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Towards Unity for Health

**COORDINATING CHANGES IN HEALTH SERVICES AND
HEALTH PROFESSIONS PRACTICE AND EDUCATION**

Medical schools and health care

Where is the synchrony?

James A. Hallock, Educational Commission for Foreign Medical Graduates, Philadelphia, Pennsylvania, USA

Upon assuming the presidency of the Educational Commission for Foreign Medical Graduates (ECFMG) on 1 February 2001, I began to assemble information about international medical education and the relative merits of the linkage between medical education and the health of populations. The World Health Organization (WHO), through its publication *Towards unity for health*, has been among the leaders in these efforts.

A recent publication of the WHO, a working paper entitled, *Challenges and opportunities for partnerships in health development*, placed proper emphasis upon the integration of health care delivery services and the need for a comprehensive approach in delivering these services. Multiple references on page 48 and page 56 challenge medical educational institutions as



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the appropriate sites and locales for the educational focus in these coordinated efforts (1).

Similarly, much has been written about the need for a linkage between medical education and the health of the population. Descriptors to identify this issue are reflected in the references cited (2,3,4,5,6,7). Each of these articles attempts to indicate and define the

continued page 3 ►

A people's affair

Charles Boelen, World Health Organization, Geneva

I must tell you about a recent encounter with the dean of a medical school in one of the poorest countries on the planet, in south-east Asia.

One could grade the school as excellent, according to standards commonly used by the promoters of quality assurance in medical education. The curriculum is designed to meet the priority health needs of people; students are exposed to community health problems very early in their training and throughout it; the most efficient



Dr Charles Boelen

learning processes are being used; learning materials exist in abundance; teachers are offered continuing education opportunities; and external evaluation of programmes is

routinely carried out and remedial action always taken when needed.

Despite managing a "centre of excellence" and an exemplary institution for many other schools in his country and in the region, the Dean looked sad as he said: "Every time I look through the window of my office and see peasants scratching the surface of the earth and struggling to grow something to feed their families, I am thinking that the majority of them and their families have no access to the most essential health services."

The Dean and some faculty members decided to make a special contribution to help their compatriots and reduce flagrant inequities in health. They undertook to set up a local health insurance scheme, and went through mountainous areas in four-wheel drive vehicles to persuade villagers to contribute the equivalent of one US dollar per year

if they lived in the most remote areas and the equivalent of three dollars if they lived closer to towns. These sums were intended to cover basic health services, such as vaccinations and management of common illnesses.

I met with the Dean one year after they launched their project, which happened to be popular and financially viable. He explained that taking such an initiative with little experience and no particular health administration skills exposed them to a number of surprises, one of which was the visit of a delegation of peasants, who said: "Professor, you will remember that we gave you a dollar. As we haven't been sick during the past year, can you please give us the dollar back?"

What was most surprising for me was that leaders in a medical school decided to set standards for themselves and for their institution—above the conventional ones—that they thought would best meet their ethical exigencies and social responsibility. Behind this there were no external constraints, only a conviction that there was a better way to perform their duties.

This school went "out of its way" and ventured into uncharted territory through its own will, the will of people. When one looks back and reflects on outstanding achievements in the health, social or eco-

nomic fields, very often one finds people who have gone "out of their way"—beyond their traditional realm of responsibilities—to take up new ones and build bridges with others to better manage critical issues for society and humanity.

Isn't it true that too often our behaviour is constrained by conventional borders, traditional thinking, administrative rules or institutional barriers that we are too shy to cross, even in the interest of the obvious? We all know that sustainable health gains are very often obtained when borders are crossed, when different stakeholders recognize the need to question their mandate and ways to best contribute to people's health, when these stakeholders further recognize that they don't have the total answer and need to express a common vision and commitment through efficient partnerships. Again, to create such a momentum towards unity of action, what matters most is the will of a few people who have the courage to go "out of their way". ■

Dr Charles Boelen, Coordinator for Human Resources for Health, WHO Department of Health Service Provision, and Executive Editor of this newsletter, contributes this regular feature. He can be contacted as follows: World Health Organization OSD/HRH; 1211 Geneva 27, SWITZERLAND (Telephone: +41 22 791 2510; Fax: +41 22 791 4747; E-mail: boelenc@who.int).

Soon to come ...

Now in preparation by WHO is *A view of the world's medical schools. Defining new roles*. This document analyses the results of a 250-question survey administered to more than half of the world's medical schools—895—in domains as varied as mission and mandate, financial support, admissions, student body, faculty, facilities, curriculum, credentials, accreditation, interactions with other groups and continuing education. Publication within the next few months is anticipated. ■

► continued from page 1

need for a social contract between the academic medical education community and the populations they serve. In Canada, and in Ontario in particular, this was taken quite seriously in a project entitled Educating Future Physicians for Ontario (EFPO), the overall goal of which was to "modify the character of medical education in Ontario to make it more responsive to the evolving needs of Ontario society" (8).

The Educational Commission for Foreign Medical Graduates (ECFMG®) has also played a significant role in these discussions by cosponsoring two invitational consultations with the World Health Organization: (1) "Toward a Global Consensus on Quality Medical Education: Serving the Needs of Populations and Individuals", Geneva, Switzerland, 1994 (9) and (2) "Improving the Social Responsiveness of Medical Schools", Barcelona, Spain, 1998 (10). These conferences highlighted a global recognition of the need for greater synchrony between the products of medical education and the health-care needs of the populations being served and of the need to share information to a much greater extent.

To that end, the ECFMG has created the Foundation for Advancement of International Medical Education and Research (FAIMER) and has recently defined the mission for this Foundation to be the linkage of health care education with the health of the population, as measured by health care outcomes. The goal will be that all future programmes of ECFMG and the Foundation, whether they be fellowship programmes, existing grant programmes, the consultation programme or new grant programmes, will be driven by this vision.

There are currently several global initiatives to look at assessment of medical schools with an eye towards international accreditation.

New WHO collaborating centre designated

The medical school of the University of Sherbrooke, in Quebec, Canada, was recently named a WHO collaborating centre in the education and practice of health personnel in response to society's needs. Sherbrooke strongly promotes the Towards Unity for Health approach. As this issue went to press, an inauguration ceremony and programme were scheduled for 8 and 9 November 2001. ■

These efforts are being sponsored by the World Health Organization, the World Federation for Medical Education and the China Medical Board of New York, Inc.

- The WHO has issued a call for an international Consortium for Accreditation of Medical Schools, suggesting that entities come together to take a unified look at international accreditation. The focus of this effort is to examine the social responsibility of medical schools in the evaluation process.
- The World Federation for Medical Education (WFME) convened a Task Force for Definition of International Standards in Basic (undergraduate) Medical Education, which has published *Quality improvement in basic medical education: WFME international guidelines* (11). This will be the basis for medical school assessment and includes a section on social interaction.
- The trustees of the China Medical Board of New York, Inc., have created the Institute for International Medical Education, which is working on a document entitled *Global minimum essential requirements in medical education* (12). The Institute was created to provide leadership in defining the global minimal essential requirements of undergraduate medical education programmes.

While these initiatives are all to be applauded and commended, they raise the very serious question

of the need for global coordination of these efforts to minimize duplication of efforts and maximize the impact of the educational process. It would certainly be a wonderful step forward if the efforts could be coordinated, with an appeal to link the educational mission to the social contract of medical schools.

The agenda appears clear: there is the need for synchrony between the educational programme and the health of the population being served. The mechanisms to accomplish this agenda—accreditation and assessment—are available.

The challenge is before us: Can we come together as a global education community and have an impact on health in a more significant way through the vehicle of education? ■

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Promoting international collaboration to enhance the quality of health care

Dale L. Austin, Federation of State Medical Boards, Eules, Texas, USA

Recent history

The success of biennial international conferences on medical regulation held since 1994 has led medical licensing authorities around the world to recognize that international collaboration is an essential element in their role as public protectors. The readiness of licensing and regulatory authorities to foster international relations has precipitated the formation of the International Association of Medical Licensing Authorities (IAMLA).

In 1993, the Federation of State Medical Boards of the United States of America, under contract with the US Department of Health and Human Services, planned and conducted the First International Conference on Medical Regulation. Participants met in Washington, DC, in May 1994 and included representatives of Australia, Canada, Ireland, New Zealand, South Africa, the United Kingdom and the United States. Observers were sent from Egypt, Israel, Mexico and Taiwan.

Designed to initiate dialogue among the participating nations, the conference focused on the current status of medical regulation in the participating nations, examining current research and identifying future research needs. The conference was successful in stimulating discussion and creating a consensus in favor of continued international dialogue. Conferees concluded that problems faced in the field of medical

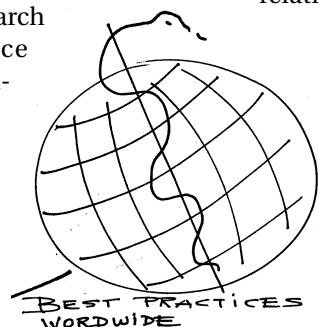


Dale L. Austin

licensure and discipline are not unique to any one nation; they decided to hold a second international conference in Australia.

The Second International Conference on Medical Regulation, held in Melbourne, Australia, in October 1996, experienced increased participation, with 20 countries represented. Topics for discussion included disciplinary procedures and practices, registration of medical students, assessment of international medical graduates, impaired physicians, recertification and maintenance of competence, management of complaints, the international movement of physicians and issues relative to telemedicine.

In September 1998, the South African Medical and Dental Council hosted the Third International Conference on Medical Regulation, in Cape Town, with 26 countries represented. The Fourth International Conference



on Medical Regulation, hosted by the General Medical Council of the United Kingdom in September 2000 in Oxford, was attended by 118 medical professionals from 23 countries.

A promising future

These conferences have been successful in providing a forum for the exchange of ideas and discussion of common problems affecting the delivery of health care and the regulation of medical practice, and have generated support for establishing an international association. Numerous areas exist in which collaboration among the international medical community will significantly benefit the public. In the last 25 years, we have experienced tremendous advances in electronic communication capabilities, increased migration of physicians and other health care professionals, individuals choosing to receive education and training outside their home countries, and treaties and trade agreements easing traditional borders. These changes are exciting and have provided an opportunity to draw upon the experiences of other medical licensing authorities, thereby improving medical regulation in the interest of enhancing public protection.

An Interim Governing Committee (IGC) for IAMLMA has been established and is composed of a core group of permanent members to provide stability and continuity. Participating countries include Australia, Canada, Ireland, New Zealand, South Africa, Sweden, the United Kingdom, and the United States. The IGC approved a planning document outlining steps that have been or will be taken to develop a permanent governance structure for IAMLMA.

The following broadly defined goals have been identified for the organization:

- To facilitate international cooperation and collaboration among licensing authorities

and the exchange of medical regulatory information.

- Encourage and support high standards for medical education, licensure and professional conduct.
- Provide a forum for the development of concepts and new approaches in medical regulation and thereby support licensing authorities in protecting the public.

The IGC has resolved that two matters be dealt with as priorities: the development of the bylaws of the Association and formulation of mechanisms by which information can be exchanged between the participating regulatory authorities. Task forces have been created to formulate proposals on each of these issues, to be presented for approval by IAMLMA membership at the Fifth International Conference on Medical Regulation, in Toronto, Canada, in June 2002. Final membership criteria and a dues structure will be included in the IAMLMA bylaws. In addition, an accurate reference listing for all known medical licensing and regulatory authorities will be developed to enhance the exchange of information.

The challenge for medical regulation in the 21st century is to create a relevant, effective medical regulatory system that can address the dynamics of global and rapidly changing medical practice environments, technologies and health care delivery systems. International cooperation is the key to enhancing the role of medical regulatory authorities as the primary vehicle for public protection in health care. IAMLMA will help this goal become a reality. ■

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■ ***Collaboration between the World Health Organization and the World Organization of Family Doctors***. Geneva, World Health Organization, and Singapore, World Organization of Family Doctors, 2001 (For copies of this 16-page brochure, please contact Dr Alfred W.T. Loh, Chief Executive Officer, WONCA World Secretariat, College of Medicine Building, 16 College Road #01-02, Singapore 169854 (Telephone: +65 224 2886; Fax: +65 222 0204; E-mail: admin@wonca.com.sg).

Coming soon

■ ***A view of the world's medical schools: defining new roles***. Geneva, World Health Organization.

■ ***Improving health systems: the contribution of family medicine. A guidebook***. Singapore, World Organization of Family Doctors, and Geneva, World Health Organization. ■

Accreditation and development of medical schools: a global project¹

Charles Boelen, World Health Organization, Geneva

“Do schools contribute to improving people’s health as much as they potentially can?” This question is further prompted by globalization trends and their corollaries for more transparency and for more widely available information for assessment. With the mobility of graduates across borders and the search for global consensuses on best practices in medicine and education of health professionals, internationally compatible evaluation schemes are needed.

Efforts have been made over the years and worldwide to improve the quality of medical education and the social responsiveness of medical schools through proposed guidelines and benchmarks (1, 2, 3). The impact of these tools remains questionable regarding sustainable changes in the mandate and scope of interventions of medical schools. While some medical schools submit themselves to a formal accreditation process, only a handful of them use measurement tools to assess their responsiveness or accountability in meeting society’s priority concerns (4).

The “social accountability” of medical schools should be defined as the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region and/or nation they have a mandate to serve, with the understanding that priority health concerns are to be identified jointly by governments, health care organizations, the health professions and the public (5).

Debates on the definition of a social mandate, on the expression of the social responsiveness of a medical school and on the necessity to consider these issues in the light of specific socioeconomic contexts are not new (6, 7). Similar concerns have been expressed regarding health professions practices and health service organizations (8, 9, 10).

The wealth of available knowledge and recommendations should be translated into sets of standards and indicators to allow proper assessment and promotion of social responsiveness. The design of accreditation models should be based on the following premises:

Accreditation: key leverage for change

Health service organizations should be guided by a universal quest for improved quality, equity, relevance and cost-effectiveness. Likewise, the health professions and educational institutions, regarded as key contributors to health development, should be held equally accountable for achieving these values. The mission of educational institutions is in principle intimately linked to the mission of the entire health system of a nation, and the appraisal of their performance is a component of that mission.

The main purpose of education is to prepare future generations of health professionals to efficiently address people’s priority health needs. While the acquisition of given sets of competences and skills should be influenced by a universal corpus of values and knowledge unique to the health professions and disciplines, the milieu in which they are expected

to practise should always be taken into account.

Advocating the global relevance of standards of social responsiveness does not mean that features of medical schools and medical education should be made uniform. A key concern is to respond as efficiently as possible to local health needs through optimal use of local health resources. But health care, medical practice and medical education are equally expected to be organized to serve the values of quality, equity, relevance and cost-effectiveness.

Because of the close relationship between medical education, medical practice and the health care system, the notion of social responsiveness of medical schools should be developed by including interventions related to these three components. The intimate interface between medical-school functions in education, research and service provision also pleads for a more holistic approach in reviewing their mission. A framework for accreditation would therefore encompass elements related to the impact of medical schools and medical education on career choices of graduates, on the work of the medical profession and the on performance of the health system. It would also consider the capacity of medical schools to contribute to creating productive and sustainable partnerships with other important stakeholders on the health scene to improve the delivery of health services as well as people’s health status.

The need to use such a comprehensive approach was recognized by the World Health Assembly in 1995 and is being increasingly advocated in national strategies (10).

¹ Extract of a paper in preparation for publication.

But it is submitted that because of the complexity of the task for individual countries and institutions and the intimate international relationships [required], these strategies will be sustainably implemented only if coordinated global action is taken with a view to suggesting standards and procedures of accreditation and encouraging development in these areas.

A global project

Table 1 outlines a global project for the accreditation of medical schools on the basis of social responsiveness, validated by a global consortium and publicized on the World Wide Web with the aim of improving the performance of schools in health systems development. Each **component** is identified by a number (1 to 9) and each transaction linking components is identified by a letter (A to P).

Component 1. The world with its 6 billion inhabitants has about 6 million physicians serving in 192 countries, trained in about 1700 medical schools. A scenario is proposed in which a medical school is aware of the existence of a global project for accreditation and development. The school contacts the global consortium for accreditation of medical schools for assistance (transaction A).

Component 2. There is a global consortium of representatives of the main international and national agencies active in international medical education. Their willingness to be part of the global consortium implies a shared vision that medical schools can and should play a significant role in helping to attain national health objectives through collaborating to shape an optimal health system, and that their capacity in this regard should be assessed and become an important reference for their accreditation. One member agency of the consortium is assigned the responsibility of main-

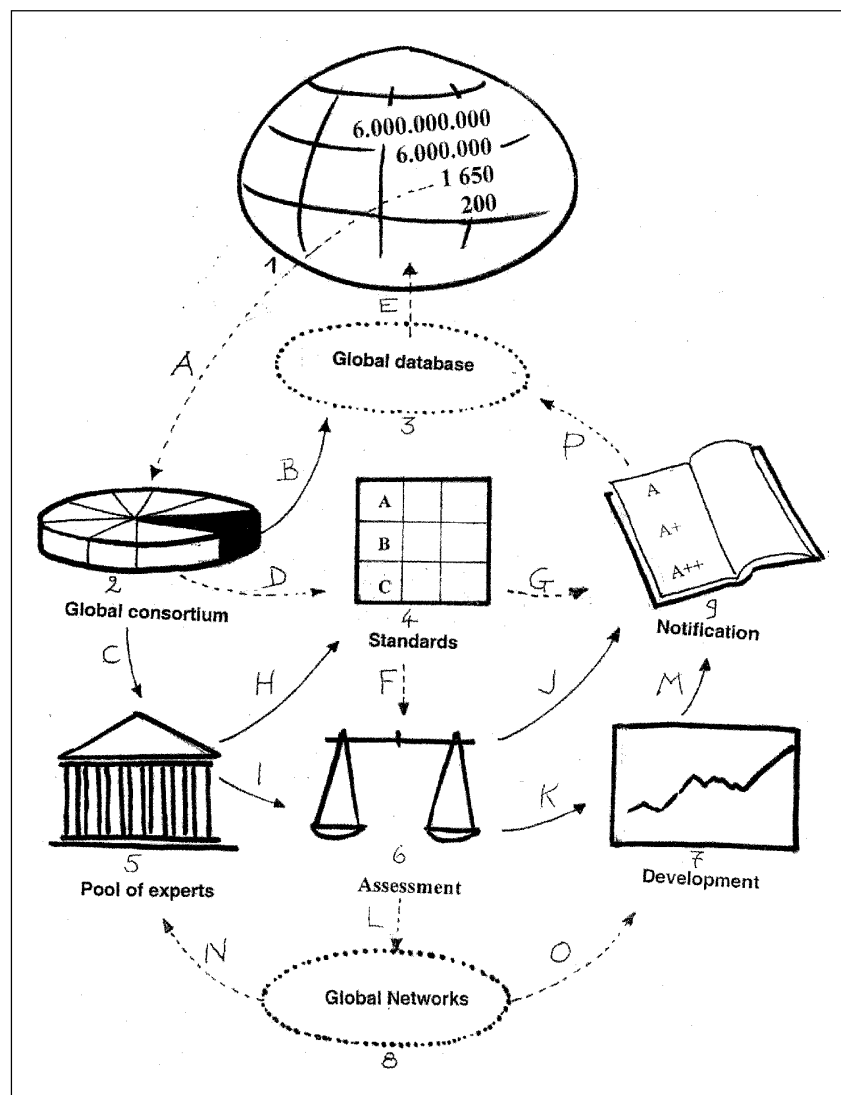


Table 1. Global project for accreditation and development of medical schools

taining a global database of medical schools (transaction B). The maintenance of the database can take different forms: (1) each medical school updates its own profile at its discretion through agreed access and validation procedures; (2) the consortium uses the database to assess progress in accreditation worldwide; (3) the consortium may seek specific information from medical schools with regard to important issues.

The global consortium establishes a pool of experts (transaction C) whose main task is to develop sets of standards. It will, however, ensure that the purpose of accreditation and development of medical

schools is consistent with the basic principle of best serving society's health needs and is well reflected by the proposed standards (transaction D).

Component 3. While several regional and subregional databases of medical schools exist, very few global databases have been developed. The World Health Organization has been active in surveying medical schools over the last three decades and publishing basic information on medical schools in its *World directory of medical schools*. The seventh and last edition, issued in the year 2000, was the occasion to develop an electronic database

with information collected through a world survey on 250 questions (11, 4). The global database could serve as a baseline. Under conditions that must be determined, WHO would allow the consortium, of which it would be a member, to use the database.

All or part of the database would be accessible to the public (trans-



action **E**), which is an essential feature of the global project. Due to clearly expressed profiles of medical schools and transparency as to how assessment is carried out, citizens would be in a better position to make informed choices to take advantage of educational and research programmes. Medical schools themselves and other health institutions would have a better base from which to negotiate collaborative ventures.

Component 4. The establishment of standards to assess the quality of medical education and the performance of medical schools to better meet priority health needs of individuals and populations is central to the global project. Standards will help to develop a typology of social responsiveness of medical schools. Medical schools could be grouped into three categories according to their degree of social responsiveness: **type C**, **type B** and **type A**. **Type A** is the highest and most desirable category, and incorporates the attributes of **types B** and **C**.

- A medical school is recognized as being of **type C** when evidence

is provided that it uses the most appropriate educational strategies to train doctors to best serve the priority health needs of society.

- A medical school is recognized as being of **type B** when evidence is provided that it prepares its graduates to properly function in a practice environment—which it would have contributed to adapting—to best serve the priority health needs of society.
- A medical school is recognized as being of **type A** when evidence is provided that it prepares its graduates to properly practise in a health system—which it would have contributed to designing—to best serve the priority health needs of society.

Standards will lead to developing measurement tools for assessment (transaction **F**) and be reflected in the notification (transaction **G**).

Component 5. The pool of experts is the scientific core of the global project. They will develop standards and measurement tools reflecting the typology in three categories (transaction **H**). They will suggest core standards that are universally applicable, as well as context-specific standards. They will also design and implement research and development activities to adapt and improve the definition and use of standards and measurement tools.

While the pool of experts will be drawn from the global consortium (transaction **C**), global networks active in health professions education and practice are encouraged to submit names of candidates (transaction **N**). The following criteria are proposed to be considered as a candidate:

- recognized expertise in assessing institutional performance;
- extensive international experience in medical education and management of medical schools;

- a history of developing strategies for more socially responsive health systems;
- current involvement in field projects in different continents;
- full commitment to the principle of social responsiveness/accountability of medical schools;
- independence from undue influences, particularly commercial ones.

The pool of experts would be composed of up to 50 members reflecting socioeconomic and cultural specificities in the world and a fair geographical distribution. Experts will be in charge of the assessment of medical schools (transaction **I**).

Component 6. The assessment could be carried out under different modes. A medical school may opt for a self-assessment mode and be advised on how to independently use an evaluation kit based on the proposed standards. Further, it may ask the pool of experts to examine the results of its self-assessment and validate them. Experts may be able to do this at a distance through an established set of procedures. Finally, a medical school may ask the experts to make a site visit and carry out the assessment, through a pre-determined protocol.

The results of the assessment are of primary interest to the medical school itself in order to improve its performance, identify areas requiring improvement (transaction **K**) and possibly call for collaboration with global networks specialized in institutional development (transaction **L**). A medical school may allow the results to be publicly known and accept these to be recorded in the global database (transaction **J**).

Component 7. The assessment and accreditation ought to be seen as means to stimulate and guide the development of a medical school towards fulfilment of its social

mandate through its different missions: educating physicians, supporting optimal practice and contributing to improving the working environment in a health system. A profile helps to capture priority domains for the improvement. Strategies can be elaborated with a view to addressing capacities within the confines of a Type (A, B or C) or increasing the general score of the school from one Type to a higher one.

The support proposed to the school to implement its developmental strategy covers a wide range of resources: a list of "how to" materials and experts, classified per Type or capacity within a Type; citation of medical schools or other institutions willing to serve as references for twinning arrangements; names and contacts of agencies interested in providing technical advisory services and possibly funding. The global consortium, through its membership and contacts with global networks, should be able to guide the medical school in obtaining the necessary support and assist in coordinating it within a coherent strategy for change and improvement.

Component 8. The expertise and experience of global networks concerned with the wide range of health development and human resources for health issues should be tapped to both nurture the pool of experts (transaction **N**) and assist in development (transaction **O**).

Component 9. With the agreement of the school, its score in accreditation and information on its state of development would be made public (transactions **J** and **M**). Regarding accreditation, notification will refer to Type A, B or C.

As indicated earlier, the medical school may assess itself and report its findings, which will be recorded as A, B or C. The second option is to have the results reviewed and possibly validated at a distance by

designated experts from the pool. If validated, results will be noted as A+, B+ or C+. Finally, the third option is an assessment made on-site by three experts designated from the pool; their opinions will be recorded as A++, B++ or C++. Notification related to options two and three is officially endorsed by the global consortium.

It may be that a school expresses the wish for its self-assessment score to be validated by the global consortium, either by distance review or site visit. In case of conflict

between scores from self-assessment and any other form of assessment (distance review or site visit), the last one will prevail and be reported in the global database (transaction **P**). Scores can always be reviewed after a given developmental process has taken place. ■

Further details on the global project for the accreditation and development of medical schools can be obtained from the Department of Health Service Provision, World Health Organization, 1211 Geneva 27, Switzerland (Fax: +41 22 791 4747).

New journal: *The meducator*

Editors: Dr Kalyani Premkumar and Dr John S. Baumber; Faculty of Medicine, University of Calgary, Alberta, Canada; Meducational Skills, Tools & Technology Pvt. Ltd. India

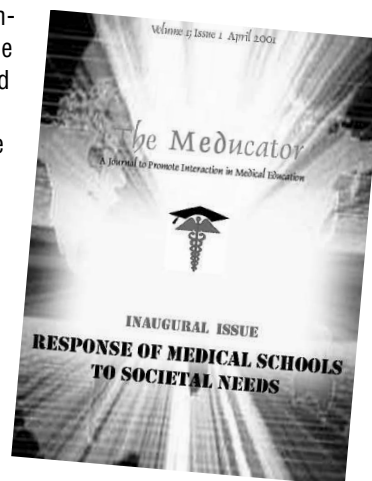
A new quarterly journal, *The meducator*, is presently available online and on paper. Independent and with no allegiance except to the world community, the journal is based on the belief that education is the key to improving world health. It aims to provide a forum through which the global village of medical educators can share experiences and discuss experimentation in medical education to serve the health needs of local communities and ultimately nations.

Each issue will have a theme. The first theme was "The Response of Medical Schools to Societal Needs". The second was "Building Bridges between Nations"; the third will be "Common Standards for all Physicians?"

The initial features of this peer-reviewed journal include the following: reviews, research and development, communications, opinions, news, a handbook for physicians and a student forum. *The meducator* will cover the spectrum of education from premedical to continuing post-graduate education.

The editors describe *The meducator* as truly a grassroots enterprise, whose success will depend on support, subscriptions and contributions. Dr Charles Boelen, Executive Editor of this newsletter, is a member of *The meducator*'s editorial board.

The first issue is available free of charge. For more information, please check the Web site: <http://www.meducational.com/journal> ■



Primary health care is still on the agenda, but...

Vincent De Brouwere and Bruno Marchal, Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgium

Primarily health care (PHC) is still high on the international health agenda, but it has lost much of its prestige. Some already consider PHC to be an old-fashioned strategy that is doomed: 20 years after its launching, it still doesn't bring health for all.

The WHO *World health report 2000* (WHR) clearly expressed the "at least partial failure" of so-called PHC programmes. The main criticism is about "too little attention given to people's demand for health care, which is greatly influenced by perceived quality and responsiveness, and instead concentrating almost exclusively on their presumed needs." The major innovation brought by PHC, i.e. community participation—the involvement of individuals and the community in health (care) decision-making—was thus restricted to its financial component.

The WHR however brought a renewed interest for the values underlying PHC, even if—and perhaps because—worn-out words such as "financial equity" and

"attention to felt needs" have been replaced by "fairness in financial contribution" and by "responsiveness", respectively. Although the debate about this report is not closed, it is not the aim of this paper to add to that polemic.

Threats to primary health care-based health systems

In our opinion, the real threat¹ against PHC is, first, the again increasingly important role of prioritizing in international health policy and, second, the fragmentation of aid programmes.

Setting top priorities

AIDS, malaria and tuberculosis are certainly the major killers in most developing countries. This being the case, it only makes sense to try to obtain significant global advances by focusing on cost-effective control programmes for these diseases—programmes that often are implemented under a project format. But this priority-setting, which is allegedly based on actual needs, tends to be done at international level with

quite limited input from recipient countries, certainly from those in which AIDS is not highly prevalent.

Believing it possible to control such complex poverty-related health problems without improving health systems seems naïve regarding the lessons learnt from our 20th century history: "sustainable primary care must be the first ambition of any global fund for health" (1). Furthermore,



Vincent De Brouwere

even if a project-oriented approach would prove to be more efficient, it may be in contradiction with the WHR, which stresses that health policy decision-making should be more responsive to people's demands.

Fragmentation

The interventions of the major actors in health have become dispersed and fragmented. First, there has been a huge increase in the number of partner organizations working in the field of health. These include the international agencies, but also many smaller-scale national or local NGOs and organizations. They all share an increasing market-driven orientation, leading to "economically sound" interventional logic's obtaining the upper hand.

Second, bilateral cooperation agencies and private philanthropic funds (for instance, the Bill & Melinda Gates Foundation) are increasingly influencing the agenda and policy of international health by the sheer size of their contributions and the specific conditions concerning the use of these funds ("earmarking"). But the social accountability of these donors can be questioned, with regard to both



¹ The Big Six as defined in the General Programme of Work of WHO in the 1950s: malaria, tuberculosis, STDs, maternal and child health, environmental sanitation and nutrition.

their home communities in the North and the end-users in the South.

Thirdly, the management approach of international agencies has contributed to misdirected efforts. Programme managers in these agencies are evaluated on their capacity to implement a programme (meaning sometimes "capacity to spend the budget", whatever the content).

But implementing a programme aimed at increasing the wealth of a population does not mean that this is a felt need, or that it is a need identified by local health personnel. Therefore, health workers and the population do not feel really concerned by the outcome of such donor-driven programmes.

Also, agencies exert a perverse influence, as they cause a local brain drain by diverting health workers from their assigned roles. In some cases, health personnel spend up to 50% of their time attending seminars and workshops, stimulated by incentives (2).

All this contributes to a vicious circle that undermines attempts to build a public service that lives up to the legitimate demand for quality care and this, with the tacit consent of all the actors (health workers, policy-makers and donors) (3).

Fourthly, verticalization, in an effort to maximize effect for money, and the measurement trap—whereby preferably quantifiable goals are pursued for results in the shortest time possible—contributes to designing fragmented interventions.

Unity: the next frontier

These four elements play a large part in the lack of a systematic view of the problems, which is essential for a "good" PHC approach. Competition, not cooperation, is at the heart of international health these days. Sector-wide approaches (SWAPs) have been attempted in several countries to overcome the fragmentation in health sector

interventions. Unfortunately, this attempt showed how limited such approaches are unless essential ingredients—among which "a country-led strategy around which donors can coalesce" is crucial—are missing (4). More than ever, we need to summon up our strength to insert integrated primary health care systems as the cornerstone of a world strategy to achieve Health Care for All. ■

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Making communities real partners

Akin Osibogun, University of Lagos, Nigeria

Rationale for partnerships in health

Health care delivery in Nigeria, as in several other developing countries, has been subject to stresses such as inadequate funding and improper management of resources that have adversely affected the quality of service and consumer satisfaction.

In the mid 1970s it was discovered—through hindsight and evaluation of past failed programmes—that community involvement had been obviously absent or lacking in most failed programmes. Most programmes were not sustained after the exit of the initiator because the recipients perceived the programmes to be alien and not their responsibility; they therefore made no effort to see that they were maintained. This led to waning of the effects of programmes such that the pro-

grammes never maintained their initial impact—if there was any impact (1).

It is thus of critical importance that health workers work in partnership with community members. Individuals and families must assume responsibility for their own health and welfare and that of others in the community



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and develop the capacity to contribute to their own and the community's development.

Communities and their members must be active partners in health development if any meaningful progress is to be made. A situation in which community representatives are included for "window-dressing" while power continues to be centralized cannot be considered as genuine participation (1).

If communities are to be real partners in planning, implementation and evaluation of health programmes, managerial skills that most often were hitherto lacking are urgently required, not only for the community members, but also for the health workers themselves. Support is therefore necessary for durable partnerships to evolve and flourish. Such support should include political commitment of the highest levels of government. Ethiopia's recent strides towards achieving this are an example (2).

Another imperative for health development is the presence of a local administration that is approachable and that can quickly respond to local community interests. There will also have to be adequate resources allocated to the local governments to achieve health goals.

It is thus obvious that the evolving partnership must involve the communities, the health workers, the local administration, the policy-makers and training institutions that can influence the orientation of the present and future health worker. There is perhaps no further argument about the desirability of empowering communities to help themselves and the sooner self-help is taken into account as one of the basic components of PHC in all countries, the likelier it will be that we shall move towards achieving health for all (3).



The impact of communities in the partnership

A small study was conducted in 19 Local Government Areas in Nigeria to determine the spread of community organizations for health development in Nigeria, the role such organizations play in health care delivery and the effects they have on the utilization and acceptance of health programmes and health services. This study showed that services were more acceptable, better utilized and better supported financially by community members in those local governments where different forms of partnerships existed between the health service and the communities (Table 1).

The study also showed that these health committees operate within favourable social and political conditions (78.9%) with good local leadership support (84.2%). This finding supports the expansion of partnerships to involve policy-makers and health administrators. The role of the academic institution will then be to ensure the right training and orientation for present and future health workers, as well as to be active in pursuing participatory research as a means of gathering evidence for decision-making by members in the partnership.

Partnerships that work: Nigerian experiences

The *Ode Remo Community* in Ogun State, Nigeria, is a quiet town inhabited mainly by farmers and petty traders. The people, like those of most other communities in southwestern Nigeria, have benefited from early contact with modern educational methods and are therefore highly enlightened. Members mobilized themselves through traditional institutions in the community and constructed a 16-bed health centre for their own use.

This facility has been staffed by the local government authority and thus effectively ensures an ongoing partnership between the community, the medical school/teaching hospital, the administrators of the health department and the policy-makers at the local government level.

In *Odogbolu Local Government Area*, also of Ogun State, members of the community have been mobilized to form a Health Society that provides health insurance cover for its members. This society is in active partnership with the health workers, the administration of the health department, the policy-makers at the local government level, and the Department of Community Health of the College of Medicine of the University of Lagos. This partnership is already about five years old.

In *Surulere Local Government*

Table 1. Community organization and implementation of health programmes

	Health committee exists or community organization affiliated with health centre	
	YES n=16	NO n=3
% with acceptable services	62.5%	33.3%
% with successful community projects	81.3%	33.3%
% with services publicized	68.8%	33.3%
% contributing labour or resources to health services	100.0%	66.7%
% in which community provides funds through fees or insurance	80.0%	66.7%
% in which community helps with community needs assessment	80.0%	33.3%

Area of Lagos State, about a one-hour drive from Odogbolu, a different kind of partnership is evolving between a nongovernmental organization set up to promote the health of the elderly, the Surulere Local Government Council health administrators and the policy-makers, and the Department of Community Health. The partnership is ensuring the provision of highly needed geriatric health services as well as the opportunity for training of post-graduate doctors.

Making partnerships work

Certain preconditions found to be necessary for the success of partnerships include a willingness to learn on the part of all partners and more especially those from academic institutions. Members of the community are not totally ignorant and often have valid explanations for their ways of life. Members from academic institutions and health workers must be

patient enough to grasp these explanations.

Policy-makers must be helped to understand the new paradigm of development, which is about people. There can be no development without people, and health is central to the lives of people. This understanding is expected to translate into better funding and support for health programmes.

Most importantly, development can happen only when all hands are on deck in the true spirit of partnership. The people must chip in their own contribution and assume responsibility for their own health, while the administrators must discharge their responsibilities equitably. Such partnerships will ensure that health programmes have a better chance of success, because health services will be consistent with local perceptions of health needs and managed with the support of local people. ■

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If I were Minister of Health: the Greek health paradox and the health policy conundrum

Anastas E. Philalithis, University of Crete, Heraklion, Greece

When I was asked to contribute a piece to this journal entitled “If I were Minister of Health”, my immediate response was that the topic was quite intriguing, since this is the sort of game that one would play, preferably in a Greek café, but not necessarily commit to paper. Still, as it was an interesting challenge, I accepted. The result is a policy statement that I would like to hear from the Minister of Health of my country today.

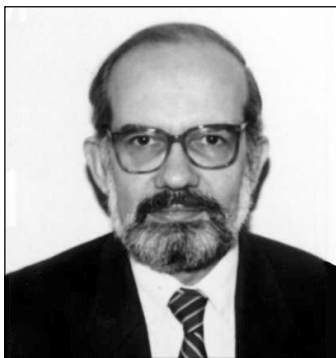
Health in Greece is characterized by a paradox: no one is content with the health care delivery system, yet health status is among the best in the world. Life expectancy is among the highest, maternal mortality and the standardized death rate for most disease categories are among the lowest; infant and perinatal mortality are steadily improving.

Of course, the apparent contra-

diction can be explained by the lifestyle, societal and environmental determinants of health. The excellent health indicators came about as a result of overall social and economic development, of the Mediterranean diet that we have not yet abandoned, of the relatively unspoiled environment, of the fact that many people still “exercise” because they are farmers. They are also due to the preservation of

family bonds and social networks whose contribution to health maintenance is increasingly being recognized. They cannot be attributed to the public health services, the staffing and performance of which have been inadequate for years.

Two significant exceptions to the favourable omens are cancer of the lung, whose incidence is rising (per capita cigarette consumption is,



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after all, among the three highest in the world), and deaths from motor vehicle accidents, where we have the worst record in the European Union.

At the same time, the health care delivery system is actually quite effective and—despite our geography (with its small islands and distant mountain villages)—quite accessible, even while it is not “user friendly”. Perhaps it is so “open” because Greek patients have the ability to “find their way about”, i.e. to circumvent any bureaucratic, administrative or financial barriers that exist, albeit while paying the additional costs that they incur because they break the rules.

But circumstances are changing. New lifestyles are being adopted, not always for the better. Family ties are weakening; social solidarity is becoming rare; the influx of a large number of immigrants is putting considerable strain on society. At the same time, advances in medical science, including genomics (and possibly cloning), and progress in biomedical technology are making health care delivery more complex and more expensive. We need a health policy that will face the challenges that loom ahead without destroying past achievements.

My answer to this conundrum is a two-pronged policy. The first axis is a multisectoral health policy that addresses the broad determinants of health, underpinned by a renovated public health service. The second axis is a reorganization of the national health system, based

on a strengthened primary health care (PHC) system. Both components must be supported by an appropriate health workforce management and development policy.

A multisectoral health policy and public health services

Policies in all areas of government responsibility must take into account their effect on health. Two examples will illustrate the point: agricultural, commercial and industrial policies affect nutrition and, Greece being a tobacco growing country, smoking.

Transport policy, better roads, stricter policing, seatbelts and helmets and the ambulance service can reduce deaths from traffic accidents. But these things will happen only if the Public Health Service is overhauled to be able to carry out regular health needs assessment and policy analysis and formulate, implement and advocate policies with a positive health impact. It should also monitor the performance of the health care delivery system, measuring its effectiveness, efficiency and responsiveness to needs.

Health care reform and primary health care

The reorganization of the National Health System is already under way. The creation of the 17 Regional Health Systems will decentralize decision-making, and measures to improve hospital management are being instituted. The next step, under preparation, addresses the financing of the system. It also focuses on PHC, with the creation of a general practice/family medicine service in urban areas and the consolidation of the existing health centres in rural areas.

The aim is to create a PHC system that is comprehensive and accessible 24 hours a day, seven days a week, that provides continuity and home care, and that can act as a familiar guide to the patient who is faced with the labyrinth of increasingly specialized services.

People will stop flocking to hospitals for the most minor ailments, as they do now, only when they have confidence in the alternative.

Health workforce development

Policies are formulated and implemented by people. Workforce planning and improving the education of health professionals are crucial for the success of any health policy. We must establish suitable training programmes for general practitioners and social medicine specialists, and the education of nurses must be upgraded. The medical faculties must introduce undergraduate courses in PHC, following the example of the University of Crete, and more university nursing faculties must be established, in addition to that in the University of Athens.

Economists, social scientists and administrators must be attracted to the management of the health sector. Of course, adequate pay for all health professionals and managers is necessary to recruit and retain people of a high calibre.

The political process

So far, I have presented the technical aspects of health policy. But nothing happens unless the political issues are addressed: In whose interest is one acting? Whose interests are threatened? Who are the allies you can rely on, and who are the foes you should isolate? Who are those whose commitment, involvement and active participation is forthcoming and who are the stakeholders who will resist any change?

Organized groups will lobby, overtly or covertly, for measures that favour their vested interests. But who will look after the interests of the public at large? Fulfilling this political role is a principal function of the ministry of health. Otherwise all technical solutions, including the laws that are passed, will just decorate one more shelf in the library of the ministry.

Conclusion

Greece has achieved an enviable position in the health league tables, without really trying. The National Health System has attained a surprisingly high degree of effectiveness, without actually realizing it. But things will not continue to improve on their own, and some trends are already deteriorating.

We must strengthen positive trends and reverse negative ones. We must face the new challenges, while building on the successes of the past. Public health services and primary health care are the two areas where any investment is most likely to bring big dividends in the future. ■

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The status and future of TUFH

Two years after the WHO international conference on Towards Unity for Health, in Phuket, Thailand, the TUFH Advisory Committee was to review achievements at global, regional and national levels. As this issue was in production, the committee was scheduled to meet from 21 to 22 September in Barcelona, Spain. The agenda included planning the next actions with respect to: TUFH field projects; educational initiatives on TUFH; use of comprehensive management of information to create unity among stakeholders; TUFH and the health professions; and global networking with NGOs. A report of the meeting will be available late in 2001. ■

Family medicine

An asset for the health of the Bangladeshi

Khaleda Islam, Centre for Medical Education, Dhaka, Bangladesh

Still facing great challenges

Bangladesh is making remarkable progress in the health and family planning sector. The country has developed a unique health care infrastructure, divided into primary, secondary and tertiary facilities, that covers everything from remote villages to big cities.

Despite its advances, Bangladesh remains one of the few countries in which life expectancy at birth is lower for females. Some 70% of mothers suffer from nutritional deficiency anaemia, 75% of pregnant women do not receive antenatal care or assistance from a trained attendant at the time of childbirth, and the maternal mortality ratio (4.2) is still high. Less than 40% of the population has access to basic health care, and use of primary and secondary health care services remains poor overall (1).

Essential Service Package and family medicine

The concept of the Essential Service Package (ESP) was adopted by the Health and Population Sector Programme (HPSP) to provide prioritized primary care with special consideration for women, children and the poor (2).

Currently about 19,000 doctors are either working in the private sector or are self-employed in professional practice. Approximately 70% of all doctors are in some form of medical practice but are not serving as true general practitioners or family physicians. A recent study revealed that 30% of the out-

patient load of district general hospitals, which are secondary-level health centres, are entirely for primary care (3). For Bangladesh, an effective generalist approach to the health care has therefore become essential to provide cost-effective care.

But most of the country's general practitioners have scarcely any opportunity for education or training.



Khaleda Islam

Considering this, some professional groups and academic institutions are making sporadic attempts to run family medicine courses for general practitioners. The Bangladesh Private Medical Practitioners Association established the Bangladesh College of General Practitioners, which offers fellowships in family medicine and is conducting a continuing medical education course. The Bangladesh College of Physicians and Surgeons has started conducting membership examinations in family medicine and offering the designation "Member of the College of Physicians and Surgeons" (MCPS), but only 37 MCPS have been confirmed to date. The University of Science

and Technology, Chittagong, has started a postgraduate diploma course in family medicine, and the Bangladesh Academy of Family Medicine is planning a Diploma in Family Medicine course.

Need for a national concerted effort

WONCA and WHO are very much behind the whole initiative of developing the discipline of GP/FM in Bangladesh. A national workshop was held in February 2000 in Dhaka to identify the ways and means of introducing family medicine at the undergraduate level. As a result, a feasibility study for the establishment of units of family medicine is under way, with the following terms of reference.

- To evaluate the current status of family medicine/general practice, and to identify the relationship between practice and education.
- To assess the current content of education for family medicine in medical schools, particularly at the undergraduate level; to identify opportunities and means to strengthen it; and to assess the



feasibility of establishing departments/units of family medicine

- To identify the means and processes for sustainability of such an initiative.

A report revealed a shortage of trained teachers and other resource constraints, and recommended that selected medical colleges start departments of family medicine. To ensure an essential service package, the country needs doctors who will not only treat the patient competently, but also possess all the aptitudes of the "five-star doctor" (5).

The introduction of an effective generalist approach is essential in Bangladesh to improve the performance of the health service delivery system. But such an effort should be guided by a clearly defined strategic action plan that should rally the most important stakeholders in the health system: policy-makers, health managers, professional associations, academic institutions and representatives of civil society. The approaches imbedded in the "Towards Unity For Health" project would be useful for its successful implementation (6). ■

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Better online access to health information for developing countries

WHO and the world's six biggest medical journal publishers recently announced a new initiative that will enable almost 100 developing countries to gain access to vital scientific information they otherwise could not afford. According to the new arrangement, almost 1000 of the world's leading medical and scientific journals will become available through the Internet to medical schools and research institutions in developing countries free of charge or at sharply reduced rates.

Until now, biomedical journal subscriptions, both electronic and print, have been priced uniformly for medical schools, research centres and similar institutions regardless of geographical location. Annual subscription prices cost on average several hundred US dollars per title; many key titles cost more than USD 15 000 per year.

Scheduled to start in January 2002, the initiative is expected to last for at least three years. For further information and to explore eligibility for reduced-cost access, interested academic and research institutions are invited to contact WHO: Mrs Barbara Aronson, IMD/LNK, World Health Organization, 1211 Geneva 27, Switzerland (Telephone: +41 22 791 2034; Fax: +41 22 791 41 50; E-mail: aronsonb@who.int). ■



The Five-Star Doctor award

Robert Higgins, immediate past President of WONCA, Anacortes, Washington, USA

The World Organization of Family Doctors (WONCA), in consultation with the World Health Organization (WHO), has established an award to honour those physicians who best meet the precepts of the Five-Star Doctor, as set forth by WHO. Five annual awards will be presented, one in each of the five WONCA regions. The winners of these awards will compete for the world award, which will be presented once every three years.

The winners of the annual regional awards will receive a certificate. The winner of the world award will receive a certificate and a plaque or sculpture. The award winners will be announced by both WONCA and WHO.

Criteria for the annual regional awards are as follows:

- A nominee must best meet the principles of the Five-Star Doctor
- A nominee should be a serving physician in mid-career who in addition to providing regular services:
 - provides innovative services for a community or special group
 - developed services where they were previously not available
 - supported colleagues in another region, country or college
 - performed academic work (teaching, research, quality assurance) of exceptional quality and relevance
- A nominee need not be a family doctor
- A nominee can work outside his or her region, or create something that can be used outside his or her region or serve as a role model to other regions

The attributes of the Five-Star Doctor

- ★ Care provider, who considers the patient as an integral part of a family and the community and provides high standard clinical care (excluding or diagnosing serious illness and injury, manages chronic disease and disability) and personalizes preventive care within a long-term, trusting relationship.
- ★ Decision maker, who chooses which technologies to apply ethically and cost-effectively while enhancing the care that he or she provides.
- ★ Communicator, who is able to promote healthy lifestyles by emphatic explanation, thereby empowering individuals and groups to enhance and protect their health.
- ★ Community leader, who having won the trust of the people among whom he or she works, can reconcile individual and community health requirements and initiate action on behalf of the community.
- ★ Team member, who can work harmoniously with individuals and organizations, within and outside the health care system, to meet his or her patients' and community's needs. (1)

- The "Towards Unity for Health" criteria will be kept in mind.

Nominations for these annual awards are invited from throughout the medical world. Any national or international health agency, such as WHO and the World Medical Association (WMA) is welcome to forward a list of nominees to the WONCA regional vice presidents and the WHO regional office. Where possible, the award will be presented at the WONCA regional conference or at the regional WHO conference. Nominations for the 2002 award must be received by the WONCA regional vice presidents by 1 March 2002.

The nominees for the triennial world award will be the winners of the regional awards over the prior three years. The WONCA Nominating and Awards Committee will make this selection in consultation with WHO. Where possible, the award will be presented at the WONCA triennial world conference. ■

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1. Boelen C. Frontline doctors of tomorrow. *World Health*, 1994, 5:4-5.

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To contact the WHO regional offices, please see the list of addresses at the end of this newsletter and address nominations to the attention of the Regional Adviser for Human Resources for Health.

Dr Robert Higgins, immediate past President of WONCA, can be reached at 2303 Highland Drive, Anacortes WA 98221, USA (Telephone: +1 360 293 5917; Fax: +1 360 293 9598; E-mail: Rhigginsmd@aol.com).

World conference 2002

The World Federation for Medical Education (WFME)—in cooperation with WHO, UNESCO and the World Medical Association—is organizing a world conference, “Global Standards in Medical Education for Better Health Care”. The conference, to be hosted by the University of Copenhagen, Denmark, and the University of Lund, Sweden, is scheduled to take place from 14 to 18 September 2002 in Copenhagen, with pre-conference symposia in Lund.



The three main themes for the conference will be:

- *The interface of health care and medical education*
- *The concept of global standards*
- *Implementation of standards in medical education.*



Hans Karle

The conference is designed specifically for those responsible for furnishing doctors and health services of the quality now required worldwide: medical teachers; medical school administrators, including deans and vice-deans; other decision-makers in medical education and health care, particularly representatives from ministries of education and health, and international organizations concerned with higher education and health; hospital administrations and other health care institutions; medical students' associations; postgraduate training bodies and institutions; and national and international medical associations. Participation will be relevant to all those interested in medical

education and its relation to health care delivery systems.

The WFME Web site (www.sund.ku.dk/wfme) will regularly update information on this conference. Interested persons are invited also to contact: Hans Karle, President WFME, World Federation for Medical Education, University of Copenhagen, Faculty of Health Sciences, The Panum Institute, DK-2200 Copenhagen N, Denmark (Telephone: +453 532 7103; Fax: +453 532 7070; E-mail: wfme@adm.ku.dk). ■

Working together

Collaboration between the World Health Organization and the World Organization of Family Doctors is a 16-page brochure that reviews eight areas of collaboration between the two organizations: a world survey of general practice and family practice; improving health systems: the contribution of family medicine; Towards Unity for Health; rural health initiatives; the Janus Project: family physicians meeting the needs of tomorrow's society; tobacco—the global issue; the health professions alliance; and the international classification of primary care. To receive one or more copies, please see the “Publications” section of this issue. ■

The way forward for the health workforce in South-East Asia

PT Jayawickramarajah, World Health Organization Regional Office for South-East Asia, New Delhi, India

The balance and relevance of human resources for health (HRH) have steadily improved since the WHO South-East Asia Regional Committee resolved in 1992 to improve the situation then prevailing. Balance refers to numerical, distributional and skill-related imbalances, while relevance implies the nature and adequacy of programmes and facilities for pre-service and continuing education of health professionals to match job-related competences.

Reorienting education

The programme for the reorientation of medical education (ROME) and nursing education has induced a number of interesting activities. The focus is on improving the relevance of educational programmes and developing appropriate professional competences to work effectively in a comprehensive health system based on primary health care (1). The main thrusts of ROME are to strive for better coordination of education and health systems; the introduction of a humanistic and holistic approach towards medical practice and use of community-oriented and problem-based approaches.

This programme resulted in the development of an educational policy for health professions and a master plan for HRH in some countries of the South East Asia (SEA) region.

Training programmes at all levels have been reoriented in many countries to adopt a community-oriented, socially accountable approach.

District hospital internship in rural settings for medical and nursing personnel is being increasingly

seen. For instance, the Medical Council of India has recommended rotational internships that include rural hospitals. Family medicine/general practice is a relatively new specialty in the region. Also, as a result of WHO collaboration with World Organization of Family Doctors (WONCA), more and more institutions are sensitized to recognize the need for a family doctor to play a central role in achieving quality, cost-effectiveness and equity in health care systems.

Linkages have been established across countries to develop training programmes in general practice. As an example, the Christian Medical College, Vellore, India, has formed a linkage with the Institute of Medicine in Tribhuvan, Nepal.

Correcting imbalances

Numerical imbalance in HRH is being solved by the creation of new institutions and programmes. However, there has been a mushrooming of medical schools in some countries without adequate need assessment and feasibility studies. WHO as a technical organization had little impact in changing this trend, due to political patronage of promoters of medical schools.

Although a regional consultative meeting in Kathmandu resolved to look into equivalence of educational qualifications and degrees, progress in this direction has been rather slow. Increasing attention is being given to quality assurance in training programmes and pre-service education. Educational policy and HRH planning are some of the concerns in streamlining the health workforce.

Recent work on HRH projections revealed a multiplicity of categories



PT Jayawickramarajah

of health workers in different Member Countries varying from tens to hundreds. Making HRH projections is impossible with the currently available computer programmes, without reducing the number into clusters of health workers to around 20 categories.

Quality assurance

Accreditation of educational institutions and programmes is being accepted as a plausible means for improving the quality of educational programmes. Professional associations and licensing bodies are responding to WHO-initiated programmes on development of accreditation guidelines. The South East Asia region is looking with great interest at opportunities for collaboration with similar bodies worldwide and therefore welcomes the initiative of WHO headquarters in developing a global consortium for the accreditation and development of medical schools, with a view to improving their social responsiveness in meeting people's health needs.

Partnerships in health

In the area of public health practice and education in South-East Asia, a regional consultation of experts

from a variety of disciplines interested in population-based medicine was held. Participants at this meeting considered the scope of public health to include poverty alleviation, equity, quality, social justice, environmental protection, community development and globalization. The leadership role of public health, creation of career structures and reforms in public health education, training and research are some of the key elements of the "Calcutta Declaration" (2).

Community-academic partnerships to improve health have been initiated in a few institutions, exemplified by community participation in health programmes piloted by academic institutions. Creation and nurturing of trust; respect for the community's knowledge and

the community's priorities; compromise; capacity strengthening of the community and community ownership are some of the key elements identified (3). Multi-professional learning programmes have been initiated in some professional schools in India, Nepal and Thailand to enable different categories of students to work together as a team in community settings.

Approaches suggested by the "Towards Unity for Health" (TUFH) initiative should facilitate the creation of productive and sustainable partnerships in the interest of people's health. ■

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MOVING TOWARDS UNITY FOR HEALTH

Towards unity for health

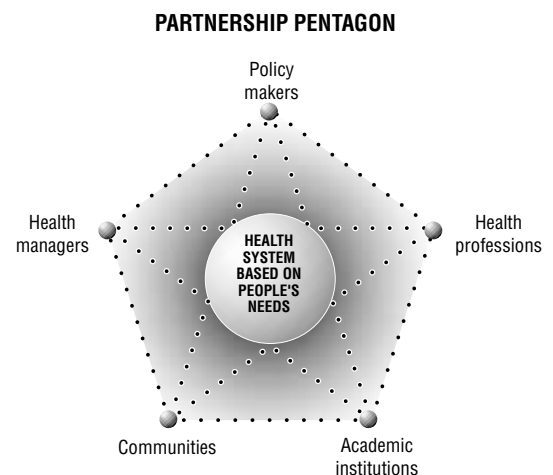
"Towards Unity for Health" designates a project—the TUFH project—whose aim is to improve the performance of the health service delivery system and make it more relevant to people's needs. To these ends, the TUFH project will facilitate coordination and integration of the wide spectrum of interventions geared towards individual health and community health at the level of a given population. It will also encourage productive and sustainable partnerships among key stakeholders working at that level: policy-makers, health managers, health professionals, academic institutions and communities.

The approach promoted in the TUFH project is to reduce fragmentation in health service delivery caused by divisions such as those between individual health and community health, preventive and curative services, generalists and

specialists, providers and users, the private and public sectors, and social and economic aspects of health. Unity of purpose and action must be created in order for all actors to come nearer to the ambitious goal of health for all and the underlying values of quality, equity, relevance and cost-effectiveness.

The political, organizational and scientific conditions to create "unity" must be identified, documented, measured, debated and responded to. Alliances and synergies must be developed at operational level as well as policy level among key interest groups with specific strengths and expectations.

The term "towards" expresses the nature of the TUFH project,



Towards unity for health through sustainable partnerships with key stakeholders

which is to mobilize different partners for greater social accountability and to promote continuous learning from practical endeavours in order to make steady progress in coordinating changes in health services and health professions practice and education. ■

Distance learning: a response to overcome current challenges in medical education?

Janet Grant, The Open University, Milton Keynes, United Kingdom

Medical education already offers its students a wealth of educational provision. Medicine has not been slow to adopt technology, not only for diagnosis and treatment, but also for the education of patients and students. Despite this, the traditional methods of teaching and learning are still of central importance—the teacher, patients, other students, other health care professionals, and printed books and other materials.

So why is there now such interest in distance learning in medical education?

Why distance learning in medicine?

In the United Kingdom, a national project to look at the potential of distance learning for medical education has been completed and this project will now extend worldwide. Our work has shown that distance learning is needed for the following reasons:

For the learner, distance learning:

- Makes expert teaching accessible to all
- Offers rich learning resources
- Allows flexibility of learning in time and place
- Provides quality-assured learning
- Is cost-effective when large numbers of students are involved
- Offers feedback on learning
- Gives students the opportunity to learn to manage their personal time and learning
- Makes learning accessible to otherwise disadvantaged groups.

For the teacher or medical school, distance learning:

- Enables teaching to be delivered to a wider audience
- Ensures quality
- Ensures relevance to educational needs
- Ensures current knowledge
- Draws on the knowledge and experience of many teachers
- Enables teaching and learning to be monitored
- Provides information about student progress
- Provides support for the teacher
- Can supplement the local faculty
- Can free local teachers to do other teaching.

For the society and the medical school, distance learning:

- Enables students to learn while in community and rural settings
- Offers social accountability of medical education by supporting learning in different physical contexts of health care systems
- Can be open to the input of the society and the medical school and as a whole
- Is flexible enough in its design to fit local circumstances and constraints.

usually print, supplemented by integrated learning resources, other learning experiences, including face-to-face teaching and practical experience, feedback on learning and student support.

For this reason, The Open University terms its provision 'supported open learning'.

Who would distance learning medical students be?

The plans for distance learning discussed here can apply to students in a number of circumstances:

- Those who are studying entirely by distance learning with an institution that is a quality-assured distance learning provider
- Those who are jointly registered with a distance learning provider and an existing medical school
- Those who are students of an existing medical school but require the support of distance learning as part of their course, either off-campus (in the community or a rural

What is distance learning?

To offer each of the above advantages to all, distance learning must be much more than just the use of technology to deliver teaching. Indeed, effective distance learning can occur without the use of technology at all. For the UK Open University, which was the world's first distance learning university, distance learning is:

Individual study of specially prepared learning materials,

attach-ment) or to supplement their on-campus studies (where, for example, certain teachers or subjects are insufficient to cover the curriculum).

Distance learning methods can



reach almost unlimited numbers of students in any or all of these categories.

Can distance learning teach clinical medicine?

During 1999 and 2000, a team from The Open University, along with seven partner medical schools in the UK, developed plans for a fully integrated distance learning medical course equivalent to the first two years of medical school, the Stage 1 course, after which students would move into year 3 of the partner school. The feasibility of using distance learning techniques to support students in developing the knowledge, skills, professional attitudes, clinical and problem-solving skills necessary in the first years of medical training was rigorously tested and proven. The boxes outline the course:

Stage 1 medicine course by distance learning:

- designed by The Open University and 7 partner medical schools
- equivalent to years 1 and 2 of medical school
- prepares students to enter year 3 of the partner school
- fully integrated course
- residential schools
- local clinical placements for early patient contact
- national network of clinical teachers

How is knowledge to be learnt?

- Print, instructional texts, course books
- Other media: CDs, virtual microscope, internet resources, kits, simulations
- Face-to-face and online teaching and peer discussion
- Illustration and cases

Developing professional attitudes:

- Practical experience of the health care system with local tutors
- Simulations
- Reflection on clinical experiences
- Analysis of paper/media-based cases
- Virtual clinical environment
- Face-to-face and online discussion with peers and tutors

How are skills acquired?

- Simulation kits supported by media demonstrations
- Specified clinical experience with local [trained] tutors
- Local/national residential schools in scientific and clinical skills labs.

Developing clinical problem-solving:

- Patient-management problems
- Reflection on clinical experience
- Problem-solving exercises
- Ethical challenges

Clinical experience at a distance

One of the most important reasons for distance learning in medicine is to enable students to experience their health care systems in a variety of community and other settings outside the medical school and teaching hospital, while ensuring that they are experiencing a properly constructed and quality-assured curriculum. So a distance learning course must be able to support that first-hand experience.

The Open University and its partner medical schools designed a clinical practice module that runs through the whole length of the course. This would entail regular

clinical attachments in primary and secondary care local to the student, with accredited teachers who are part of a distance [ital]learning clinical network[endital]. The clinical experience would be managed by:

- A curriculum map of content to be covered
- An analytical, reflective portfolio
- Structured preparatory and reflective exercises and projects
- Formative assessments
- Ongoing assessments by the clinical teachers.

The capacity of the local health care system to incorporate such experience is an important factor, as is its quality assurance.

Quality assurance in distance learning

By definition, distance learning takes place outside the main responsible institution. For that reason, quality assurance is of paramount importance. Quality assurance would incorporate:

- Awareness of the needs of students, teachers, the health care system and regulatory bodies
- Carefully managed partnerships with existing medical schools
- Expert development of course materials by distance learning and subject specialists
- Drafting and testing all course components before final course production
- Student support via local tutors and advisory services
- Regular contact with and between students
- Formative assessments with feedback to students
- Student records to chart progress
- Selection, training, support and monitoring of local teachers
- Selection of and support for local clinical sites
- Regular evaluation and course review to ensure the WHO criteria of relevance, equity, quality and cost-effectiveness. ➤

The international networked medical school

Plans for an International Networked Medical School (INMS) will be developed over the next two years by an expert team, through the International Medical Education Trust (IMET2000) based in the Northwick Park Institute for Medical Research in London, under Professor Colin Green.

Enquiries from interested medical schools about developing the INMS should be addressed to j.r.grant@open.ac.uk. ■

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Online help: What's in a name?

Now available via the World Wide Web is Pharma-lexicon (<http://www.pharma-lexicon.com>), which offers the meanings of some 27 000 pharmaceutical acronyms and abbreviations free of charge. For more than a year, a volunteer team of health professionals has laboured to build the database and put it on the Web, all in the interest of providing a useful service and learning a new skill.

The Pharma-lexicon team would be grateful to be informed of abbreviations or acronyms not now included. These must be in the following fields: agrochemicals, biochemistry, biology, biotechnology, chemicals, general medicine, health care, lab equipment, medical devices/diagnostics, nursing, pharmaceutical production, pharmacy, physiotherapy, public health, toxicology and veterinary medicine. ■

For more information or to contribute new entries, please contact: Christian Nordqvist, Pharma-lexicon International, 83 Filsham Road, St. Leonards-on-Sea, East Sussex TN380PE, United Kingdom (Telephone: +44 1424 434208; E-mail: CNordqvist@aol.com).

Medical schools without walls: medical education and the World Wide Web

Roderick Neame, Goodnestone, England, United Kingdom

In 1827 Thomas Hodgkin, speaking of and to students at Guy's Hospital in London, said: "I consider our present system of medical education liable to objection ... and confess that I regard it ... as objectionable in nearly all its stages". Some might still say the same, and, indeed, the current medical programme in most institutions would be clearly recognizable by Hodgkin's students of that time, at least in style if not in content.

Learning from history

Almost a century later, in 1910 Abraham Flexner drew attention publicly to the sorry state of medical education in the USA at that time. His report was intended to constitute a baseline and agenda from which to move forward, although in the intervening 90 years his report has been twisted out of context by conservatives and used as a justification for continuing outdated educational approaches.

His recommendations for change have passed largely unheeded. Flexner ensured that the educational methodology used at the time came in for well-deserved criticism: he regarded the reliance on "didactic presentation" as "hopelessly antiquated", belonging to "an age of accepted dogma or supposedly complete information, when the professor knew and the students learned". Medical education should be an active student learning process, and should continue indefinitely as the biomedical knowledge base extends.

He also addressed the issue of

better aligning the basic sciences study with the realities of clinical practice, pointing out that medicine is "a technical or professional discipline which calls for the possession of certain portions of many sciences arranged and organised with a distinct practical purpose in view". That purpose is the key for selecting what content to include and what to ignore: it provides the organizing principle whereby the components can be "organically combined" into a meaningful and purposeful educational programme. "Medical education should be explicitly conscious of its professional end and aim", he wrote, in support of his observation that the teaching of the basic sciences by those without any medical knowledge or understanding had become discredited as no more than a mechanical drill, too often having lost sight of the main educational objective.

A leap in quality

Some leaders in medical education have been improving the programmes of study, to make them both more stimulating and more effective. Some have introduced problem-based or case-based study, integrated programmes with new discipline areas (e.g. community medicine) and a greater degree of orientation towards the communities they serve. Some have experimented with the use of new technology and the Internet. The author has been privileged through time in the University of Newcastle, New South Wales, Australia, and elsewhere as a consultant to many new medical schools, to be

involved in all of these initiatives—and now once again to be involved in another new venture with the International University of the Health Sciences (IUHS).

The initiative I wish to report on in this article embraces problem-based learning and community orientation, and then goes one step further—it introduces a high level of flexibility, enabling the students to study as, when and where they choose, to progress at a rate with which they feel comfortable, and to do so at a greatly reduced cost. The conservatives will no doubt immediately retort that this must be at the expense of quality and integrity: there is no evidence to support such a contention, and the quality of all the graduates of the programme is assured externally by independent examining bodies, e.g. USMLE in North America.

WWW medical education

IUHS differs from the start, opening its doors to a much wider-than-normal range of students, based on research findings that are unable to demonstrate significant associations between prior study of specific subjects or overall academic grades and successful performance as a doctor. However, students with stronger academic backgrounds in health and biomedicine are preferred for admission to the off-campus programme (see below).

The IUHS programme is divided into two parts: the first 80 weeks, which is problem-based, and the second 80 weeks, which is a series of conventional clinical rotations/attachments. It is especially during the first 80 weeks that IUHS pioneers a new path. The basic sciences are learned in an integrated way in the context of a series of prototypical problems, organized into organ-system blocks.

The materials are all Web-based and delivered to students over the Internet, and can be picked up by students wherever they are located. Whether on or off campus, the

student works through the structured problem presentations, part of the time with an MD: the MD is a local health professional who acts as guide and mentor, as well as the means whereby the student is able to access both patients and local clinical facilities throughout the study period.

To support the students, the university has established a number of online services and facilities.

- Electronic messaging systems, each serving the needs of students at the same stage of the course: these enable students to share information, advice, notes and comments with their colleagues and with staff.
- Electronic conferences, divided into forums and “threaded discussions”. Each discussion has a common theme and allows students to pose questions or raise issues they wish to share with colleagues and staff experts.
- Online archives of materials prepared by a variety of experts from different disciplines. Some are specific to a particular study problem, but many are of general interest and importance.
- Web links. Many links to a large number of excellent resources on the Web have been included.
- Chat rooms, where staff and students can meet together in pre-arranged groups and at pre-determined times to discuss specific issues or topics.
- Streamed presentations whereby didactic presentations and materials prepared by staff can be distributed according to a fixed schedule or on demand to students. This can include real-time or delayed broadcasts of lectures and presentations taking place in other locations and institutions.
- E-problem of the week: students are continually challenged by a series of “problems-of-the-week”, which are used to stimu-

late thinking and reasoning. Students are required to submit their response to the challenge within a limited time period, after which the “correct” response is then circulated. Responses are reviewed and assessed.

- E-journal club: an electronic journal club is held every week, with a different student taking the lead, preparing the presentation and responding to comments and criticisms. These (and other) student-generated materials are held in an archive for future students to study and learn from.

Much of the cost of the conventional study programme is generated by staff performing repetitive tasks (e.g. lectures): the content of these can be better disseminated in other ways. The conventional programme is based on inflexibility in that all staff and students must be in the same place (usually away from home) at the same time for a session, or else they miss it; all students have to progress at the same speed in a lock-step approach. These restraints serve only to limit the accessibility and affordability of medical education to the community. IUHS has taken some steps towards changing these parameters and opening up the study of medicine to a wider group of potentially well-qualified and particularly well-motivated candidates. ■

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Healing fragmentation

A Chinese viewpoint

Yuhua Dai, Zhenglai Wu and Depei Liu, Peking Union Medical College, Beijing, China

“Towards Unity for Health” is a concept that is well accepted and appreciated by Chinese medical workers. There is a very famous popular song in China entitled “Unity is Strength”. Every Chinese can sing it and interpret it with his or her own experiences. The song’s message is: “When unity was harder than iron and stronger than steel, the enormous strength of unity buried the feudalism, imperialism and bureaucratic capitalism of the old China and created a peaceful, independent and democratic new China”.

It is also the enormous strength of unity that has won for China a stable environment in which to carry out a series of reforms in different areas. In the last two decades, China’s GNP has been growing at an annual rate of 7% to 8%. Although the average GNP per capita is still low (about USD 800), this is the most important economic base for the improvement of health care and medical work in China for her 1.3 billion people in the year 2001.

During the past century, China has experienced some important changes in health status (Table 1). According to the most recent survey by the Beijing Municipal

Bureau of Statistics, the people

Table 1. Changes in health status in China

	1950	2000
Population size	0.45 billion	1.3 billion
Average life expectancy	35 years of age	71 years of age
Maternal mortality	1500 per 100 000	56 per 100 000
Infant mortality	200 per 1000	32 per 1000
Major causes of death	Infectious and parasitic diseases	Noncommunicable, chronic diseases: cancer, cerebrovascular disease, cardiovascular disease, chronic obstructive pulmonary disease

of Beijing want most of all to be: (1) healthier and happier (63.4%); and (2) wealthier; with (3) a bigger and brighter living space; and (4) more time to stay with their family members. In 1995, the answers to the same questions were ranked (4), (1), (3), (2).

Of course, the income differences in China are important: urban people’s income is higher than that of rural people; the coastal area is richer than the interior; and the economy of the western areas is just developing. No matter the actual difference, a healthier and happier life is the desire of all Chinese people everywhere.

The TUFH pentagon concept summarizes well how organizations and stakeholders should unite to meet people’s needs and make “Health for All” come true. Perhaps we can identify some



other unities between health workers:

- Unity between generalists, specialists and paramedical personnel
- Unity between practitioners of Chinese traditional medicine and allopathic medicine
- Unity between doctors in clinical medicine, preventive medicine and basic medical sciences
- Unity between the doctor and the patient.

It is not necessary for a doctor to know everything and do everything. No one is omnipotent. But everyone has his or her special strong point that may be useful to others. Unity means with a com-



Depei Liu, Yuhua Dai, Zhenglai Wu.

mon desire: to serve the people better, health workers should know each other, learn from each other and collaborate with others amicably and closely. Be agonists but not antagonists. Enhance cohesion to heal fragmentation.

Patients also should be active participants in the whole process of preventing and healing their diseases: providing relevant information, symptoms and responses to any interventions. Patients are their own masters in implementing pre-

ventive procedures, such as smoking and drinking cessation, and compliance with the treatment regimen.

Our opinion is that the TUFH approach focuses on the most important issues and challenges for our national health system as it strives to make the best and most coordinated use of our talents and resources to provide high-quality, cost-effective and equitable health services to our people. ■

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The Making Pregnancy Safer initiative The power of partnerships

Luc de Bernis, World Health Organization, Geneva, Switzerland

Many maternal and newborn deaths are unnecessary and unacceptable, particularly as we know that the five main causes of direct obstetric deaths—which account for nearly 80% of maternal deaths—can be prevented by actions that are effective within local settings and are affordable even when resources are limited. But to sustainably implement these interventions is a complex challenge that requires strong collaboration between key partners at all levels of the health care system.

Experience has shown that inadequate coordination between key actors and partners has led to lack of progress in maternal health outcomes. Many safe-motherhood programmes have suffered from piecemeal efforts, with lack of coordination and poorly defined priorities between as well as within programmes. In addition, available resources have not been maximized effectively and efforts have often been unnecessarily duplicated.

An important lesson learnt has been that interventions to reduce

maternal deaths cannot be implemented as vertical, standalone programmes. Maternal mortality is not merely a “health disadvantage”, it is a “social disadvantage”. Health, social and economic interventions are most effective when they are implemented simultaneously. This being the case, maternal and newborn health interventions must be implemented through effective partnerships in the context of broader programmes.

Evidence clearly indicates that addressing the complex challenge of maternal illness and death depends on a functioning health care system, together with interventions at community and policy levels that are needed to ensure that unwanted pregnancies are reduced and appropriately managed, and that women and their newborns have access to and can use the care they need, when they need it. Experience over the past decade has also shown that no single intervention is sufficient by itself; what is needed is a continuum of care.

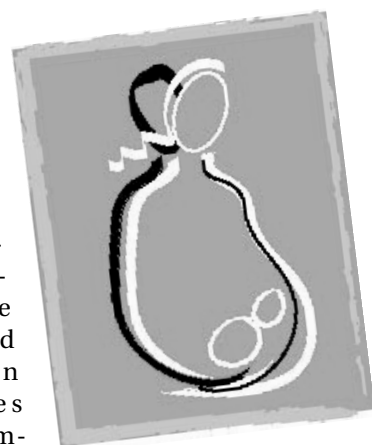
Reducing maternal mortality requires coordinated, long-term

efforts among key partners. Actions are needed within families and communities,

in society as a whole, in health systems, and at the level of national legislation and policy. Further, interactions among the interventions in these areas are critical to reducing maternal mortality and to building and supporting momentum for change. The challenge facing the Making Pregnancy Safer initiative is to create and build effective partnerships, which will lead to positive health outcomes for mothers and their newborns.

Legislative and policy actions

Long-term political commitment is an essential prerequisite for making pregnancy safer. The necessary resources are mobilized and the essential policy decisions are taken only when decision-makers at the



highest levels are resolved to address maternal mortality. Without this long term commitment, programmes and activities cannot be sustained.

Women may overcome the various obstacles that limit their access to health care, such as distance from their homes to appropriate health facilities, lack of transport and, more critically, financial and social barriers, only if a supportive social, economic and legislative environment exists. Experience has shown that women are deprived of proper maternal health care when they have to pay for services and essential drugs and when they must bear substantial hidden costs, such as time lost for child care, domestic chores, paid employment, food production and community services.

Furthermore, legislation that supports women's access to care must be formulated to permit health workers at the periphery of the health system to perform specific life-saving functions.

Community interventions

Community and religious leaders, women's groups, youth groups, other NGOs and families are key contributors to reducing maternal and newborn mortality. Health facilities and communities may create partnerships in investigating maternal deaths and identifying and implementing strategies for improvement in such areas as referral, emergency transport, deployment and support of health care providers, and cost-sharing.

Because many women deliver alone or with a relative, it is crucial to train community members to recognize danger signs. It is also essential to develop plans for emergencies, including transport to hospitals or health centres, and local insurance funds to help cover the costs of care.

In some countries, communication (radios, telephones and transport for emergency cases) has been organized with financial support from communities. Partnerships

have been essential between health care providers, policy-makers, health professionals and the communities in ensuring the above, as well as providing cheap and simple delivery kits that are distributed to pregnant women for deliveries in primary health care facilities or for home births.

Another area of essential partnership has been in instances where services of skilled professional health care providers are not available and traditional birth attendants (TBAs) have been women's only source of care. In such cases it is crucial to establish effective partnerships through which TBAs are trained to recognize problems during delivery and, when necessary, to guide women to and through the formal health care system.

Health care providers must inform, educate and mobilize the community regarding danger signs and work with communities to improve access to care, such as through development of transport schemes, better communications and maternity waiting homes, and local insurance schemes.

It is also crucial that health care providers work with policy-makers to promote family and community support for delayed marriage and childbearing; timely and planned pregnancies; and improved health, nutrition, and education for all girls and women.

Health care providers and professionals

Partnerships between health care providers, health professionals, teaching institutions, policy-makers and communities are essential to ensure that maternal deaths are prevented through the prevention of unwanted pregnancies, prevention of complications during pregnancy and appropriate management of complications. The presence of skilled birth attendants is crucial for the early detection and appropriate, timely management of life-threatening complications. It

is also essential to strengthen the referral system through supportive supervision, regular communication and logistic/managerial support, including ensuring the availability of essential drugs and supplies as a functioning referral system.

Partnership must be established with teaching institutions to ensure midwifery training programmes, and, for personnel already trained, in-service training based on updated standards for care. Experience has shown that it is essential to strengthen the midwifery skills of relevant staff and intensify training in counselling skills. Research institutions should be involved to promote and coordinate research and disseminate findings in areas that are crucial to improving maternal and newborn health.

Lastly, partnership between health care providers, policy-makers and professional associations is necessary in advocating revision and amendment of legislation to enable an appropriate health service response to obstetric needs, including delegation of responsibilities for essential life-saving interventions. Here, the mass communications media should be a crucial partner. ■

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Changing roles: a half-century odyssey on Planet “Health”

Christopher Wood, Nairobi, Kenya

Three events shaped my early career. As a wartime medical student I spent my vacations working at the face of a Welsh coal mine. There were doctors at the top of the mine repairing injuries and awarding compensation for pneumoconiosis, but little thought was given to preventing accidents and improving ventilation at the bottom.

After qualification (as a result of a mistake made by the hall porter at the Colonial Office, who ushered me into an interview for a job for which I had never applied) I did my internship, and simultaneously my National Service, in the Singapore General Teaching Hospital. I was attached to the professorial surgical unit and had the opportunity to do more surgery in three years than many surgical trainees would do in ten.

After completing my Singapore assignment I spent a year riding a motorcycle back to the UK, pausing to work in my sister's mission hospital in India and my brother's surgical practice in Kenya.

From disease to health

Somewhere along the line I lost much of my interest in what to do when people are sick or injured, and became more concerned with how to prevent this from happening. So to learn more about preventive health services—a subject given grossly inadequate attention during undergraduate training—I went to the London School of Hygiene and Tropical Medicine.

Then, after a spell in general practice, the best way to be involved in preventive medicine—without losing sight of individual patients—seemed to be in the field of occupational health. So the next years were spent in the Industrial

Hygiene Department of the Harvard School of Public Health.

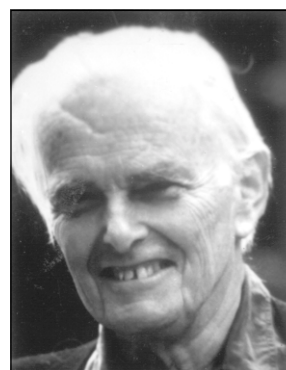
On returning to England, I joined Richard Schilling at the LSHTM and helped develop the new Department of Occupational Health, where we had a large number of international postgraduate students. At the same time, my involvement with a chronic-bronchitis prevention clinic at the Central Middlesex Hospital led to starting the first anti-smoking clinic in England. I also developed a fundraising office in London for my brother's East African Flying Doctor Service (the African Medical and Research Foundation, Amref). This activity led unexpectedly to the next major change in my career—heading for Africa.

Shortly before Tanganyika's independence, Amref was invited to survey its health services and make recommendations to the new government for future development. I joined Professor Richard Titmus' team, which produced a report, *The health services of Tanganyika*, on which the first post-independence development plan was based.

Shortly thereafter I received a phone call from the then-Minister of Health, asking if I would come to Dar es Salaam and help implement some of our report's recommendations. A few months later, having obtained two years' leave of absence from LSHTM, we—my wife and I and our four children—were on our way—and never returned!

From home to world

My principal assignment, in what had become Tanzania, was to help upgrade the former Medical Assistant Training School to a Medical Practitioner School. Starting a medical school for the Ministry of Health rather than a university had



Christopher Wood

many interesting and important features.

In particular, the ministry's prime concern was that the graduates be competent to perform as government medical officers. The ministry was less interested in research or later specialization.

The new curriculum was therefore based on the job description of a District Medical Officer. Each of the five main subjects—medicine, surgery, child health, obstetrics and gynaecology, and community health—was assigned one-fifth of the study time in each of the five years.

While the structure and function of the cell and individual human being were taught as anatomy and physiology, the structure and function of the community were taught as demography and behavioural science. When the director of the school and I had problems, we would visit the Principal Secretary in the MOH (a triple gold medallist from Makerere). After hearing our problem he always replied, “I know nothing about medical education - that is why I appointed you. If you think we should do it—do it—and I will support you”. What more could two enthusiasts want!

From university to field

In addition to working in the medical school, my duties also concerned the training of all the other cadres of health workers. In Africa only a small proportion of sick people ever see a doctor—the majority are managed by medical assistants, nurses and community-based health workers.

I began to appreciate that one of the key causes of maldistribution of health staff lies in the disparity between the skills, interests, living habits and expectations of the health worker and the community he or she is to serve. If the gap is too great, the health worker migrates to where the difference is less.

The health worker should be two or three jumps ahead of the community in his/her lifestyle—but not ten, or he/she will leave. In other words, the development of health services cannot be separated from development of the communities' other activities—education, agriculture, administration, etc.

Putting "doctors" in remote areas doesn't work. Paramedical and community-based health workers are an essential step in development.

Tanzania has developed a system of encouraging the best in any one cadre to undertake further training and be upgraded to the cadre above. This includes accepting clinical officers, nurses and laboratory technicians as mature entry students into the medical school.

On one occasion, when I was running a workshop for the staff of the six Medical Assistant training schools, they indicated that they had trouble teaching community health because of the absence of a suitable textbook. I suggested that together they should write the book they needed, and I would edit it. This started another mainstream of my future activities—publishing appropriate para-

medical health learning materials.

I joined Amref, in Nairobi, when they received a grant from the Danish aid agency Danida to develop a training programme. The Danida grant gave us considerable freedom to do what we thought was best. Experience in Tanzania had shown both the importance of paramedicals and that their training requirements received only a small proportion of the attention, the staff or the funds available for the education of health staff. I therefore proposed three main activities for the Amref training programme: training teachers of paramedical staff, providing continuing education for paramedicals, and developing appropriate health learning materials for them.

The medical and allied professions had been slow to appreciate that teaching requires skills not always present in those who may be very competent in practice. But teachers' skills can be enhanced even by short courses in educa-

tion from any updating sources.

A system of continuing education is essential. Also the importance of appropriate learning materials—in particular books/manuals—for paramedicals has now been appreciated. A key feature of an "appropriate" book is that not only should it have the relevant information, clearly presented, but also it should not have too much irrelevant material. Postgraduate students may recognize irrelevant information (though sometimes they don't), whereas less-experienced students may take what they are given as gospel!

From institution to people

Since leaving Amref I have been helping with the training of different cadres of health staff in the southern Sudan. As a result of the ongoing civil war, the government health services have disintegrated. Different NGOs started training people to run "emergency" services. A hotchpotch of programmes, of varying duration, leading to various certificates, were instituted.

To establish some sort of standardization, a Provisional Health Personnel Council was formed and standard curricula were developed. To have one council for all health cadres instead of the usual medical, nursing, etc., councils with their turf wars, is an advantage.

Also, training lasting more than one year is broken into phases, each of one year. Each phase leads

to a qualification and is followed by a period of service. This system, originally started to enable those who, in a war situation, could not be away from their homes for long periods, has worked well and is likely to be continued. Interspersing training and practice, as in continuing education, can be started during basic training. If you want to introduce changes, never underes-



tional methodology. Continuing education for paramedicals had only slowly been recognized as important.

Looking at this problem encouraged me to explore "the epidemiology of continuing ignorance"! It is a disease to which we are all susceptible. The high-risk factors are short initial training, a long interval since last training and isolation

timate the advantage of not having a government!

Information and communication technology has revolutionized many activities in big hospitals, universities and research institutions. However, it has as yet made virtually no impact on community health services. Recognizing this failure we have recently established a consortium of health NGOs and the MOH to "harness information and communication technology for community health". The partner members of the consortium—*AfriAfya*—are pooling both their experience and their ignorance to see whether the use of computers, WorldSpace receivers, etc. can assist health communication at the peripheral level.

Having abandoned the heights of "centres of excellence" (which frequently develop into "islands of irrelevance") I am, in my dotage, finally looking at health from the community up! ■

Dr Christopher Wood can be reached at PO Box 15036, Nairobi, KENYA (Telephone: +254 2 891550; Fax: +254 2 890747; E-mail: drchw@wananchi.com).

HIF-net at WHO

HIF-net at WHO is an e-mail discussion list for all those interested in improving access to reliable information for health care workers in developing and transitional countries. HIF-net is a joint venture between the WHO and the Health Information Forum, which in turn is part of the International Network for the Availability of Scientific Publications (INASP), itself a programme of the International Council for Science. Participation is free of charge, but subscription to the list requires the approval of the list moderator. To subscribe, send an e-mail message to the list moderator, Neil Pakenham-Walsh, INASP Programme Manager: <INASP_Health@compuserve.com> asking to join the list and briefly describing your professional interest in health information. ■

Diary dates



TUFH field project managers "Health for All Rural people"

27—29 APRIL 2002, TRARALGON, VICTORIA, AUSTRALIA

This worldwide consultation, cosponsored by WHO and the World Organization of Family Doctors (WONCA) and drawing on their programmes and activities as well as specific case scenarios of successful rural projects, will explore the major issues and challenges of health and health services in rural and remote areas around the world.

For more information, please contact Professor Roger Strasser, Chair, WONCA Working Party on Rural Practice; Head of School, Monash University School of Rural Health; PO Box 424; Traralgon 3844, Victoria, Australia (Telephone: +61 3 5173 8181; Fax: +61 3 5173 8182; E-mail: roger.strasser@med.monash.edu.au).



"Global Standards in Medical Education for Better Health Care"

14—18 SEPTEMBER 2002, COPENHAGEN, DENMARK

This world conference is being organized by the World Federation for Medical Education, in cooperation with WHO, UNESCO and the World Medical Association. [Please see the article on this conference in this issue.]

For more information, please contact Dr Hans Karle, President WFME, University of Copenhagen, Faculty of Health Sciences, The Panum Institute, DK-2000 Copenhagen N, Denmark (Telephone: +453 532 7103; Fax: +453 532 7070; E-mail: wfme@adm.ku.dk).

UNISOL congress in Nairobi

More than 20 countries were represented at "Universities and Health of the Disadvantaged", a congress in Nairobi in June 2001. A *Declaration of Nairobi* was adopted, engaging African universities to work in a multidisciplinary manner in favour of disadvantaged individuals and populations. "UNISOL" stands for "universities in solidarity for the health of the disadvantaged".

A temporary UNISOL African Council has been formed to lead the development of the UNISOL project in Africa. The next UNISOL African conference is planned for 2003 at the University of Capetown, South Africa, where the permanent UNISOL African Council will be constituted. ■

For information on UNISOL Africa, please contact Dr Dan Kaseje, Tropical Institute of Community Health and Development in Africa, PO Box 60827, Nairobi, Kenya (Telephone: +254 2 441 046; Fax: +254 2 440 306; E-mail: tichnbi@net2000ke.com).



Till we meet again

DR CHARLES BOELEN, Coordinator for Human Resources for Health, WHO, Geneva, and Executive Editor of this newsletter, will retire from WHO late this year. After 30 years of service with WHO at national, regional and global level in health services and human resources development, and interaction with numerous networks worldwide, he will start a career as an independent consultant in health systems and health personnel.

From 1 December 2001 he can be reached as follows: Route d'Excenevex, 74140 Sciez-sur-Léman, France (Telephone and Fax: +33 450 72 51 41; E-mail: boelen.charles@worldonline.fr).

Au revoir

LE DR CHARLES BOELEN, Coordonateur des Ressources Humaines à l'OMS à Genève et Editeur de cette revue, sera à la retraite de l'OMS à la fin de cette année. Après 30 années de service à l'OMS au niveau national, régional et mondial dans les domaines du développement des services de santé et des ressources humaines pour la santé, et une collaboration étroite avec de nombreux réseaux à l'échelle mondiale, il entreprend une nouvelle carrière de consultant indépendant en systèmes et personnels de santé.

A partir du 1 décembre 2001, il pourra être contacté à l'adresse suivante: Route d'Excenevex, 74140 Sciez-sur-Léman, France; Téléphone et Fax: +33 450 72 51 41; Courriel: boelen.charles@worldonline.fr).

Dear Charles

As November draws near and you plan to take flight,
Your friends here in Rockford have urged that I write.

"Write what?" I replied, to which all uttered sighs.
"But of course, Buz, the truth!" So I'll tell you no lies.

Far be it from me to bend my perceptions,
Providing I maintain synaptic connections.

So here, dear friend Charles, is where it is at:
The consults, the speeches, the artwork and that;

The planning, the meetings, and all the discussion;
The reports in English, Spanish, French and some Russian.

Many may herald your ongoing inspiration;
Others may note hard work and dedication.

You traveled the globe, week in and week out,
But the voice of persuasion: that was your clout.

For as is well known, the Organization lacks funds
And Human Resources was left with the crumbs.

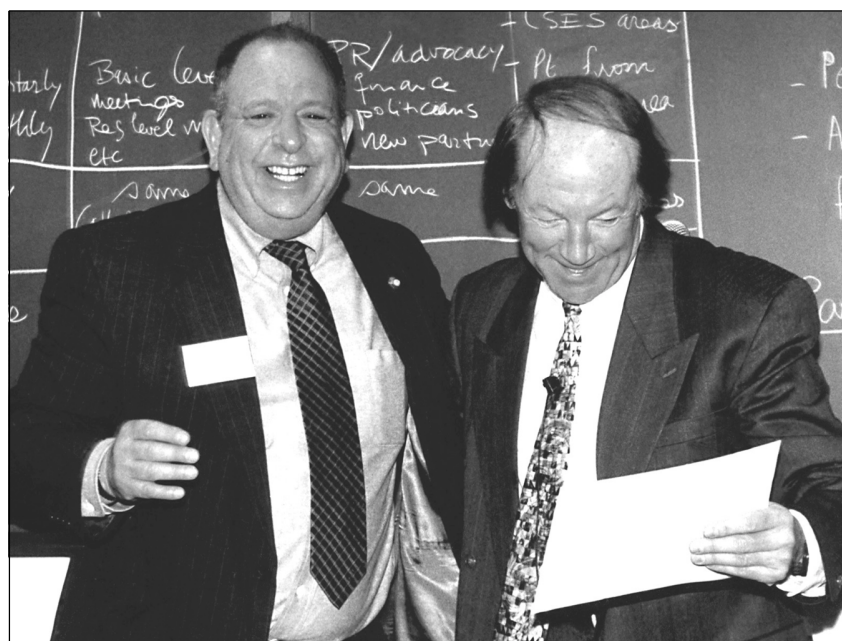
Thankfully, though, your friends have been legion,
So paucity in Geneva was gain from each region (or at least in some).

And now, at last, as you prepare for your fling,
What, indeed, are the praises that we should all sing?

I think it is clear, and would state with impunity,
The crowning achievement, above all, has been UNITY.

With fond wishes, and apologies to limerick writers everywhere,

Buz Salafsky, Dean, University of Illinois, College of Medicine-Rockford, Rockford, Illinois, USA (WHO Collaborating Centre for Educational Development of Health Professionals and Health Care Systems)



Charles Boelen receiving his "graduation certificate" in Managing Field Projects in TUFH from Dean Salafsky

Dear Charles

Among my very good memories is the time (1991–92) that I spent at WHO working with you. I learned a lot in a wonderful setting.

I know you won't be fading from the scene; you have too much energy and too many great ideas for that to happen. I do hope your consulting practice brings you this way from time to time.

I often think of you, my friend, sailing around Lac Léman; I hope you continue to sail through life as well.

Fondly,
Dan

Daniel S. Blumenthal, MD; Associate Dean for Community Programs, Department of Community Health and Preventive Medicine; Morehouse School of Medicine; Atlanta, Georgia, USA

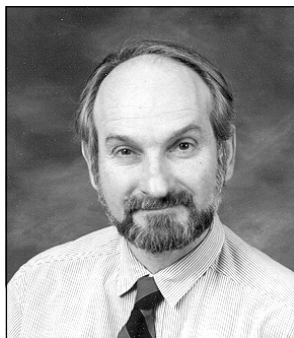
Dear Charles

In my name as well as in the name of our medical school, I want to thank you for all your help and support. Your counselling, ideas and suggestions have represented some of the most

important inputs for the direction our institution has decided to take. Many of the changes we had already started were directly related to your work and your bright and clear ideas. In this way, you must know that you are part of this small institution at the end of the world.

We wish the best for you, but I have to say: We will miss you.

Benjamin Stockins, MD; Professor of Internal Medicine and Cardiology; Former Dean, Medical Faculty; Universidad de la Frontera; Temuco, Chile (WHO Collaborating Centre for Medical Education and Practice)



Arthur Kaufman

Dear Charles

I want to express my deepest appreciation and that of the entire Network for the wonderful partnership we have enjoyed with you and with WHO over the years and, more recently, with your visionary TUFH project. Charles, you helped rebuild these links between WHO and The Network, envisioning how we could become allies, share complementary strengths and provide mutual support for each other.

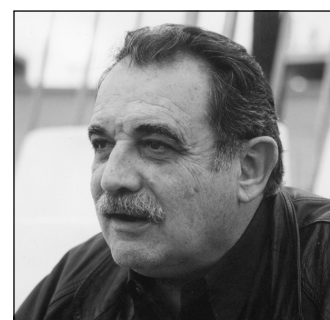
You have never been shy about sharing your opinions. It was partly at your prodding that we changed our name and broadened our mission beyond education to include service and research for development, thereby incorporating all academic missions in the struggle to make health professions universities relevant and accountable toward community health. We are thus now called, The Network: Community Partnerships for Health through Innovative Education, Service and Research.

On a more personal note, I will miss your signature ascots, the gentle line sketches with which you illustrate your talks, and your animated and theatrical body language during conversations. I have always been impressed with your "can do" attitude, so rare in the large, bureaucratic organizations in which we work, where caution too often rules the day. It is this energy that helped you drive so many important initiatives.

Though we will miss you in

your current role, we are sure you will continue to struggle for relevance and accountability of our health institutions in whatever endeavour you choose to pursue in the future. You can rest assured we will be ready to join you when asked.

Arthur Kaufman, MD; Professor and Chair, Department of Family and Community Medicine; University of New Mexico; Secretary General, The Network; Albuquerque, New Mexico, USA (WHO Collaborating Centre for the Dissemination of Community-oriented, Problem-based Learning)



A. Oriol-Bosch

Charles: An unconventional international officer

Charles is* an old-timer who belongs to a limited group of individuals serving as reference to many: a kind that should never disappear.

Charles is* an atypical expert in many trades: a long-term civil servant who has managed to keep improving himself without blending into his environment.

Charles is* a performer, a thinker and a dreamer, with an artistic soul branching into poetry and figurative representative drawings.

Charles is* to me an enjoyable person with whom time flies and topics of conversation are never exhausted, no matter where the encounter happens to take place.

* I do not know really know what complex Charles is, but at least this is what he seems to be to me. ■

Professor A. Oriol-Bosch, Director, Institut d'Estudis de la Salut, Barcelona, Spain (WHO Collaborating Centre for Health Care Professionals Development)

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WHO Regional Office for Africa

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BE 773; Harare, Zimbabwe
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WHO Regional Office for South-East Asia

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WHO Regional Office for the Western Pacific

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■ WHO regional training centre

WHO Regional Training Centre for Health Development

School of Medical Education;
University of New South Wales;
Sydney 2052, Australia
(Telephone: +(612) 9 385 2500;
Fax: +(612) 9 385 1526;
E-mail: meded@unsw.edu.au)

■ WHO collaborating centres in human resources development

Centre collaborateur de l'OMS pour la Recherche en matière de Développement des Ressources humaines pour la Santé

Faculté des Sciences de la Santé;
Université nationale de la République du
Bénin; B.P. 188; Cotonou, Benin
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Fax: +(229) 301 288)

WHO Collaborating Centre for Education and Medical Practice

Faculdade de Medicina; Universidade
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Fax: +(55 31) 3 248 9664)

WHO Collaborating Centre in Medical Education and Practice

Centro de Ciências da Saúde; Universidade
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(Telex: +(55 432) 268;
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WHO Collaborating Center for Health Manpower Development

McMaster Health Sciences International;
McMaster University;
1200 Main Street West; Hamilton, Ontario,
Canada L8N 3Z5
Please contact: Helen Wagner,
Administrative Assistant;
(Telephone: +(1905) 525 9140,
ext. 22318; Fax: +(1905) 524 5199;
E-mail: wmhsi@mcmaster.ca))

PAHO/WHO Collaborating Centre for Health Professionals Education and Practice Responsive to Health Needs of Communities

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Sherbrooke; 3001, 12^{ème} Avenue Nord;
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Fax: +(56 45) 212108)

WHO Collaborating Centre for Development of Human Resources for Health

Faculty of Medicine; Suez Canal
University; Ismailia, Egypt
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Telephone: +(20 64) 328 935;
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WHO Collaborating Centre for the Development of Human Resources for Health and for Primary Health Care

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Centre collaborateur de l'OMS pour le Développement des Ressources humaines pour la Santé

Département de Pédagogie des Sciences
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et Biologie humaine de Bobigny; 74, rue
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/ (3311) 48 38 76 41;
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WHO Collaborating Centre for Problem- based Learning in Health Professions Education

International Health Management Centre;
Istituto Superiore di Sanità;
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WHO Collaborating Centre for Training of Health Professionals

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WHO Collaborating Centre for Problem- Based/Problem-Solving Approaches to Education and Practice in Public Health

Faculty of Health Sciences;
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Centro Colaborador de la Organización Mundial de la Salud para la Formación de Recursos Humanos

Facultad de Medicina; Universidad Nacional Autónoma de México; Edificio "B" Primer Piso; Apartado Postal 70-443; México, DF 04510, Mexico
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WHO Collaborating Centre for Health Manpower Development

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WHO Collaborating Centre for Research in Health Manpower Development; Community-Based Educational Systems (COBES) Programme

Faculty of Health Sciences; University of Ilorin; PMB 1515; Ilorin, Nigeria
(Telex: 33144 unilon ng;
Telephone: +(23431) 221 844)

WHO Collaborating Centre for Research and Training in Educational Development of Health Personnel

Department of Medical Education (DME), College of Physicians and Surgeons, 7th Central Street, Defence Housing Authority, Karachi 75500, Pakistan
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Fax: +(92 21) 589 3062)

WHO Collaborating Centre for Quality of Care

Medical University of Southern Africa, Box 203 Medunsa 0204, Republic of South Africa
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Telephone: +(27 12) 529 4669;
Fax: +(27 12) 560 0274)

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E-mail: aob@ies.scs.es;
Web: <http://www.iesalut.es>)

WHO Collaborating Centre for Research and Training in Educational Development

Educational Development Centre; Faculty of Medicine; University of Gezira; P.O. Box 20; Wad Medani; Sudan

WHO Collaborating Centre for Medical Education

Faculty of Medicine; Chulalongkorn University; Rama IV Road; Bangkok 10330; Thailand
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Fax: +(662) 254 1931)

Centre collaborateur de l'OMS pour la Recherche et la Formation en matière de Développement de la Formation des Personnels de Santé

Centre National de Formation Pédagogique des Cadres de la Santé; 67, boulevard Hedi Saidi; Bab Saadoun; Tunis 1005, Tunisia

WHO Collaborating Centre for Primary Health Care/Public Health Education

School of Public Health; Loma Linda University; Loma Linda 92350; California; USA

WHO Collaborating Centre for Leadership Development for Health for All

School of Public Health; University of Hawaii; 1960 East-West Road; Honolulu; Hawaii 96822; USA
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Fax: +(1808) 956 5286)

WHO Collaborating Centre for Educational Development of Health Professionals and Health Care Systems

Department of Medical Education (M/C 591); University of Illinois College of Medicine at Chicago; Box 6998; Chicago, Illinois 60680, USA
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Fax: +(1815) 395 5887;
E-mail: BuzS@uic.edu or cbs4601@uicvmc.aiss.uic.edu)

WHO Collaborating Centre for Postgraduate Public Health Education and Research

School of Hygiene and Public Health; Johns Hopkins University; 615 North Wolfe Street; Baltimore, Maryland 21205-2179, USA
(Telephone: +(1410) 955 3540;
Fax: +(1410) 955 0121)

WHO Collaborating Centre for the Dissemination of Community-oriented, Problem-based Learning

Primary Care Curriculum; Social Medicine Program; Department of Family and Community Medicine; School of Medicine; University of New Mexico; 2400 Tucker Avenue, NE; Albuquerque; New Mexico 87131-5241, USA
(Telex: 660 461;
Telephone: +(1505) 277 2165;
Fax: +(1505) 277 0657)

WHO Collaborating Centre for International Health

University of Texas Medical Branch at Galveston; 1.142 Bethel Hall; 301 University Boulevard; Galveston, Texas 77555-0862, USA
(Telex: 765603;
Telephone: +(1409) 772 0870;
Fax: +(1409) 772 0875)

■ Nongovernmental organizations in official relations with WHO in educational development
Conférence internationale des Doyens des Facultés de Médecine d'Expression française

(Monsieur le Professeur Pierre Farah, Président); Doyen de la Faculté de Médecine; Université St.-Joseph; B.P. 11-5076, Beirut, Lebanon
(Telephone: +(961) 1 614 004;
Fax: +(961) 1 614 054;
E-mail: pfarah@usj.edu.lb)

International Federation of Medical Students' Associations

IFMSA General Secretariat; c/o World Medical Association; B.P. 63; 01212 Ferney-Voltaire, France
(Telephone: +33 450 40 4759;
Fax: +33 450 40 5937;
E-mail: gs@ifmsa.org;
URL: <http://www.ifmsa.org>)

The Network: Community Partnerships for Health through Innovative Education, Service and Research

(Coordinating Secretary: Mrs P. Pluggen); P.O. Box 616; NL-6200 MD Maastricht
(Telephone: +(31 43) 388 1522/1524;
Fax: +(31 43) 367 0708;
E-mail: secretariat@network.unimaas.nl
World Wide Web: <http://www.the-network.org>)

World Federation for Medical Education

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Towards Unity For Health

The newsletter *Towards Unity for Health* is issued in April and October by the World Health Organization, Geneva, Switzerland. It aims to provide a forum for reflection on initiatives worldwide to foster coordinated changes in health services organization and health professions practice and education. It is also intended to help create a climate of solidarity among health authorities, academics, health professionals and representatives of the community to encourage more appropriate approaches to pursuing relevance, quality, cost-effectiveness and equity in health services.

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Comments are invited from individuals and institutions interested in health systems development and health services delivery. Contributions of short articles (less than 800 words long) are particularly welcome. Please address comments and contributions to:

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