i.e. justice and equity (>80%)" (p.4).

Furthermore, based on results of interviews and the questionnaire, the pilot test of the educational program consisted of interactive online seminars on HHR given by public health and human rights experts. Students also wrote and analyzed case studies. The pilot test also incorporated a community-based project addressing a relevant HHR problem in the community "to be identified, planned, and implemented by each student" (p.5). Topics included "child labor, discrimination and violence against women, discrimination and violence against persons with mental health problems, [and] torture" (p.4). The training had a high level of satisfaction (>80%) and participation. Despite limitations associated with internet connectivity, instances of plagiarism, and heterogeneity of the student body, the needs assessment and pilot program approach to creating the training program fostered "public health relevance and educational effectiveness" (p.7).

# Methods

## Study Design

This study used two needs assessment methods: an electronic survey and key informant interviews. We conducted the electronic survey from September 4, 2015 to December 1, 2015. We conducted key informant interviews from June 9, 2015 to June 10, 2015. In-depth interview participants were Locally Employed (LE) staff members taking part in an annual regional training with the Centers for Disease Control and Prevention (CDC) in Atlanta. For both study methods we used convenience sampling methods since participation in the study was voluntary.

## Participants

Participants for the electronic survey were all CDC staff members, of which there are approximately 15,000 (CDC, 2015a). The participants for the in-depth interviews were LE staff members attending the Latin America Regional Training which took place in Atlanta, Georgia on June 9, 2015 and June 10, 2015. Our population of interest in this study were the approximately 1,546 LE staff in more than 50 countries world-wide employed by the CDC (Mitchell, 2015). LE staff members are citizens or residents of the countries in which they work outside of the United States. These LE staff members work closely with their respective national health ministries, or with WHO, addressing the CDC's global agenda abroad (NIH, 2014). LE staff members occupy a variety of positions, both supervisory and non-supervisory. The cross-sectional survey was available to this entire population. LE staff members attending the regional training were those in higher level supervisory roles, including regional team leaders, public health advisors, branch chiefs, deputy country directors, and country directors. These LE staff members could shed light on their own needs as well as inform the needs of the LE staff members they supervise.

## Study Tools

We developed the survey by first reviewing the survey instrument utilized by Chastonay, et al (Chastonay et al., 2009). This allowed us to identify an approach and relevant themes to include in the survey. Through collaboration with leaders in the Health and Human Rights Workgroup at CDC, we adopted questions within these themes which would be relevant to the study population. Previous surveys, including those for training needs, created and conducted by the CDC informed demographic questions within the survey. Publications on HHR education informed questions concerning HHR and HHR training (De Negri Filho & Furio, 2008; London & Baldwin-Ragaven, 2008; Sirkin et al., 1999). The survey was then reviewed by experts in four fields: public health and human rights experts, and training pedagogy and adult education specialists. The survey included four sections: demographic information, current experience/education, knowledge, attitudes, and practices (KAP) in HHR, and training methods.

*Demographic Information:* The demographic section was consistent with demographic information collected in previous CDC surveys. Collected information included:

- gender
- age
- country of origin
- race (if US born)
- years working with the CDC
- CDC office location

*Current Experience/Education:* We included questions concerning level of education and position in order to inform the background of respondents. These questions included

- current position at the CDC
- supervisory status
- education level

*Knowledge, Attitudes, and Practices (KAP) in Health and Human Rights:* We based our identification of knowledge gaps in HHR on respondent's level of exposure to the following concepts. These concepts are essential in connecting human rights to public health.

- the general idea of HHR
- HHR as it specifically applies to public health practices
- human rights treaties (including the right to health)
- the Siracusa Principles in relation to public health emergencies

We identified HHR skills gaps based on the ability to:

- identify HHR violations
- communicate HHR violations,
- use data to promote human rights
- develop programs for HHR
- evaluate programs for impacts on HHR

The knowledge and practices sections together shed light on learning needs in HHR. The attitudes section highlighted interest in HHR training through questions concerning whether respondents

- felt they had enough knowledge to adequately address human rights in their work
- believed public health could benefit from an HHR framework

- believed the CDC could benefit from a HHR framework

Respondents answered questions on knowledge in HHR on a self-report scale which included the following responses:

- "I have heard of"
- "I have read about"
- "I have received training on"
- "I have not heard of"

Practices and attitudes in HHR included responses on a self-report scale which included

- "Yes"
- "No"
- "Don't know"

The study by Chastonay et al. demonstrated the use of a Likert Scale for these measures (Chastonay et al., 2009).

*Training Methods:* The training section of the survey included questions specific to educational methods in a training. These included

- Educational techniques (lecture, case study, problem solving, workshop, webinar series, combination)
- Types of trainers (local public health experts, local human rights experts, local HHR experts, international public health experts, international human rights experts, and international HHR experts)
- Public health topics

Respondents were able to rank training methods and select the types of trainers and public health topics they preferred. The KAP and training methods sections of the survey in particular had the purpose of informing the training objectives and format.

The in-depth interview guide also reflected these four sections of the survey. The questions elicited information concerning the knowledge and needs among LE staff leaders and their staff. The guide included ten questions: three concerning the roles of the participants and their knowledge in HHR, four concerning the roles of the staff working under the participants and their staff's knowledge in HHR, and two questions concerning training methods. The in-depth interviews were also subject to the same expert review procedures as the survey instrument.

See Annex D for the complete electronic survey and Annex E for the in-depth interview guide.

### Data Collection Procedures

We created the survey in Survey Monkey and disseminated to staff via the CDC global listserv on September 4, 2015. This listserv reaches about 5,000 CDC staff members. On September 8, 2015, we disseminated the survey to the entire CDC community, about 15,000 employees, via the CDC Today Announcements. The survey was available to respondents from September 2015 to December 2015.

The principal investigator conducted the in-depth interviews at the Latin America Regional Training held in Atlanta, GA. The principal investigator of the study had training through a masters-level qualitative methods course in conducting in depth-interviews. Interviews took place over two days, June 9-10, 2015, and lasted 12-24 minutes in quiet conference rooms.

Eight staff members participated in the interviews. These participants were regional team leaders, prevention advisors, strategy information advisors, branch chiefs, deputy country directors, and country directors.

### Data Management and Sharing

Data collected for this study were anonymous. We collected no unique identifiers via the electronic survey or the in-depth interviews. Survey Monkey software aggregated and electronically stored survey data. The Survey Monkey account belonging to the CDC's Center for Global Health was password protected. We extracted survey data from Survey Monkey as an excel spreadsheet which we saved on a password protected computer for analysis. The interviewer recorded interviews on a password protected smartphone and saved transcripts resulting from the recordings on a password protected computer for analysis. Only the investigators of this study have viewed the data from the assessments.

### Data Analysis

We extracted survey data from Survey Monkey as an excel spreadsheet and imported into SAS for analysis using SAS statistical software. We conducted analysis for LE staff only for the purposes of this assessment. Descriptive analysis of the demographic and education/experience questions provided an overall description of the survey respondents. We conducted univariate analysis of knowledge, attitudes, and practices in HHR, as well as educational techniques.

Within the survey, respondents were able to indicate their level of exposure to concepts within Health and Human Rights as "I have heard of," "I have read about," "I have received training on," and "I have not heard of." Within analysis, we recombined these variables for "I

have heard of" and "I have read about" to indicate "limited knowledge," "I have received training on" to indicate "trained," and "I have not heard of" to indicate "no knowledge."

All questions other than "Are you a locally-employed staff member?" were not set to require response in the survey software. This led to missing responses for some variables. Missing data were not included in the analysis, however indicated on results tables as missing.

LE staff members work primarily in African, Asian, Latin American, and Caribbean regions. Due to the potential for regional differences between LE staff and the opportunity to specify trainings by region, we stratified LE staff survey data by region in the analysis and reporting of results. We stratified this data to in order to observe any potential differences specific to the region of LE staff. Other demographic and background information was also collected in order to provide the potential to detect subgroup differences in training needs or interests which would allow for the creation of differentiated HHR trainings, however we identified no other significant subgroup differences.

The interviewer transcribed the interviews and imported them into MaxQDA software for analysis. Within this qualitative data analysis software, we reviewed with memos to assist in the creation of codes. Codes included "current responsibilities," "human rights impact on work," "current HHR knowledge," "training interest," "training methods," and "facilitators." We then analyzed segmented areas corresponding with these codes to determine themes. We based themes on review of ideas within codes, mainly based on repetition and variation of ideas within the codes.

## Ethical Considerations

We included explicit statements of the confidentiality of information and the voluntary nature of participation in the introduction of the survey and semi-structured interview guide. We informed participants that the purpose of the survey and interviews were to inform a needs assessment of a training in HHR. We provided survey participants the choice to begin the survey by choosing "Next" after reading the introduction. Survey respondents were not required to answer any questions other than whether they were a LE staff member. The interviewer asked participants for consent to begin the interview, as well as consent to record the interview, prior to beginning any interview questions or recording. We informed interview participants that they could choose to not answer any question they did not want to or stop the interview at any time.

We submitted the study protocol for review through the CDC human subjects review process for formal determination. The review board determined the study was public health practice and not research. The information collected through this assessment met an exception for surveys conducted on federal government employee populations. We also submitted the study to the Emory Institutional Review Board (IRB) for review and approval. The Emory IRB determined that this study did not constitute research and therefore did not require IRB review.

## Limitations

The main limitation of this study is the use of convenience sampling methods. We used convenience sampling for both the interviews and the electronic survey. Results of the survey are particularly subject to bias due to this non-probability sampling. Those who participated in the survey chose to review their CDC announcements as well as to go to the link to participate in the survey. Therefore, survey respondents are likely to be inherently different from those who

decided not to participate in the survey. Interview participants also voluntarily participated in the interview upon request. Those deciding to participate were potentially different from those who did not. This manner of sampling does not allow for the generalizability of the results of this study to all CDC LE staff.

Another limitation of this study is the use of non-validated study instruments. We created the study instruments based on HHR literature, and experts in adult learning, human rights, and public health reviewed the instruments. However, these instruments have not been widely used nor validated. Due to time constraints as a result of the survey creation and review process, we were unable to pilot either of the study instruments in the study population before dissemination of the survey. Also, the use of a survey and interview required respondents to self-report needs. There may be inconsistency or cultural differences in self-report responses.

Other limitations include the brevity of the in-depth interviews. Interviews took place while LE staff members were in the US for a training. Therefore, interviews could not interfere with the training schedule of the participants. This necessitated a short interview guide and short interview duration. The brevity of the interview window may have stifled the ability for the interviewer to build rapport that would lead to more genuine responses and may have stifled the ability to probe for more depth. Moreover, we wrote and conducted the survey instrument and the in English which is likely not the first language of the majority of LE staff members.

Additionally, we did not require response to any of the questions in the electronic survey other than whether the staff were Locally Employed. We made this decision so as to not decrease the sample size if respondents did not want to answer a question. However, this led to missing responses particularly toward the end of the survey which may be due to the length of the survey.

# Results

## Electronic survey of CDC LE staff

This section provides findings from the survey of all LE staff and in-depth interviews. We highlighted key findings in the tables in order to draw attention to important information.

We limited data analysis of survey results to LE staff only. Due to small sample size represented in Table 1, we did not include respondents working in the Caribbean (n=4) and in Latin America (n=7) in the comparative analysis.

Table 1. Frequency distribution of characteristics among CDC locally-employed staff respondents

| | Frequency | Percentage (%) | | Frequency | Percentage |
|---|---|---|---|---|---|
| **Gender** | **104** | **100** | **Supervisory Status** | **103 (missing=1)** | **99.04** |
| Male | 46 | 44.23 | Non-supervisor | 62 | 60.19 |
| Female | 58 | 55.7 | Team Leader | 6 | 5.83 |
| | | | Supervisor | 24 | 23.30 |
| **Age** | **104** | **100** | Manager | 11 | 10.68 |
| 26-29 | 4 | 3.85 | | | |
| 30-39 | 41 | 39.42 | **Education** | **103 (missing=1)** | **99.04** |
| 40-49 | 39 | 37.5 | Some College or less | 14 | 13.60 |
| 50-59 | 19 | 18.27 | Associate's Degree | 2 | 1.94 |
| 60 or older | 1 | 0.96 | Bachelor's Degree | 31 | 30.10 |
| | | | Master's Degree | 40 | 38.83 |
| **Location** | **100 (missing=4)** | **96.15** | Doctoral/Professional | 14 | 13.59 |
| Africa | 63 | 63 | Other | 2 | 1.94 |
| Asia | 26 | 26 | | | |
| Caribbean | 4 | 4 | | | |
| Latin America | 7 | 7 | | | |
| | | | | | |
| **Years at CDC** | **104** | **100** | | | |
| <1 | 19 | 18.27 | | | |
| 1-3 | 28 | 26.92 | | | |
| 4-5 | 22 | 21.15 | | | |
| 6-10 | 20 | 19.23 | | | |
| 11-14 | 10 | 9.62 | | | |
| 15-20 | 4 | 3.85 | | | |
| >20 | 1 | .96 | | | |

All LE staff had the opportunity to take part in the survey. Of the approximately 1,546 LE staff LE staff members, 104 took part in the survey (6.7% response rate). Sixty-three percent were African LE staff, 26% Asian, and the remainder Caribbean and Latin American.

A slight majority of respondents were female respondents (55.7%) between the ages of 30-49 (76.92%). Most of the respondents were not in a supervisory role, meaning that they do not have a role as a team leader, supervisor, or manager (60%). Respondents were also highly educated, the majority having either a Bachelor's or a Master's degree (69%).

Table 2. Frequency distribution of attitudes on HHR among CDC locally-employed staff (LES) respondents

| Attitude | All LES [n(p)] | Africa LES [n(p)] | Asia LES [n(p)] |
|---|---|---|---|
| **Do you feel you have enough knowledge to adequately address human rights in your work?** | | | |
| **Total** | **89 (missing=15)** | **55 (missing=8)** | **23 (missing=3)** |
| Yes | 15 (16.85) | 11 (20) | 4 (17.39) |
| No | 64 (71.91) | 37 (67.27) | 16 (69.57) |
| Don't Know | 10 (11.24) | 7 (12.73) | 3 (13.04) |
| **Do you believe that public health could benefit from incorporating a Health and Human Rights framework into program, policy, and research?** | | | |
| **Total** | **87 (missing=17)** | **53 (missing=10)** | **23 (missing=3)** |
| Yes | 75 (86.21) | 45 (84.91) | 21 (91.3) |
| No | 2 (2.3) | 1 (1.89) | 0 (0) |
| Don't Know | 10 (11.49) | 7 (13.21) | 2 (8.7) |
| **Do you feel that CDC should do more to address Health and Human Rights issues in its program, policy, and research?** | | | |
| **Total** | **87 (missing=17)** | **54 (missing=9)** | **23 (missing=3)** |
| Yes | 71 (81.61) | 47 (87.04) | 17 (73.91) |
| No | 3 (3.45) | 2 (3.7) | 1 (4.35) |
| Don't Know | 13 (14.94) | 5 (9.26) | 5 (21.74) |

We determined interest in a HHR training through two attitude indicators. Overall, 86% of LE staff felt that public health could benefit from incorporating a Health and Human Rights framework into program, policy, and research (Africa LE: 85%; Asia LE: 91%). Additionally, 82% of LE staff felt that the CDC should do more to address Health and Human Rights issues in its program, policy, and research (Africa LE: 87%; Asia LE: 74%).

Table 3. Frequency distribution of HHR knowledge needs among CDC locally-employed staff (LES) respondents

| Knowledge | All LES [n(p)] | Africa LES [n(p)] | Asia LES [n(p)] |
|---|---|---|---|
| **The concept of the progressive realization of the right to health and relevant obligations** | | | |
| **Total** | **88 (missing=16)** | **54 (missing=9)** | **23 (missing=3)** |
| Trained | 3 (3.41) | 2 (3.7) | 1 (4.35) |
| Limited Knowledge | 56(63.64) | 36 (66.67) | 13 (56.52) |
| No knowledge | 29 (32.95) | 16 (29.63) | 9 (39.13) |
| **The connection between international human rights treaties related to the duties of public health professionals** | | | |
| **Total** | **88 (missing=16)** | **54 (missing=9)** | **23 (missing=3)** |
| Trained | 2 (2.27) | 2 (3.7) | 0 (0) |
| Limited Knowledge | 57(64.77) | 36 (66.67) | 14 (60.87) |
| No knowledge | 29 (32.95) | 16 (29.63) | 9 (39.13) |
| **The Siracusa Principles in relation to public health emergencies** | | | |
| **Total** | **87 (missing=17)** | **53 (missing=10)** | **23 (missing=3)** |
| Trained | 0 (0) | 0 (0) | 0 (0) |
| Limited Knowledge | 12 (13.79) | 8 (15.09) | 2 (8.7) |
| No knowledge | 75 (86.21) | 45 (84.91) | 21 (91.3) |
| **Health and human rights in the protection of the overall health of populations** | | | |
| **Total** | **86 (missing=18)** | **53 (missing=10)** | **22 (missing=4)** |
| Trained | 5 (5.81) | 4 (7.55) | 0 (0) |
| Limited Knowledge | 69 (80.23) | 42 (79.25) | 19 (86.36) |
| No knowledge | 12 (13.95) | 7 (13.21) | 3 (13.64) |

| | | | |
|---|---|---|---|
| **The right to health based on the underlying determinants of health such as food, water, housing, and health environment** | | | |
| **Total** | **87 (missing=17)** | **53 (missing=10)** | **23 (missing=3)** |
| Trained | 5 (5.75) | 3 (5.66) | 2 (8.7) |
| Limited Knowledge | 71 (81.61) | 46 (86.79) | 16 (69.57) |
| No knowledge | 11 (12.64) | 4 (7.55) | 5 (21.74) |
| **Health and human rights approach to health planning, implementation, and monitoring** | | | |
| **Total** | **88 (missing=16)** | **54 (missing=9)** | **23 (missing=3)** |
| Trained | 5 (5.86) | 5 (9.26) | 0 (0) |
| Limited Knowledge | 66 (75) | 39 (72.22) | 19 (82.61) |
| No knowledge | 17 (19.32) | 10 (18.52) | 4 (17.39) |

*Knowledge in Health and Human Rights*

In order to determine training needs in HHR, we assessed knowledge in key concepts in HHR. On any knowledge indicator, no more than 6% of LE staff respondents have been trained (Africa LE: 9%; Asia LE: 8%). The lowest level of knowledge was on the Siracusa Principles in relation to public health emergencies -- no LE staff in any region were trained, 14% had limited knowledge (Africa LE: 15%; Asia LE: 9%), and 86% had no knowledge (Africa LE: 85%, Asia LE: 91%). In all other categories, most LE staff reported having "limited knowledge" compared to "no knowledge" or being "trained." On the concept of the progressive realization of the right to health, 64% of LE staff had limited knowledge (Africa LE: 67%; Asia LE: 57%). On the connection between international human rights treaties related to the duties of public health professionals, 65% had limited knowledge (Africa LE: 67%; Asia LE: 61%). On health and human rights in the overall protection of populations, 80% had limited knowledge (Africa LE: 79%; Asia LE: 86%). On the right to health based on the underlying determinants of health, 82%

had limited knowledge (Africa LE: 87%; Asia LE: 70%). On a Health and Human Rights approach to health planning, implementation and monitoring, 75% had limited knowledge (Africa LE: 72%; Asia LE: 83%).

Overall, African LE staff had the most training in a HHR approach to planning, implementation, and monitoring (9%), while Asian LE staff had the most training in the right to health based on the underlying determinants of health (8%). The overall prevalence of limited to no knowledge in HHR was reflected in the response among LE staff that 72% did not feel that they have enough knowledge to adequately address human rights in their work (Africa LE: 67%; Asia LE: 70%).

### *Skills in Health and Human Rights*

As an additional indicator of knowledge in Health and Human Rights, we asked respondents to consider their current skills in HHR. As is evidenced in Table 4, respondents felt that they were unable to develop programs for HHR. Ninety percent of LE staff indicated that they did not have this skill (Africa LE: 89%, Asia LE: 96%). On the other hand, most LE staff felt that they were able to identify HHR violations with 53% of LE staff claiming to have this skill. However, this was the first indicator in which African LE staff and Asian LE staff greatly differ. Sixty-one percent of African LE staff claimed to have the capacity to identify HHR violations in comparison to 35% of Asian LE staff. However, among Asian LE staff, this was the skill that the highest number of Asian respondents claimed to have, indicating that skills in HHR are particularly low for Asian LE staff. In fact, Asian LE staff had a lower percentage of respondents having any of the skills presented in the survey compared to their African counterparts. The one exception was knowing how to evaluate programs for impacts on HHR,

for which they had virtually the same prevalence as African LE staff. This was potentially a cultural difference in self-report.

In the other HHR skills presented in the survey, 75% of LE staff did not know how to communicate HHR violations (Africa LE: 70%; Asia LE: 78%) and 82% of LE staff did not know how to use data to promote HHR (Africa LE: 81%; Asia LE: 83%).

### *Preferred Health and Human Rights Training Methods*

As indicated in Table 5, 41% of LE staff preferred a combination of the presented training methods (lecture, case study, problem solving, workshop, webinar series). This was especially true among African LE staff, 52% preferring a combination of methods as compared to 29% of Asian LE staff. Asian LE staff seemed to equally prefer lectures as a training method. Workshops were also relatively preferred among LE staff.

Overall, LE staff preferred trainers who are experts in Health and Human Rights as opposed to experts in public health or in human rights alone. Forty-nine percent of LE staff preferred local HHR experts (Africa LE: 51%; Asia LE: 58%), while 55% of LE staff preferred international HHR experts (Africa LE: 57%; Asia LE: 54%). Overall, African LE staff had a slight preference for international experts, whether public health, human rights, or HHR experts. Asian LE staff had a slight preference for local experts, as indicated in Table 5.

Table 5 also includes topics of interest within a HHR training. We included only topics for which 30% or more of staff expressed interest in the table. Across the board, LE staff had an interest in HIV/AIDS as a topic within a HHR training more than any other topic (All LE: 54%; Africa LE: 57%; Asia LE: 42%). There was also a preference for training in Emergency Preparedness, with 42% of LE staff indicating this as a topic of interest (Africa LE: 48%; Asia

LE: 35%). However, a point of difference among Asian and African LE staff as the interest in Behavioral Epidemiology among African LE staff (Africa LE: 49%; Asia LE: 31%).

Table 4. Frequency distribution of HHR skill needs among CDC locally-employed staff (LES) respondents

| Skill | | All LES [n(p)] | Africa LES [n(p)] | Asia LES [n(p)] |
|---|---|---|---|---|
| **Do you know how to identify HHR violations?** | | | | |
| | **Total** | **88 (missing=16)** | **54 (missing=9)** | **23(missing= 3)** |
| | Yes | 47 (53.41) | 33 (61.11) | 8 (34.78) |
| | No | 41 (46.59) | 21 (38.89) | 15 (65.22) |
| **Do you know how to communicate HHR violations?** | | | | |
| | **Total** | **87 (missing=17)** | **53 (missing=10)** | **23 (missing=3)** |
| | Yes | 22 (25.29) | 16 (30.19) | 5 (21.74) |
| | No | 65 (74.71) | 37 (69.81) | 18 (78.26) |
| **Do you know how to use data to promote HR?** | | | | |
| | **Total** | **88 (missing=16)** | **54 (missing=9)** | **23 (missing=3)** |
| | Yes | 16 (18.18) | 10 (18.52) | 4 (17.39) |
| | No | 72 (81.82) | 44 (81.48) | 19 (82.61) |
| **Do you know how to develop programs for HHR?** | | | | |
| | **Total** | **88 (missing=16)** | **54 (missing=9)** | **23 (missing=3)** |
| | Yes | 9 (10.23) | 6 (11.11) | 1 (4.35) |
| | No | 79 (89.77) | 48 (88.89) | 22 (95.65) |
| **Do you know how to evaluate programs for impacts on HHR?** | | | | |
| | **Total** | **88 (missing=16)** | **54 (missing=9)** | **23 (missing=3)** |
| | Yes | 11 (12.5) | 7 (12.96) | 3 (13.04) |
| | No | 77 (87.5) | 47 (87.04) | 20 (86.96) |

Table 5. Frequency distribution of preferred training methods among CDC locally-employed staff (LES) respondents

| Training Methods | All LES [n(p)] | Africa LES [n(p)] | Asia LES [n(p)] |
|---|---|---|---|
| **Education technique** | | | |
| **Total** | **71** | **44** | **17** |
| Lecture | **(missing=27)** | **(missing=68)** | **(missing=9)** |
| Case Study | 10 (21.28) | 5 (11.36) | 5 (29.41) |
| Problem Solving | 1 (2.04) | 1 (2.27) | 0 (0) |
| Workshop | 5 (10.2) | 2 (4.55) | 2 (11.46) |
| Webinar Series | 13 (22.03) | 7 (15.91) | 3 (17.45) |
| Combination | 8 (12.12) | 6 (13.64) | 2 (11.76) |
| | 34 (41.46) | 23 (52.27) | 5 (29.41) |
| **Trainers** | | | |
| **Total** | | | |
| Local Public Health Experts | **104** | **63** | **26** |
| Local Human Rights Experts | 32 (30.77) | 22 (34.92) | 9 (34.62) |
| Local Health and Human Rights Experts | 22 (21.15) | 14 (22.22) | 6 (23.08) |
| International Public Health Experts | 51 (49.04) | 32 (50.79) | 15 (57.69) |
| International Human Rights Experts | 29 (27.88) | 22 (34.92) | 4 (15.38) |
| International Health and Human Rights | 25 (24.04) | 19 (30.16) | 3 (11.54) |
| Experts | 57 (54.81) | 36 (57.14) | 14 (53.85) |
| **Topics** | | | |
| **Total** | **104** | **63** | **26** |
| HIV/AIDS | 56 (53.85) | 36 (57.14) | 11 (42.31) |
| Emergency Preparedness and Response | 44 (42.31) | 30 (47.62) | 9 (34.62) |
| Behavioral Epidemiology | 43 (41.35) | 31 (49.21) | 8 (30.75) |
| Applied Epidemiology | 40 (38.46) | 26 (41.3) | 8 (30.75) |
| Infectious Diseases | 38 (36.54) | 25 (39.68) | 8 (30.75) |
| Environmental Health | 36 (34.62) | 22 (34.92) | 10 (38.46) |
| Surveillance | 35 (33.65) | 26 (41.3) | 6 (23.08) |
| Maternal, Neonatal, and Child Health | 33 (31.73) | 25 (39.68) | 6 (23.08) |
| Emerging Infectious Diseases | 33 (31.73) | 22 (34.92) | 9 (34.62) |

### In depth interviews with CDC LE staff

We interviewed eight LE staff members as a part of this needs assessment. Three were working in countries in Asia and five working in countries in Africa. Seven of the eight participants worked in HIV prevention or treatment as a part of the PEPFAR program, and one participant worked with the Global Immunization Division. Preliminary analysis at the end of the second day of interviews indicated the depth as well as repetition of responses. There were no

apparent differences between responses from those working in African or Asian regions. Therefore, we determined that we reached saturation at the end of the second day of interviews.

The interviews revealed five themes concerning the relevance of and need for training in HHR, and the preferred educational methods.

### *Human Rights Violations Impact Universal Access to Health*

All participants were able to identify instances in which violations of human rights have impacted health related to their field. Much of this surrounded discrimination experienced by marginalized groups overseas. Of the participants working with HIV/AIDS, six identified LGBT groups as a particularly stigmatized group, three participants identified sex workers, one identified injection drug users, one identified criminals, and one identified those living in remote areas. One participant elaborated upon the attitudes of people working in the health facilities for which he is responsible:

> "'*Hey, this guy is gay, he's got HIV, so why should we treat him? He's suffering for his sins so leave him alone. And we don't even have enough to take care of people who are considered normal citizens. Why should we waste our money on this?'* And we have to tell them that that's not the point. The issue is that they are humans. They have the right to health, and they are the ones that are affected. So we need to treat them." (African LE staff member)

All participants were able to cite instances of cultural and political practices of discrimination as preventing access to the right to health for marginalized populations in the regions in which they work. Additionally, the participant working with the Global Immunization Division referred to corruption, people in power being "more preoccupied by their own pocket

for instance, and they do not see that ultimate goal of reaching the last child with vaccination." (African LE staff member)

### *Lack of Knowledge in Health and Human Rights*

Participants were able to verbalize the ways in which a lack of human rights, specifically those related to discrimination, could lead to a lack of access to health services. However, when asked the extent of their knowledge in HHR, five of the eight participants answered with some version of "no idea" or "not much." Two revealed a limited amount of knowledge which they gained through reading or partnering with human rights and advocacy groups. However, both also did not feel they had "sufficient knowledge" to either overcome the obstruction to providing their services in the face of human rights violations or to take on a human rights approach to their health issue. The extent of knowledge of the majority of the participants was well articulated by one participant who felt,

> "more and more given the work that we do on HIV/AIDS with our local partners we become aware of the areas, of arenas, where human rights clearly has a role in it, you know. But me personally, I have to admit that I've not always know what to do with that." (African LE staff member)

One participant was able to articulate his knowledge of fundamental human rights and how such abuses impact health. He also revealed the ways in which his staff members have perpetuated human rights violations. All of the participants expressed the feeling that their staff did not have knowledge in a human rights-based approach to health to avoid the frustration that results from the interference of rights violations. One participant revealed, "They come back and talk to me and there's nothing I can do for them in some ways." (African LE staff member)

*Need for Health and Human Rights Training*

Despite varying knowledge levels, all participants verbalized a desire for training in HHR. Participants expressed the need for general knowledge in human rights in order to know what to look for and to know what their responsibilities may be. Participants felt they were unable to ensure human rights if they do not have this knowledge. Some wanted the ability to communicate in a human rights framework. They want to understand not only the language of human rights, but how to speak about and promote human rights in a non-confrontational manner with people of varying perspectives, including political leaders. One participant pointed to the ability to evaluate programs in order to know that they are reaching all groups, even marginalized groups. Others too expressed the desire to know which entities and organizations to reach out to or direct problems. As one participant explained the potential benefits of such a training:

> "Well, I think it would, at the very least, awaken me to recognize where there may be insufficient human rights in a particular, in a sector where I am working at. It may awaken me to see where that are gaps and help me to develop the programs and the strategies to hopefully be able to bridge those gaps...and eventually some, you know, implementation of practice, you know, to respect people's rights, to design systems in ways in which we do not victimize people because of their differences, because of their orientation, or whatever the case may be." (African LE staff member)

Whether for themselves as leaders and advisors, or for their staff as implementers, participants expressed a strong interest in a HHR training.

*Need for Interactive Training Methods*

Consistent with adult learning theory, all participants expressed the need interactive training methods. Recommended methods included case studies, problem solving, answering questions using clickers, roleplays -- methods which allow for a hands-on learning experience. No participants found a lecture to provide the engaging environment they were seeking at this point in their education. Instead, participants wanted to be involved in the learning by sharing experiences and lessons. One participant shared his reasoning for this form of cooperative learning:

> "the mere fact that we, that I would know, you know, that another country director, another program is facing some of the same difficulties that I am facing in a different part of the world, I think, brings about a certain understanding as to what the challenges are, and how we can, together, you know, find ways to deal with those challenges." (African LE staff member)

Along with an interactive learning environment, participants also wanted to leave with practical skills which they could apply to their work. As one participant expressed, "Adult learning is not the volume of information you pour in. It's to make it more practical and what they can relate to and apply…" (African LE staff member)

Though not widely expressed, some more interesting preferred training methods included the use of a panel with people who work with human rights issues, as well as people who have experienced human rights abuses which have affected their health. Two participants also expressed the desire for the training to take place within their country. This would save resources for those coming from low-income areas, and allow facilitators "to actually see what we are

dealing with; to see some of the challenges we are dealing with, some of the dynamics that we, I don't know, whether they be power dynamics, whether they be dynamics that revolve around economics...some of the cultural realities." (African LE staff member)

### *Combination of Facilitator Types*

Participants, overall, saw the value in having a variety of types of facilitators. Participants felt international experts were the most equipped to offer best practices occurring in other settings, as well as a broader perspective on the concepts related to HHR since different countries engage with human rights differently. Two participants did stress, however, that there should not be a US-focus. They felt that the US does not face the problems that they do overseas. Participants felt local experts have more knowledge of the context and experience in the overseas setting. Local experts would be more important if there was a language barrier in an audience which has low English proficiency. Overall, participants seemed to find that both local and international experts could be useful as long as, as one participants expressed, they were "subject matter experts" and able to effectively "deliver the message." (Asian LE staff member)

## Summary

Results of the survey of CDC LE staff revealed that staff feel that public health, as well as their work at the CDC, would benefit from a HHR training. Moreover, there was a high prevalence of limited to low knowledge in human rights concepts related to health, particularly in the Siracusa principles. Skills in HHR were primarily related to program and data use for human rights. Survey respondents indicated preference for a combination of training methods, international and local HHR experts to facilitate training, and HIV/AIDS as a topic area for a human rights-based approach. Similarly, participants of the interviews indicated a lack of

knowledge in HHR, and an interest in a HHR training in order to gain knowledge and skills which are practical to their work. Trainings must include interactive educational methods and include a range of facilitator types, including international and local subject matter experts.

## Discussion

A human rights approach to health recognizes that violations of fundamental human rights has the potential for serious implications on the health and well-being of populations (J. M. Mann, 1997). The work of health professionals, whether intentionally or not, can impede upon a population's ability to fulfill their basic rights. The participants of this needs assessment are CDC LE staff working mostly in the African and Asian regions. They have demonstrated their recognition of the potential for violations of human rights to impact the health of the populations they serve. This finding is particularly apparent in the interviews conducted among LE staff in leadership positions. Many of these participants articulate the pervasiveness of discrimination toward marginalized groups within their regions due to cultural and political inclinations. They are aware of the effect this discrimination has on the access to medical care for these groups. WHO has identified the disproportionate rate at which disease affects marginalized and vulnerable groups due to these very experiences of discrimination, both socially and at times by law (WHO, 2015). Based on these practices of discrimination and the resulting effects on health, WHO promotes a human rights-based approach to health which serves populations universally and without discrimination. A few of the interview participants are able to point out the need for a human rights approach to their work in order to "design systems in ways in which we do not victimize people because of their differences, because of their orientation." (African LE staff member)

The recognition of the connection between health and human rights among interview participants is further demonstrated in their desire for a training in HHR. All of the interview participants responded definitively that their work and that of their staff would benefit from a training in HHR. Participants communicate training needs which include being able to recognize

human rights violations, communicate human rights violations, promote human rights, and create programs which uphold human rights for all. Survey respondents, which include 104 of the approximately 1500 CDC LE staff, echo this sentiment. The majority of respondents (86%) believe that public health could benefit from incorporating a HHR framework into program policy and research, as well as the CDC itself (82%). These finding are consistent among both African and Asian LE staff. Although Caribbean and Latin American LE staff also participated in the survey, the data they have provided is not analyzed separately due to very small sample sizes.

Not only do participants articulate a desire for a training in HHR, but also demonstrate a need for knowledge in the field. More than half of the interview participants reveal a lack of knowledge in HHR. This finding may seem to contradict the ability of participants to articulate infringements on the right to health due to human rights violations. However, the lack of knowledge among participants particularly concerns not having an understanding of their responsibilities in a human rights-based approach. Those interview participants who do express having more exposure to HHR still expressed the need to better understand their role in a human rights approach to health:

> "it's good to know about how to address infringements on a person's right to health, or any other such things, so that you can identify when they are being infringed upon and also what to do about it. It would be good to know. So I think every public health worker needs to know that." (Asian LE staff member)

As public health practitioners begin to build a general understanding of human rights, an education in HHR should provide the ability to make these general ideas applicable to the work of public health practitioners in improving the health status of people everywhere through a consideration of rights (Easley, Marks, & Morgan Jr, 2001).

Like interview participants, the majority of survey respondents do not feel that they have enough knowledge to adequately address human rights in their work (72%) -- a finding consistent among African and Asian LE staff. Respondents are able to indicate their level of knowledge in specific content areas within HHR. Knowledge of the Siracusa Principles in relation to public health emergencies is the area where LE staff have the least knowledge or training. However, across the board, very few LE staff respondents have received training in any content area related to HHR which is relevant to their duties as public health professionals. These content areas include the progressive realization of the right to health, the use of international human rights treaties, the right to health based on the underlying determinants of health, and more general HHR principles and practice. Many respondent are able to express having heard of or read about these topic areas. Yet the need for training even among those with limited knowledge is evident in the fact that the majority of respondents still feel that they do not have adequate knowledge to address human rights in their work.

In addition to knowledge needs, skill needs are also revealed through the survey. The majority of respondents indicate having the ability to identify HHR violations. Interviews in which LE staff leaders were able to attribute health impacts to specific rights violations reinforce this need. Skill needs lie more so in the ability to develop and evaluate programs for impacts on HHR. Another skills gap respondents indicate is the ability to use data to promote human rights. Public health research and programs are two major components of work in public health. There

is an evident inability of public health practitioners to address the realm of human rights, which is intertwined with their work, through these practices (Sirkin et al., 1999). Interview participants also express an inability to communicate HHR violations.

Interview participants make abundantly clear the need for an interactive, cooperative learning environment. In this environment trainees experience the use of hands-on activities such as case studies, problem solving, and role plays. Trainings must also encourage the sharing of ideas and expertise among training participants. Just as important is the ability to derive practical skills which staff members can apply to their work, and which fits their context and content area. These finding mimic adult learning theory rhetoric and lessons (Merriam, 2001). The findings from the survey also reveal the desire for a combination of methods among respondents. A surprising finding among Asian LE staff is that the same percentage of respondents who prefer a combination of methods would prefer the use of lecture. This is a method which interview participants adamantly dismiss, finding lectures inappropriate for adult learners. However, this finding among Asian LE staff may be due to the low sample of respondents answering this question, as only 5 respondents select either category. It may also be due to the fact that interviewed participants are taking part in a regional training at the time of the interviews in which facilitators utilized the interactive methods they acclaimed. In fact one participant, while describing his preferred methods, mentions “So you want to just be focused on things that will be engaging and you can pick up on things quickly. So it’s what we’re having this week so it’s easy to describe” (African LE staff member). The current environment of the interview participants may have therefore biased them toward the training techniques they are exposed to at the time of the interview. However, the highest percentage of LE staff, and even higher for African LE staff

alone --both of which have larger sample sizes than the Asian LE respondents -- prefer a combination of methods.

LE staff survey respondents, like interview participants, appear to be overall indifferent to the use of local experts versus international experts. Interview participants associate either type of expert with their own benefits -- local experts providing the context-specific knowledge and local experience, international experts providing broader perspective on various ways of engaging with and tackling human rights in public health work. However, survey respondents do show a strong preference for HHR experts versus experts in human rights or public health alone. This particular type of facilitator would be the "subject matter expert" to which a few of the interview participants refer.

The majority of survey respondents are interested in HIV/AIDS as a topic area in a HHR training. This is true for African and Asian LE staff alike. Seven out of the eight interview participants are involved in HIV/AIDS related work, which reinforces this topic interest. Another common topic area of interest is Emergency Response and Preparedness. This is a particularly interesting finding in that respondents note having the least amount of knowledge in the Siracusa Principles. These principles provide the guidelines which public health professionals, particularly those working in emergency and control situations, must follow when a situation requires them to deny rights to individuals (CESCR, 1985). African LE staff also show an interest in Behavioral Epidemiology as a topic area, and Asian LE staff in Environmental Health.

## Implications and Recommendations

The CDC recognizes that its "programs are often tied to economic, social, and political issues" (CDC, 1996). This awareness calls for CDC staff to be prepared to identify and address the bidirectional relationship between public health and the economic, social, cultural, civil, and political realms of human rights. A context-specific understanding of this relationship can provide the practical tools for effective and culturally relevant health policies and practices (J. M. Mann, 1997). This needs assessment sets out to determine 1) whether Locally Employed (LE) staff of the CDC desired a training in HHR, 2) whether CDC LE staff needed a training in HHR, 3) the training needs in this field, and 4) the appropriate training methods. Based on the combined results of the survey and in-depth interviews, we have determined that CDC LE staff desire a training in HHR in order to benefit their work as public health professionals. There are also HHR knowledge and skill gaps which indicate the need for a training. Therefore, we recommend the creation and implementation of a training in Health and Human Rights for LE staff. The objectives of this training should include using data to promote human rights, developing programs for HHR, and evaluating programs for impact on HHR. Topic areas of this training should include HIV/AIDS and Emergency Preparedness and Response. The training of LE staff should utilize a combination of interactive, cooperative learning measures, and a combination of local and international HHR experts.

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# Appendices

I. Select International Instruments and Other Documents Related to the Right to Health (in chronological order)

**International treaties**

Charter of the United Nations (1945)

Constitution of the World Health Organization (1946)

European Social Charter (1961)

International Convention on the Elimination of All Forms of Racial Discrimination (1965)

International Covenant on Economic, Social and Cultural Rights (1966)

International Covenant on Civil and Political Rights (1966) and its two optional protocols (1966 and 1989)

Convention on the Elimination of All Forms of Discrimination against Women (1979) and its Optional Protocol (1999)

African Charter on Human and Peoples' Rights (1981)

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) and its Optional Protocol (2002)

Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador) (1988)

Convention on the Rights of the Child (1989) and its two optional protocols (2000)

ILO Convention No 169 concerning Indigenous and Tribal Peoples in Independent Countries (1989)

International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (1990)

Convention on the Rights of Persons with Disabilities (2006) and its Optional Protocol (2006)

Source: WHO. (2015). Health and Human Rights Fact Sheet.

## II. Core Competencies for Human Rights Training in Health

| | |
|---|---|
| Knowledge | International human rights declarations and professional ethical codes<br>History of human rights abuses in South Africa and the role health professionals played under apartheid<br>SA Constitution, Batho Pele and Patients' Rights Charter<br>Identification of vulnerable groups<br>Clarity about forms of justice in the South African context<br>Awareness of constitutional structures and agencies that promote democracy (e.g. Human Rights Commission, Gender Commission)<br>Legislation pertaining to health and health care<br>Understanding the relationship between bioethics and human rights<br>Awareness of services for survivors of human rights abuses |
| Attitudes or Values | Seeing all people as worthy of dignity and respect<br>Awareness of one's own inherent prejudices or bias (i.e., race, class, sexual orientation, gender or disability)<br>Willingness to assume an advocacy role and to work for change<br>Approaching patients in non-judgemental and non-discriminatory ways<br>Identification with altruistic values that underpin the healing professions<br>Empathy and caring<br>Appreciating and nurturing diversity |
| Skills | Inter-personal communication skills<br>Community development skills<br>Advocacy and lobbying skills<br>Ability to work in interdisciplinary and diverse settings<br>Critical thinking and problem solving skills<br>Ability to recognise a human rights violation in one's usual work environment<br>Ability to report a human rights violation for investigation and redress<br>Ability to work with trauma survivors |

Source: London, L., & Baldwin-Ragaven, L. (2008). Human rights and health: challenges for training nurses in South Africa. *Curationis, 31*(1), 5.

## III. Needs Assessment Methods (Advantages and Disadvantages)

**Advantages and Disadvantages of Needs Assessment Methods**

| | Method | Advantages | Disadvantages |
|---|---|---|---|
| **Surveys/ Questionnaires** | May be in the form of surveys or polls of a random or stratified sample or an entire population.<br>Can use a variety of question formats: Open-ended, projective, forced-choice, priority ranking. | Can reach a large number of people in a short time.<br>Are inexpensive.<br>Give opportunity of response without fear of embarrassment.<br>Yield data easily summarized and reported. | Make little provision for free response.<br>Require substantial time for development of effective survey or questionnaire.<br>Do not effectively get at causes of problems or possible solutions. |
| **Interviews** | Can be formal or casual, structured or unstructured.<br>May be used with a representative sample or whole group.<br>Can be done in person, by phone, at the work site, or away from it. | Uncover attitudes, causes of problems, and possible solutions.<br>Gather feedback; yield of data is rich.<br>Allow for spontaneous feedback. | Are usually time-consuming.<br>Can be difficult to analyze and quantify results.<br>Need a skillful interviewer who can generate data without making interviewee self-conscious or suspicious. |
| **Performance Appraisals** | May be conducted informally or systematically.<br>Conducted by manager; appraisal developed by HR.<br>Should be conducted on a regular basis and separately from merit discussions. | Indicate strengths and weaknesses in skills, and identify training and development needs.<br>Can also point out candidates for merit raises or promotions. | Can be costly to develop the system, implement the appraisals, and process the results.<br>May enable managers to manipulate ratings to justify a pay raise.<br>May invalidate the appraisal because of supervisor bias.<br>May be prohibited for union employees. |
| **Observations** | Can be technical, functional, or behavioral.<br>Can yield qualitative or quantitative feedback.<br>May be unstructured. | Minimize interruption of routine work flow or group activity.<br>Generate real-life data. | Requires a highly skilled observer with process and content knowledge.<br>Allow data collection only in the work setting.<br>May cause "spied on" feelings. |
| **Tests** | Can be functionally oriented to test a board, staff, or committee member's understanding.<br>Can be administered in a monitored setting or "take home." | Can be helpful in determining deficiencies in terms of knowledge, skills, or attitudes.<br>Easily quantifiable and comparable. | Must be constructed for the audience, and validity can be questionable.<br>Do not indicate if measured knowledge and skills are actually being used on the job. |

**Advantages and Disadvantages of Needs Assessment Methods** (cont.)

| | Method | Advantages | Disadvantages |
|---|---|---|---|
| **Assessment Centers** | For management development.<br>Require participants to complete a battery of exercises to determine areas of strength that need development.<br>Assess potential by having people work in simulated management situations. | Can provide early identification of people with potential for advancement.<br>More accurate than "intuition."<br>Reduce bias and increase objectivity in selection process. | Selecting people to be included in the high-potential process difficult with no hard criteria available.<br>Are time-consuming and costly to administer.<br>May be used to diagnose developmental needs rather than high potential. |
| **Focus Groups/ Group Discussion** | Can be formal or informal.<br>Widely used method.<br>Can be focused on a specific problem, goal, task, or theme. | Allow interaction between viewpoints.<br>Enhance "buy-in"; focus on consensus.<br>Help group members become better listeners, analyzers, problem solvers. | Are time-consuming for both consultants and group members.<br>Can produce data that is difficult to quantify. |
| **Document Reviews** | Organizational charts, planning documents, policy manuals, audits, and budget reports.<br>Include employee records (accidents, grievances, attendance, etc.).<br>Also include meeting minutes, program reports, and memos. | Provide clues to trouble spots.<br>Provide objective evidence or results.<br>Can easily be collected and compiled. | Often do not indicate causes of problems or solutions.<br>Reflect the past rather than the current situation.<br>Must be interpreted by skilled data analysts. |
| **Advisory Committees** | Secure information from people who are in a position to know the training needs of a particular group.<br>Supply data gathered from consultants by using techniques such as interviews, group discussions, and questionnaires. | Are simple and inexpensive.<br>Permit input and interaction of a number of individuals with personal views of the group's needs.<br>Establish and strengthen lines of communication. | Carry biased organizational perspective.<br>May not represent the complete picture because the information is from a group that is not representative of the target audience. |

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Source: Brown, J. (2002). Training needs assessment: A must for developing an effective training program. *Public Personnel Management, 31*(4), 569-578.

## IV. Electronic Survey Instrument

Electronic survey can be found at:
https://www.surveymonkey.com/create/survey/preview?sm=QNu8PlJv_2BXr6H_2BvHHBXes3hrbu9pAJQcfeoOuBeV_2Bww_3D

## V. In-depth Interview Guide

**Key Informant Interview Guide for Health and Human Rights Training Needs of CDC Staff**

### Question

What are the health and human rights training needs among Centers for Disease Control and Prevention (CDC) staff?

### Study Population

CDC staff

### Instructions for interviewer

Good afternoon, and thank you for being here today. My name is Izraelle, and I am a student at Rollins School of Public Health, and working through the U.S Center for Global Health at the Centers for Disease Control and Prevention. We are conducting a training needs assessment in order to understand the training needs of CDC staff. We want to understand not only the experiences that staff will be coming to the training with, but the knowledge and skills the staff would find important. This type of assessment has never been done in this population, and has the potential to offer insight into creating a sustainable health and human rights training program.

I have a list of topics and questions I would like to ask you, but please feel free to bring up any other topics that you feel are relevant to your experience, or that of the locally employed staff. Your participation in this interview is completely voluntary and if you are not comfortable you should feel free to not answer a question, or to stop the interview at any time.

If it is ok, I would like to tape record our interview because I won't be able to take notes as fast as we are speaking, and I don't want to miss any important information. The tape recording and everything you tell me will only be used for this project, and will not be shared with anyone other than myself and supervisors. No personal identifiers, such as your name, will be used to be sure that no one can connect you to any of the responses you share with me today, and I will be sure to keep all the information we discuss confidential. So, is it ok for me to tape-record the interview?

Do you have any questions before we begin?

I want to emphasize that there are no right or wrong answers, and we are truly interested in your experiences and opinions, so please feel free to speak honestly. Shall we begin?

I will start with a few background and general questions about you.

### Your Work in HHR

1. Please describe for me your role with the CDC.
   Probe: interactions with the staff, specific tasks, previous roles, health issues
2. What knowledge do you have in HHR (rights-based approach to heath)?
   Probe: HHR documents, past education/trainings

3. What work do you do with health and human rights issues in your day to day work?

Probe: knowledge in HHR, skills in HHR

I would like to ask a few questions on the current work and experiences of your staff that are related to health and human rights.

**Your Work in Health and Human Rights**

4. What knowledge do the staff currently have in addressing human rights through their work as health professionals?

Probe: past experiences, where did the skills come from, what is intrinsic in the current work

5. What work do your staff do with HHR issues in their day to day work?

Probe: knowledge in HHR, skills in HHR

6. In what ways may the work of staff be negatively or positively impacting human rights?

Probe: specific tasks, what human rights

7. What experience do staff have in interacting with legal systems?

Probe: authorities/judicial, communication

Let's talk about some of the educational methods that should be used in the health and human rights training.

**Training methods**

8. What are some of the teaching methods that would be important to use in a health and human rights training for staff?
   Probe: lecture, case study, problem solving, why
9. What kinds of experts should be utilized in the health and human rights training of staff?
   Probe: local/international, health/human rights experts

**Closing**

10. Is there anything else I should know?

I would like to thank you so much for participating in this discussion. Your views and opinions are absolutely invaluable to helping me gain a better understanding of health and human rights training needs of CDC staff.