SUMMARY OF COURSE

The International Bioethics, Social Justice and Health Seminar is a one-credit seminar scheduled in winter and spring quarters. Students may enroll in any or all quarters of the seminar. Class sessions are two hours. The winter quarter class series begins on January 11. The next sessions are as follows: January 25, February 1, February 22, March 7.

The overarching goal of the seminar series is to bring together law, health sciences and other graduate/professional students to discuss a series of problem-based case studies and provide an opportunity for multidirectional, multidisciplinary learning and problem-solving. Our cases will be drawn from current issues articulated in the media and scholarly journals in law, bioethics and global health. Over the course of each quarter, students will not only participate in selecting the topics and developing case studies, but they will have the opportunity to engage in discussion about leading issues in global health from a bioethics and social justice perspective. Using the format of prepared case studies from which to launch an analysis, the problem-solving sessions will allow students to discuss issues based on their own experiences and cultures. There will also be targeted readings assigned for each session that complement the case study.

COURSE OBJECTIVES

By the end of the course, students will be able to:
• Compare and contrast bioethics and human rights standards in different country settings and cultural contexts using international norms and foundational documents in bioethics and human rights.
• Demonstrate and be conversant with the moral, legal and political challenges and perspectives that are relevant to evolving controversies in international research and population health.
• Describe and analyze the bioethics and social justice aspects of health disparities as articulated in case studies from low- and middle-income countries and in marginalized populations in wealthy countries.
• Apply knowledge of international human rights and bioethics in formulating solutions to health problems that impact individuals and populations locally and globally.

Required Readings and Course Materials

The syllabus will be based on studies drawn largely from resource poor countries and wealthy country contexts, in which ethnically distinct populations are marginalized. There will be a series of targeted readings corresponding to the case studies. These will be available on the website along with the case studies for discussion.

Course Grade

This is a credit/no credit course. Credit will be accorded on the basis of active participation in class discussions and group work in selecting a topic and developing a case study with readings. With respect to active class participation, the expectation for each class will be that the student arrives prepared and ready to engage in discussion, having previously briefed the assigned reading and discussion questions.

Access and Accommodations

Your experience in this class is important to me. If you have already established accommodations with Disability Resources for Students (DRS), please communicate your approved accommodations to me at your earliest convenience so we can discuss your needs. If you have not yet established services through DRS, but have a temporary health condition or permanent disability that requires accommodations (conditions include but not limited to; mental health, attention-related, learning, vision, hearing, physical or health impacts), you are welcome to contact DRS at 011 Mary Gates Hall or 206-543-8924 or uwdrs@uw.edu or disability.uw.edu. DRS offers resources and coordinates reasonable accommodations for students with disabilities and/or temporary health conditions. Reasonable accommodations are established through an interactive process between you, your instructor(s) and DRS. It is the policy and practice of the University of Washington to create inclusive and accessible learning environments consistent with federal and state law.
Case Study #1: Leper Colonies and Leprosy

A 21-year-old woman is committed to a rural sanatorium in India with suspicions of having the multibacillary (MB) type of leprosy. The sanatorium practices forced isolation for those with the disease because the community believes that patient isolation is both effective and necessary. She presents with several well-defined hypo-aesthetic patches over her arms and legs and is very concerned about disfigurement. The conventional therapy, the WHO six-month leprosy MDT regime, calls for 600mg of rifampicin, 400mg of daposone, and 100mg clofazimine. Unfortunately, these drugs are in short supply at the institution. Some say that a single dose of the three drugs can be effective, although studies about the effectiveness of this regime are ongoing and not yet confirmed. Given the limited supply of the drug, the doctors opt for a treatment of the single-dose of the three drugs for the woman.

Background:

India contributes about 80% of the global leprosy caseload, with approximately 400,000 new cases detected every year. In spite of all measures taken to contain the disease, it remains a major public health problem in India, particularly for the poorest of the poor. In fact, the Annual New Case Detection Rate (ANCDR) for leprosy is 2.34 per 10,000 people. The government of India has launched a Modified Leprosy Elimination Campaign in order to raise general public awareness.

Experts believe that access to multidrug therapy would significantly impact the prevalence in India. The development of methods to increase the specificity of diagnosis between the two types of leprosy will also enhance the public health disease eradication strategy.

India’s strategy to care for patients with chronic and stigmatizing diseases, such as leprosy, is to build separate institutions, or sanatoria. These sanatoria serve the dual purposes of removing the sick from the general population and reducing the risk of the spread of the disease to others. However, despite the fact that the large majority of the patients discharged from the sanatoria are cured, many continue to be chronically debilitated (along with their families) and are forced to settle in one of the 630 leprosy colonies in India. They are always welcome in these leper colonies and not often welcome anywhere else.

A typical day of leprosy patients at a sanatorium:

7:30 am – Breakfast.

8:00 am – Patients assembled to collect their daily medicines and for inspection of their hands and feet for fresh injuries by health personnel.

9:00 am–12:30 pm: Patients attended one of the following as per their prescription:
* Ulcer dressing/bed rest.

* To be present at the grand rounds for treatment reviews by consultants and the rehabilitation team.

* Ulcer surgery including partial removal of decayed bones mostly in the foot and occasionally in hands.

* Orthopedic workshop for special footwear or artificial limb fittings.

* School-going patients attend sessions by a fellow patient with teaching skills.

**12:30–2:00 pm** – Lunch and rest.

**2:00–3:30 pm** – Continuation of morning sessions.

**3:30–4:30 pm** – Re-education session on care of their eyes, hands and feet and other leprosy-related topics.

**4:30–6:30 pm** – Free time.

**6:30 pm** – Dinner.

Access to information, diagnosis and treatment with MDT are the key elements in the strategy to eliminate the disease as a public health problem, the goal being a prevalence of less than 1 leprosy case per 10,000 people. Since 1995, the World Health Organization (WHO) has supplied MDT free of cost to leprosy patients in all endemic countries, including India. A typical treatment plan includes a combination of rifampicin, clofazimine and dapsone for multibacillary (MB) leprosy patients and rifampicin and dapsone for paucibacillary (PB) leprosy patients. Among these, rifampicin is the most important anti-leprosy drug and is therefore included in the treatment of both types of leprosy. Treatment of leprosy with only one anti-leprosy drug is known to result in development of drug resistance.

Novartis has pledged to donate an unlimited MDT supply to WHO for as long as needed. However, no significant donations have been made to develop diagnostic technologies for the disease or distribute the rifampicin and dapsone used for treatment. Logistically, this is a significant problem because sanatoria and leper colonies are generally located in rural areas, which are difficult to reach.

**Questions for Discussion:**

What are the ethical and human rights issues that arise in this case study? Specifically, how do they relate to leper colonies and individuals living in leper colonies?
What are the challenges for India’s Modified Leprosy Elimination Campaign? What are the duties that India has to provide treatment to people living with leprosy? Are there international responsibilities to assist?

How can Novartis improve its commitment to combatting leprosy? What recommendations would you make if you were consulting for the Neglected Tropical Disease team in a global health, Seattle-based Foundation?

Readings:

World Health Organization, Leprosy Today, Available at http://www.who.int/lep/en/ (Links to an external site.)

World Health Organization. Global Leprosy Situation, 2012 (Links to an external site.). Weekly epidemiological record, August 24, 2012; 87:317-328. See also: http://www.who.int/wer/2014/wer8936.pdf?ua=1 (Links to an external site.)


(SKIM) United Nations Declaration of Human Rights (Links to an external site.), International Covenant on Economic Social and Cultural Rights (Links to an external site.)

(SKIM) Principles of Bioethics (Links to an external site.)

Optional:

Watch the following video (Links to an external site.).

World Health Organization, Leprosy: Situation and Trends, Interactive Map (Links to an external site.). (requires Flash player)

January 25, 2016

Case Study #2: Uganda’s Anti-Homosexuality Bills of 2009 and 2012

Seven years ago, a Ugandan politician introduced the Anti-Homosexuality Bill of 2009 (Links to an external site.) (Links to an external site.). The bill threatened to hang homosexuals. One month prior to the introduction of this bill, three American evangelists held a conference in Uganda and allegedly preached that homosexuals posed a threat to Bible-based values and the traditional African family.

The U.S. and other countries demanded in 2009 that Uganda’s government drop the proposed law, saying it violates human rights. At the time, the Ugandan Minister of Ethics and Integrity was quoted as saying, “Homosexuals can forget about human rights.”

Faced with the prospect of losing millions in foreign aid, the Ugandan Government indicated that it would back down, slightly, and change the death penalty provision to life in prison for some homosexuals. Ultimately, the bill did not pass.

Prior to the introduction of the 2009 Anti-Homosexual Bill, American evangelists helped set in motion a very dangerous cycle, according to human rights advocates in Uganda. Gay Ugandans described an environment of beatings, blackmail, death threats, constant harassment and even so-called ‘correctional rape’. “Now we really have to go undercover,” said Stosh Mugisha, a gay rights activist who said she was pinned down in a guava orchard and raped by a farmhand who wanted to cure her of her attraction to girls. She was impregnated and infected with H.I.V., but her grandmother’s reaction was simply, “You are too stubborn.”

The anti-homosexuality bill was reintroduced in Parliament in 2012. Contempt for the West and Western diplomacy has fueled the anti-gay movement in Uganda. In 2012, the anti-homosexual parliamentary bill’s author, David Bahati stated, “If there was any condition to force the Western world to stop giving us money, I would like that.” Many governments, including the U.S. and Britain have publicly stated their strong opposition to these bills. The Obama administration said it would use its foreign diplomatic tools, including aid, to promote equal rights for lesbian, gay, bisexual and transgender people around the world. Prime Minister David Cameron of Britain has threatened to cut aid for countries that do not accept homosexuality. African nations have reacted bitterly to this diplomatic engagement, saying it smacks of neo-colonialism.

Many in Africa think that homosexuality is an immoral Western import. Harsh laws against homosexuals and homosexual behavior are common. In fact, more than 36 countries criminalize homosexuality in Africa. In northern Nigeria, gay men can face death by stoning. Beyond Africa, a handful of Muslim countries, like Iran and Yemen, also have the death penalty for homosexuals. However, not all Ugandans believe that laws should be so harsh against homosexuals, although few openly speak out in support of gay people.

Since 2009, several anti-homosexuality bills were introduced in the Uganda Parliament but never passed until 2013. In 2014, a Ugandan court, composed of a five judge panel, struck down the law on technical grounds. This leaves open the possibility that the law could be revived.
Questions for Discussion:

1. What are the ethical issues in the case described in the NYT articles?
2. What specific human rights are being violated in the bills introduced in 2009 and 2012?
3. What are the public health implications of harsh criminal laws like the Anti-Homosexual Bills in Uganda?
4. The Ugandan Penal Code is not an outlier in Africa. In Daniel Englander’s article, “Protecting the Human Rights of LGBT People in Uganda in the Wake of Uganda's Anti Homosexuality Bill 2009", what reasons are given as the cause of this discrimination in Uganda and other countries in Africa?
5. What models have been used in other countries to decriminalize homosexuality or homosexual sexual acts? Are there lessons that can be learned, including those from the U.S.?
6. What solutions, both within and outside the country, are proposed to eliminate LGBT discrimination in Uganda and to respect, protect and fulfill their human rights?

Readings:

(Review) Universal Declaration of Human Rights:
http://www.un.org/Overview/rights.html (Links to an external site.) (Links to an external site.)

(Review) Universal Declaration on Bioethics and Human Rights, available at


The International Lesbian, Gay, Bisexual, Trans and Intersex Association, or ILGA, 76+ countries where homosexuality is illegal, Available at: http://76crimes.com/76-countries-where-homosexuality-is-illegal/ (Links to an external site.) (Links to an external site.)