Towards Unity for Health

COORDINATING CHANGES IN HEALTH SERVICES AND
HEALTH PROFESSIONS PRACTICE AND EDUCATION

New scope, new hopes

Charles Boelen, World Health Organization, Geneva

From this issue on, the WHO newsletter Changing Medical Education and Medical Practice will be called Towards Unity for Health. The subtitle of the transformed newsletter, “Coordinating changes in health services and health professions practice and education”, is intended to show that while there is continuing interest in the areas covered by its predecessor, its scope has now been enlarged to deal with health system-wide concerns and approaches.

More and more leaders in education, research and services in the health sector realize that to ensure sustainable achievement in their work, it is equally important to excel in a specific area of expertise and to be able to relate to the wider context of health and development. This means understanding that to create mutually reinforcing links with other areas and partners is not only intellectually rewarding but strategically important for support, expansion and impact.

This issue is transitional: most of the articles refer to health professions practice and education issues, while only a few relate to the new focus. We who produce the newsletter anticipate that future issues will more fully reflect and contribute to an understanding of the challenges of implementing unifying approaches in health services delivery. Please read the column “Towards Unity for Health” on continued page 2 ➤
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, 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.

Rapid changes ahead

Buz Salafsky, University of Illinois College of Medicine at Rockford

Change comes slowly but eventually it comes, and for those in my age cohort it certainly comes faster today than it did 30 or 40 years ago. More important is the issue of direction of change and our ability (or inability) to guide change. These past two years, WHO and the Ministry of Health, Thailand, with support from the W.K. Kellogg Foundation, created an international consortium that led to the conference “Towards unity for health”, held this past August.* Multiple stakeholders were represented, and most participants felt the meeting began to define the terms for change. I would urge all of you to read the WHO report when it becomes available.

The conference document provided by Charles Boelen spoke to four criteria or values that need to be more operational in health care. They are: quality, equity, relevance and cost-effectiveness. Because there is an interrelationship between the education of health professionals, the framework in which care is provided (i.e. “the practice of medicine”) and the totality of the health system, unity in health must come into play at multiple levels.

I will argue here that all of us rep-
Health promotion will increasingly become a centre point in national budgets, as chronic disease among an unaware or unresponsive public would otherwise consume available resources.

**Global challenges**
First, let me spell out some of the reasons why multiple stakeholders need to come together to create a better unity:

- Globalization is pervasive. It will have an impact on medicine in general, and specifically in terms of the differences in the way we educate providers, the way medicine is practised and health care is delivered. All these systems will increasingly come under scrutiny.

  For example, we note that ministries of health and/or education, international NGOs and WHO are beginning to look at educational standards relative to the accreditation of medical schools. Until now, such standards existed in relatively few countries.

  In terms of the practice of medicine, we increasingly note that HMO-like systems have already begun in a few short years to spread globally. HMO entities by their very nature will increasingly call for practice guidelines, standards of quality in medicine and uniformity in providing optimal care that is cost-effective.

- As mass communication continues unabated, there is a greater awareness of the wide disparities in health status as a function of race, ethnicity and socioeconomic status. Advances in technology and post-genomic therapeutics will only heighten these disparities that will be broadly perceived by global populations.

- Health promotion will increasingly become a centre point in terms of the practice of medicine and will need to operate under this type of system.

  To define how this will be brought about, medical schools, teaching hospitals, ministries of health, professional organizations and—most important, communities—will need to come together to design country-appropriate models of health care and health education that adhere to the time-honoured principles and values of what is best in medicine. Our collective inability to bring this off will result in squandered resources, non-articulated health delivery systems, narrowly focused practitioners and an unserved, possibly increasingly frustrated and angry public. In some places government directives will dictate direction, and possibly that has already happened.

What therefore is our role? I believe that those who espouse unity for health now need to begin to create multi-stakeholder dialogues in their regions. Pilot projects at grassroots level need to be defined and funded. We need to reach out to local, regional and national governmental agencies and NGOs alike. Private sector resources need to be harnessed. All of us need to become catalysts guiding change. Our roles would include:

- soliciting interested constituents
- facilitating communication
- helping parties develop agendas for change and meaningful templates
- brokering alliances
- and above all, being *advocates*.

These are common pathways in all our cultures. The map for unity needs to be in front of all of us. All of us need to be players.

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**Interested in accreditation?**

The issue of accreditation is being raised worldwide by governmental authorities, health service organizations, the health professions and academic institutions. Often heard are questions such as: "Are we good enough?" "Are we as good as our neighbours?" "Are there any international norms?" "Is there an international accrediting body?"

Accreditation as a means to permit an institution or organization to function and deliver certain goods in reference to a set of values is being increasingly seen as a powerful lever for change.

The international implications of accreditation are important in the wake of globalization. Within the scope of accreditation, components relative to the capacity to respond to people’s health needs from the perspective of improved quality, equity, relevance and cost-effectiveness in health are of particular concern to WHO. Look for more information in the next issue of the TUFH newsletter.
Towards unity for action: in the field

Victor Neufeld, Hamilton, Ontario

A WHO international conference, “Towards Unity for Health: challenges and opportunities for partnership in health development”, took place in August 1999 in Phuket, Thailand. Some 200 delegates from 45 countries participated, representing public health authorities, professional associations, academic institutions and communities. Twenty case studies among the 52 submitted were selected to illustrate endeavours to create unity in health and were presented in plenary sessions, group discussions or as posters. The following article is an analysis by Dr Vic Neufeld of the six case studies discussed in groups. A monograph will be published by WHO this autumn with a selection of fully developed case studies.

Participants at the Phuket conference discussed six case studies in breakout groups. In each group, rapporteurs were asked to prepare summaries of the discussions under three headings: special features, main challenges and specific suggestions. The synthesis below is based, to a large extent, on the excellent work of these rapporteurs.

Seven key messages can be identified from the case study discussions.

1. Define the right problem

The great American educator John Dewey once said: “A problem well defined is half solved”. All the case studies illustrate this idea, and they represent a rich variety of approaches, even though all of them share an ultimate goal: to enhance the health and well-being of a particular population.

Some examples of defining the right problem include:

- the Liverpool story, where clear needs were articulated by community groups, and where a response was mobilized to address these needs;
- the Australia story, where the problem was that initially doctors did not understand the social and environmental determinants of health;
- the Botswana story, in which, faced with a special need to look after persons with HIV/AIDS, the challenge was to find a home care solution that matched the available resources.

2. The lesson of context specificity (or “no easy models”)

It was clear, from listening to the six stories, that each situation was quite distinctive. In Baranquilla, Colombia, for example, there was a community with a special problem. In response to this problem, local leaders seized the opportunity of the resources made available through the UNI project. In addition, there was a favorable political climate to support this initiative. In the Liverpool example, the model that emerged was one of progressive involvement of partners. Initially, only two or three partner organizations were in the coalition; none of them were academic institutions, which were added later.

The lesson here is that we must not be too hasty and glib in “pushing” models and approaches that are right for one setting but may be inappropriate in another context.

3. Continuity and persistence: the importance of the long term

Those of us involved in development work understand this lesson, where much too often we have seen projects with artificially short timelines, dictated not by the nature of the project but by the requirements of the funding arrangements. Several of the case studies illustrate the importance of long-term commitment and persistence. For example, the Australia case study summarized 30 years of experience of a group working with an Aboriginal community. The story from Vellore, India, where some very important learning was accumulated over several decades, shows us the importance of continuous institutional commitment.

4. New roles for academic institutions

Both the Australia and the India case studies illustrate this lesson. In India, for example, the Christian Medical College, Vellore, combines education and research with a clear and central commitment to community service. In the Australia case study, the university played a key role in documenting actions and inputs, thus providing an institutional-memory base over time. This included documenting the two-way learning that occurred between academe and the community, including an account of the mid-course corrections that were made. This project also produced and disseminated an impressive set of publications over a 30-year period.
5. The need to develop new capacities
As part of the response to various kinds of community needs, several of the case study accounts included a description of new capacities that were developed. Examples include the “skill” of team-building and collaboration (particularly inter-sectoral collaboration); capacities related to the appropriate use of information and communication technologies; and the capacities involved in leadership development and succession planning. Two of the case studies also described how the groups involved learned how to “go to scale” from initial pilot projects. These were the Botswana story, where a small-scale home care project for HIV/AIDS patients evolved to a similar system that was applied to other problems. In South Africa, a pilot project focused on tuberculosis was later expanded to include other conditions.

6. Combining action and learning
All the cases illustrated this important lesson. In one way or another, all the case study reports involve the documentation of lessons learnt and the importance of setting up a system for combining action with periodic reflection. In some cases, for example in the Vellore story, the documentation and subsequent learning included the identification and use of basic performance measures, in the form of community health indicators. It was also interesting to see, in several of the case studies, that the learning occurred at several levels: individual, team and organization.

7. Building a global knowledge base
The case studies illustrate the importance of developing a local knowledge base related to a project and disseminating this experience locally. In Colombia, for example, the project experience was well documented and disseminated to politicians, to the public and to policy-makers. The Liverpool project included the preparation of attractive materials, disseminated in large part through the WHO.

Now with the TUFH project, we have some important contributions to the global knowledge base, provided by case studies from many parts of the world. Let us disseminate these important contributions using a variety of existing networks and coalitions, such as the “Healthy Cities” movement, the Network of Community-Oriented Educational Institutions for Health Sciences, the Council on Health Research for Development, and of course, the WHO network.

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Partenariat pour la santé en Afrique francophone
Ayité M. D’Almeida, former Director of Programme Management of the WHO Regional Office for Africa

Summary
The author describes the WHO international conference “Towards Unity for Health” (Thailand, 1999) as a historic landmark for the implementation of the health-for-all strategy. The “Towards Unity for Health” approach focuses on reference values and suggests organizational patterns of health service delivery as well as conditions for productive and sustainable partnership. As such, it is relevant to the African context of health system development, promoting innovative ways to generate new alliances between key stakeholders that are very much needed to revamp health development in Africa.

Introduction
La conférence internationale organisée par l’OMS à Phuket (Thaïlande) du 10 au 13 août 1999, vient de poser un jalon historique vers la réalisation de l’objectif de la santé pour tous et pour chacun.

Ses travaux ont concerné une préoccupation partagée par toute la communauté des hommes et femmes de santé publique: la convergence des énergies et des ressources en faveur de la santé. La conférence suggère une approche originale et intégratrice qui repose sur trois piliers complémentaires:

- des valeurs de référence pour inspirer la planification
- des stratégies organisationnelles censées guider les interventions
- un appel au partenariat où les ressources humaines et institutionnelles se voient affecter des rôles et des responsabilités nouvelles.

Elle fait, par ailleurs, siennes les orientations prônées par les grandes approches conceptuelles, stratégiques et opérationnelles de promotion de la santé dans le monde.

Le contexte
Complexité croissante, interdépendance et interaction dominent tous les secteurs de l’activité humaine.
contemporaine. Etablir désormais comme l’un les déterminants essentiels du développement humain, la santé partage les mêmes caractéristiques. De plus, en raison de sa nature et de ses cibles, elle est plus que jamais soumise aux effets de ses caractéristiques. De plus, en raison de sa nature et de ses précédentes, sur la santé partage les mêmes essentiels du développement humain. Par conséquent, la santé partage les mêmes déterminants contemporains.

Les nombreux acquis, enregistrés notamment au cours des cinq dernières décennies, sont manifestés mais inégalement partagés. Les philosophies, les approches et stratégies mises en œuvre n’ont pas produit les effets durables escomptés.

En effet, les Services de Santé de Base, les Soins de Santé Primaires et l’Initiative de Bamako furent utiles, mais jamais déterminants pour assurer l’accès universel à des soins et services de santé de qualité. Plus récemment, les efforts et sacrifices consentis en vue de la réforme des secteurs nationaux de santé ne semblent pas non plus concluants. Les inégalités paraissent même s’être approfondies dans certaines régions du globe, sur le continent africain en particulier.

La caractéristique principale de ces approches semble de ne considérer que certaines composantes du système de santé ou de sa gestion. Elle paraissent également en avoir privilégié les dimensions technique, technologique et parfois sociale. Les préoccupations pour les aspects éthiques et moraux sont plus récentes, sans que celles-ci constituent les sources d’inspiration pour l’action de santé publique et individuelle.

Pour l’unité en faveur de la santé
L’originalité de la présente initiative est de suggérer une vision holistique et un cadre de référence à la fois conceptuel et stratégique qui intègre cette triple exigence. Sa conceptualisation se fonde sur l’identification de quatre valeurs complémentaires et, à bien des égards, fondamentales en matière de santé:

- l’équité, valeur éthique
- la qualité, valeur technique
- la pertinence, valeur sociale
- le cout-efficacité, valeur gestionnaire.

Dans le contexte africain, la solidarité—valeur culturelle et opérationnelle—devrait compléter les exigences énoncées ci-dessus. Les relations établies entre ces valeurs présentent deux avantages:

- servir de référence pour déterminer l’écart entre la situation d’un système de santé donné au regard de son adhérence aux dites valeurs. Il sera nécessaire, pour opérationnaliser chacune de ces dernières, d’en identifier les indicateurs;
- mesurer les progrès réalisés dans la mise en œuvre des initiatives visant à répondre aux exigences de couverture universelle en soins de qualité.

La stratégie énoncée vise à rassembler ce qui est épars, incohérent et parfois contradictoire. Elle est censée induire un environnement favorable à la coordination et à l’intégration, pour une plus grande convergence et une efficience accrue des interventions. Les conditions s’inscrivent du succès résident dans l’intégration de la santé publique et de la médecine, ainsi qu’en la mise en place d’un système d’information sanitaire fonctionnel qui en soutienne les décisions et les prestations. Ces dernières découleront des fonctions essentielles de promotion et de restauration de la santé, de prévention de la maladie et de ses séquelles, de réduction des incapacités. On admet aujourd’hui que la santé publique se préoccupe aussi de santé de l’individu au sein de sa communauté ou de son groupe d’appartenance.

La mise en œuvre de ce cadre stratégique requiert une révision des rôles et responsabilités des ressources humaines impliquées. Elle exigera de réévaluer les attributions des institutions concernées et de procéder, en conséquence, à leur restructuration. La réforme des programmes de formation et de prestation de soins sera tout aussi nécessaire pour les adapter à ces nouvelles exigences.

Enfin, l’initiative appelle la génération et la mise en place de nouvelles alliances, ainsi que le renforcement des anciens partenariats. Elle nous semble, plus que toutes les autres, constituer une source d’inspiration suffisamment holistique pour guider les réformes des systèmes de santé.

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Création d’un réseau “Francophonie Santé”

A la suite de la conférence internationale francophone des sciences de la santé, qui s’est tenu à Moncton, Nouveau-Brunswick, Canada, au mois de juin 1999, et en marge du sommet des chefs d’États francophones qui s’est tenu en septembre 1999 dans la même ville, le projet de la création d’un réseau Francophonie Santé est né.

Ce réseau a pour but d’offrir l’opportunité d’échanges d’information et d’expériences, ainsi que d’une collaboration internationale sur le problématique d’une meilleure réponse des systèmes de santé aux besoins des individus et des populations. Le partenariat entre décideurs politiques, gestionnaires de santé, professions de santé, institutions académiques et communautés sera mis en exergue. Ce réseau s’appellera tout simplement “Vers l’Unité Pour la Santé”, le correspondant de “Towards Unity for Health”.

Pour toute information, prière de contacter le secrétariat du réseau:
C.P. 946, Moncton (N.-B.), CANADA E1C 8N8.
Decentralized health information management: the glue of a TUFH project?

Theo Lippeveld, John Snow, Inc./Morocco

“Towards unity for health” activities aim at the integration of individual health and public health interventions. The assumption is that such activities would contribute to the development of a coherent and cohesive health system, able to improve the health status of individuals in a population.

Health status is classically known to be determined by at least four main groups of factors: (1) biological assets; (2) personal lifestyle; (3) the environment; and (4) the health care system. The potential impact of interventions within each of these groups can be debated, but several authors have stressed that the contribution of the health care system alone is only marginal compared to the potential impact of interventions on personal lifestyle and on the environment.

While health care interventions focus primarily on individuals, interventions on personal lifestyle and on the environment are in essence community-oriented. Clearly, individual health interventions and community health interventions are complementary and interdependent and need coherence to ensure maximum impact on health status. The question is where to find the glue to stick them together.

Information and integration

Well-conceived health information systems can definitely play a major role in facilitating the integration of individual health and public health interventions. In fact, poor use of information for evidence-based decision-making is probably one of the main causes of the present lack of linkages between individual care and public health systems.

A well-conceived health information system (HIS) generates the information necessary for rational decision-making at each level of the health services system: the primary level, the secondary level and the tertiary level. Each of these levels has specific “management” functions that can be grouped in three categories:

- individual care management functions, directly related to the delivery of high-quality care to individuals consulting the health services system;
- health unit management functions, related to the provision of health care to a defined population in the catchment area surrounding the health unit;
- health system management functions, which include, in addition to coordination and management support for delivery of health services, a set of public health functions for a particular reference population.

When management functions are clearly defined, it is relatively easy to identify the information needed to make appropriate decisions at each management level.

The next question is how to obtain this information in the most effective and efficient way. Classically, two main sources of information exist: routine data systems, mainly health unit-based, and non-routine data systems, such as surveys. No single data source can provide all the information required for planning and management of health services. A national health information system in support of health services will always use a combination of data collection methods, depending on the nature and use of the information for which data need to be collected. Since both individual health care and public health interventions are carried out within the health services system, it seems obvious that the main information source for integration of both activities should be the routine health information system.

Yet most experts agree that routine health information systems in most countries, industrialized as well as developing, are generating irrelevant and low-quality information. Various explanations for this situation have been cited in the literature, but one is particularly detrimental to the TUFH approach: centralization of information management.

Routine health information systems in most countries are centrally planned and managed. Indicators, data collection instruments, and reporting forms usually have been designed by centrally located epidemiologists, statisticians and administrators (the “data people”), with minimal involvement of lower-level line managers and providers of the health services (the “action people”).

Data processing and analysis are mainly the responsibility of a centrally located office. Complex data transmission and compiling sys-
tems slow down the production of feedback, so that information is frequently obsolete for decision-making when it arrives at the lower levels. The result is that information use is found to be the weakest at the district and health unit levels, where the main individual and community health interventions are planned, implemented and monitored.

The challenge of simple, efficient and integrated data collection
In order to transform routine health information systems into management tools for integration of both individual health and public health functions, the key strategy is to decentralize the information system management responsibilities to the district level (see Fig. 1). Yet the task of developing such district-managed routine information systems is both formidable and complex, particularly in the context of government bureaucracies in developing countries.

Broad participation of future users in the system design is required, especially at critical steps such as the definition of information needs and of key indicators. The challenge is to combine simple, efficient, and integrated data collection with the production of high quality action-oriented information. District managers need training in the use of this information in order to implement both individual care and community interventions in a coherent manner.

Most of all, the district level is the ideal starting point for the development of community health and information systems. Community health systems stress local participation of communities in responding to the health needs of the population.

Thus, within the district health system the community adds another management level with its own information needs. The community itself provides information for the management of most essential public health functions. Examples include reporting of births and deaths; notification of cases of infectious diseases and outbreaks; identification of high-risk children, pregnant women, and families; coverage and defaulters of critical services; coverage and quality of water and sanitation; monitoring air, water, land, and noise pollution; coverage of disadvantaged populations with health and social services.

Most examples of community managed health information systems come from research settings, for example, Matlab (Bangladesh), Aga Khan University (Pakistan) and Kasongo (Zaire). Private voluntary or nongovernmental organizations in numerous developing countries as well as in developed countries (Goldfield, 1996) have also adopted this approach.

The glue
Although they are clearly ambitious and long-term efforts, district-managed and at least partially community-managed HIS could provide the glue to bind together individual and community health interventions. Further research and experiences are required to expand and scale up existing projects.

First of all, a comprehensive review study should be set up to gather existing scientific evidence that decentralized routine HIS contribute to more effective and efficient integration of individual and community health interventions. We also invite the research community to help answer the following illustrative list of research questions:

- How can district managers, service providers and particularly communities—as key information users—be more actively involved in HIS development efforts?
- How can community-managed health information systems most effectively be linked to routine health unit-based HIS?
- What management structures are required to better link routine health service statistics with other data collection systems (surveys, vital events registration, rapid assessment methods)?

Figure 1. District-managed routine health unit-based information systems

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**HEALTH SERVICES SYSTEM**
The community-oriented primary care (COPC) approach and Towards Unity For Health: unity of action and purpose

Jaime Gofin, Hebrew University, Jerusalem

The practice of community-oriented primary care (COPC) integrates clinical medicine with public health at the community level and is directed to the epidemiologically defined health needs of the population under care. (1) The COPC approach was initiated in a rural area of South Africa in the 1940s and since the 50s was further developed by Sidney Kark and his team in a neighborhood of Jerusalem, Israel. (2) The principles of COPC are embodied in the Alma Ata Declaration (3–4), and the ongoing application of COPC in various countries (5) creates a rich experience attesting to the feasibility of this approach.

In the COPC approach, the local health service decides on one or more health priority conditions, carries out a detailed community diagnosis, formulates and implements an appropriate intervention programme and evaluates the impact of the programme. Thus, the development of a COPC practice is based on a cyclical process in which programme activities are continuously fed and influenced by epidemiological information. (6)

Our purpose in this paper is to briefly illustrate this approach according to specific elements that have been formulated by the Towards Unity for Health (TUFH) project.

Range of services

The COPC approach considers all stages of the natural history of selected conditions and therefore the aims and activities of the health programmes are to integrate curative, promotive, preventive and rehabilitative care at the clinical site together with an active outreach approach.

Population and territoriality

In the COPC approach, health care is provided to all members of the defined population (not only the users or the ill) and therefore the service is required to know the “name and address” of each member of the population, to identify the target population and to use denominator data for the required population's measurements. While services might be provided for all age groups, specific programmes might address subsegments of the population according to the prioritized health problem (e.g. child immunization) or age-related health risks (e.g. smoking among adolescents, physical functioning in the elderly).
Linkage
The same health team implements the activities directed to individual clinical primary care and to community health programmes directed at individuals (e.g. promoting physical activity) and the community (e.g. organizing groups for physical exercises at a local facility).

Availability of information
The recording of the community programme activities and the individual health status data are an integral part of the same clinical file, and should be easy to retrieve for monitoring purposes. The team periodically reviews data about individuals and the community.

Use by all
Selected information gathered as part of clinical care and related to the community health status is shared with community members and leaders and with other health agencies operating in the area.

Health professionals and their new roles
Whenever possible, the health workers involved in COPC practices have public health training (in addition to their basic training), which allows them to perform the integrated individual-based and population-based care. This training facilitates the complex (but effective!) complementarity of clinical and epidemiological skills required by this type of approach. A multidisciplinary team is essential for COPC.

Social accountability of educational institutions
The COPC programme in Jerusalem was initiated as part of an extension of services provided by a university teaching hospital, and very soon became integrated into the the university. As in many other sites where COPC is practised, teaching to health science students is based on the work done at the practice, and therefore is related to the health priorities identified in the particular population.

Educational programmes
The “dialogue” between the health services and the challenging academic involvement have created a rich environment for continuous critical analysis and renewed proposals for changes and improvements at the service level.

Principal partners
Although care is provided by the health service, there are different levels of coordination with other local agencies (community centres, schools and social welfare).

Community involvement
Throughout the years we have observed various expressions of community involvement. At the beginning of this type of delivery of care in Jerusalem, both the health service and the community were going through the stages of developing a new type of health care and of finding answers to the community’s basic needs. During that period there was an intensive involvement of the community in the service affairs. Later on, with economic and social progress, community members changed to a more passive attitude of “tell us what to do”. The type of links between health services and the community relates to the particular cultural and social values prevailing in each population.

Dissemination
There is an extensive literature on the planning, implementation and evaluation of COPC programmes developed in different countries (3, 7–10) that illustrates their impact on the populations’ state of health. In Israel, the outcome of these evaluations has been the basis for policy-making and the establishment of an Iron Supplementation Programme at national level by the Ministry of Health and an Early Stimulation Programme in the Public Health Services of the Municipality in Jerusalem. In addition, the largest Sick Fund in Israel adapted the Hypertension Control Programme in half of the community clinics in the country.

Usually the professionals involved in the COPC approach are also involved in research and teaching activities, which in itself promotes the dissemination of the concepts and experiences within the scientific and clinical communities.(11)

COPC is a care delivery approach at the community level that could initiate and facilitate a cascade effect and lead other stakeholders to integrate their policy and actions in the “country-wide” approach of TUFH. This in itself would facilitate the desired unified approach of practice and education. TUFH could/should learn and grow (from purpose to action!) from experiences of various approaches, like COPC, which have already been evaluated and proven their feasibility of integrating individual care and community medicine with improvement of the health status of the population.

References
Towards unity for health in medical education

Zamboanga Medical School Foundation – a case study in the Philippines

Fortunato L. Cristobal, Zamboanga Medical School Foundation, Inc.

The call for health for all articulated in the Alma-Ata Charter is a formidable goal with great potential for "unity for health". But 20 years after the charter’s inception, the need for innovative reforms in medical education is still great. Although medical schools have been highly criticized as isolated ivory towers, lacking in proactive contributions to society’s health needs, academic institutions actually have large potential for addressing the complex issues of health unity and therefore to create synergies between the community, health professionals, health managers and policy-makers towards unity for health. Here we report the experience of stakeholders collaborating to establish an innovative medical school in the southern Philippines.

Health in our region

Nearly one-third of the Philippines’ 72 million people live on Mindanao Island. Zamboanga City (population 0.5 million) is the hub for services in Western Mindanao and the Sulu Archipelago (population 3.5 million), one of the most underserved areas of the southern Pacific. Travel is predominantly by boat, and access to inland areas is mostly by foot. Some 70% of the people live along the shorelines of the islands; 80% of this rural population has no health services.

Neonatal tetanus, measles, typhoid, cholera, dengue fever, tuberculosis, malaria, diarrhoea and respiratory infections are major problems. The fertility rate is about 5, and infant mortality is more than 75 per 1000 births. Safe water, balanced nutrition, prenatal care and full immunization remain long-term health goals. There are 29 medical schools in the Philippines, but until recently none in this region, and few physicians are willing to move to this under-resourced area.

Planning a medical school in partnership

Against this background and aware of the challenge of starting a new medical school with very limited resources, community leaders, health professionals and academic stakeholders initiated consultations in 1992. As a result of these intensive intersectoral meetings, a new, private, not-for-profit medical school was proposed as a collaborative effort.

A local university was to share the use of teaching facilities, library, buildings and other infrastructure resources free of charge. Local doctors would serve as volunteer faculty. The community would assist in setting priority curriculum areas and in student selection, and provide support and protection to students during their community-based experiential learning placements. Local business people would provide fund-raising support. The local health system would provide financial assistance for community health research.

A board of 15 members, com-
The Zamboanga Medical School Foundation (ZMSF) was born in 1994.

The vision and mission were established by the dean and board of trustees at the beginning:

**The Vision:** The ZMSF envisions that the medical school will pioneer and implement a curriculum that combines competence and problem-based instruction with experiential learning in the community that is responsive to the changing patterns of health care development and the needs of these communities and is sensitive to the social and cultural realities of Western Mindanao.

**The Mission:** The medical school exists to help provide solutions to the health problems of the people and communities of Western Mindanao . . . . not limited to individual medical care alone, but achieved through social, economic, political and educational development of the communities.

Piece by piece, we developed an integrated curriculum with problem-based learning, community-oriented and community-based education and competence-based evaluations. All basic science, clinical issues and social/community contexts for health are integrated into the problem-based learning approach.

Three educational strands are intertwined: a working-problem strand, a population strand and a professional skills strand. As early as their first year, students are exposed to patients both in clinics and communities, where the focus is on the practice of medicine in its social or community setting. About 18 months are spent studying and working under supervision in remote rural communities; of this, only 20% is spent in hospital-based training.

Since 1994 we have enrolled 15 to 25 students each year, depending on the quality of the applicants. Ten graduates of the first class (1998) passed the examinations of the Philippine Medical Board in 1999, and some are now working as physicians in remote regions, equipped with skills in community health development. We have already seen many changes in some communities where the students work.

Developing an innovative medical school in pursuit of the goals of health for all is a challenging and demanding project. However, the pressing unfulfilled health needs of our communities require no less than that we focus our efforts on collaborating with all sectors to this end.

**A snapshot from Canada**

Aurel Schofield, Université de Sherbrooke

New Brunswick is one of the four Atlantic Provinces of Canada. It is a small province, covering about 77 000 square kilometres. It has a total population of 760 000, of whom 33% are French-speaking and another 66% are English-speaking; within its boundaries a few small native communities are also dispersed. It is the only officially bilingual province in Canada.

This small province offers a well-structured health system organized through a central health ministry. Regional hospital corporations are responsible for health services to the communities, and mental health services and public health are delivered through regional offices. New Brunswick also has a well-developed education system in both official languages, but it lacks a medical school and does not offer specialty training in health services. There is also a well-developed information network throughout the province.

However, the rising cost of health services; the relative lack and maldistribution of physicians, nurses and other health care providers; insufficient services for high-risk populations; increasing demand for mental health services; and special health needs of the aged, adolescents and native populations are all factors that will certainly contribute to a major crisis in the years to come. A major innovative effort must be made to reduce the present fragmentation in the health system and make the best use of all existing resources.

For these reasons, a “Towards
Unity for Health” approach to the New Brunswick health services system would be most beneficial. With a small province like ours and with a well-developed infrastructure, it would certainly be possible to engage in a province-wide project. How should we proceed?

We are convinced that the principal partners must share a commitment towards interventions that positively influence the health of the population. A joint consultative group has already been formed to pursue a medical education initiative for the French-speaking population. This consultative group could be expanded to include all major stakeholders to identify common goals and objectives and to determine joint actions.

We will soon make a proposal to policy-makers, health managers, health professions associations, academic institutions and community representatives in New Brunswick to develop a “Towards Unity for Health” project and we look forward to reporting on its development in a future issue of this newsletter.

Dr Aurel Schofield

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Towards Unity for Health Project


The activities of the TUFH project are grouped as follows:

- Advocacy and strengthening of collaboration
- Learning from field project sites
- Consultation with stakeholders’ groups
- Scientific and technical work
- Production and exchange of information.

Year 2000

1st quarter
Establishment of a “Towards Unity for Health” Advisory Committee (TUFH-AC) composed of representatives of different stakeholders and health agencies.

2nd quarter
Dissemination of the first issue of the WHO newsletter Towards Unity for Health.

3rd quarter
Selection of up to 12 field project sites with contracts to document endeavours over a period of two to four years in developing the TUFH approach.

4th quarter
Regional meeting (site to be decided) to promote the TUFH approach and develop opportunities for its application at national level.

Year 2001

1st quarter
International consultation to strengthen collaboration of NGO’s (non-governmental organizations) in the TUFH project.

2nd quarter
Planning/implementation of joint work with selected NGOs, as determined during the international consultation held in the first quarter of 2001.

3rd quarter
Regional meeting (site to be decided) to promote the TUFH approach and develop opportunities for its application at national level.

4th quarter
Fourth issue of the WHO newsletter Towards Unity for Health.
Towards Unity for Health: The Phuket Consensus

Background

The participants in the international “Towards Unity for Health” Conference in Phuket, Thailand, on this day of 13 August 1999 present this statement of Consensus to serve as a foundation for the development of partnerships to promote health for all people worldwide.

This Consensus is grounded in the fundamental principles outlined in the United Nations Universal Declaration of Human Rights, resolution 1997/71 of the United Nations Commission on Human Rights; the Declaration of Alma Ata; and the World Health Organization’s Global Strategy for Health for All, derived from resolution WHA30.43 (1977) of the World Health Assembly and the World Health Organization’s definition of health. In addition, the Consensus has imbedded within it the notions of health-related human rights found in the codes of professional ethics and conduct and patients’ rights promulgated by many professions in many nations.

We agree that:

- The health of individuals and families reflects the health of the communities and environments in which they live, work and play.
- Each person has the right to healthy environments and equitable, humane and ethical health services.
- The good of individuals, communities and the environment must be respected and considered in all matters relating to health.
- Policies and practices that affect health must be evidence-based, rational and sustainable and must aim at achieving both individual and societal good.
- Effective partnerships between individuals and communities and all sectors—private, public, professional and voluntary—are essential to creating and sustaining effective health interventions and programmes.
- Global society must ensure adequate resources for the health of all its members.
- Responsibility and accountability for health, particularly that of the most vulnerable, are shared by all partners across all sectors.

Recommendations for Action Agenda

The following agenda for action is proposed. Implementation of this agenda will depend on a fundamental reorientation of the education, training and continued development of the wide range of stakeholders in health.

- Synthesise and promote the TUFH Consensus.
- Identify the key determinants of partnerships that impinge on health.
- Create mechanisms for developing the new skills needed for community alliances: cross-sectoral consensus-building, community engagement, leadership training, management and resource development and deployment.
- Develop shared knowledge and information systems for appraising partnerships and benchmarking the outcomes and impacts of TUFH projects.
- Engage civil society, the public and private sectors and community leadership in the TUFH partnership movement.
- Ensure support for TUFH by all stakeholders.
- Ensure adequate resources to provide appropriate technical assistance, demonstration projects, research and evaluation of sustainable TUFH partnerships.
- Develop, disseminate and implement a strategic plan to advance expand a sustainable collaborating TUFH network.

The World Health Organization, as the world’s key agency in international health, should take the lead in developing and promoting this Consensus. A resolution should be drafted for adoption by the World Health Assembly to give effect to the implementation of Unity for Health.

Towards Unity for Health: collaboration wanted

If your organization or institution is interested in participating in WHO’s “Towards Unity for Health” (TUFH) project, please read further. An WHO contract and grant will be offered to 12 field project sites worldwide, selected on the basis of written proposals.

The TUFH project aims at reducing fragmentation in the health service delivery system and facilitating the implementation of a primary health care-oriented system for a given population through innovative patterns of services to integrate medicine and public health and promote sustainable partnerships among key stakeholders at the level of the target population. A description of the TUFH project appears in the WHO working paper “Towards unity for health: chal-
The field projects should aim to meet the four following sets of criteria:

1. Innovative patterns of services for integrating medicine and public health
   1.1 using a reference population and focusing on a territory
   1.2 developing an organizational model for integration
   1.3 promoting comprehensive health information management
2. Implications for health professions
   2.1 promoting new roles and rewards in practice
   2.2 ensuring social accountability of educational institutions and programmes
3. Partnerships
   3.1 creating alliances with principal partners (policy-makers, health managers, the health professions, academic institutions, communities)
   3.2 ensuring sustainability in partnership
4. Evidence of impact
   4.1 planning dissemination
   4.2 measuring effects in terms of quality, equity, relevance and cost-effectiveness.

The UNI-SOL project expects to weave global links among universities that share the values and commitment outlined in the “Arizona Charter” (ratified at the WHO and UNESCO-sponsored global conference, “Universities and Health of the Disadvantaged”, held in Tucson, Arizona, USA, in July 1999). UNI-SOL will be a strong advocate to encourage the academic world to study and actively participate in both improving the health of the disadvantaged and in peace and social justice issues that support the design and implementation of international programmes.

Proposal UNI-SOL: collaboration wanted

Proposals are invited from universities interested in collaborating with the WHO/UNESCO project UNI-SOL (which stands for “Universities in Solidarity for Health of the Disadvantaged”). A WHO contract and grant will be offered to six universities worldwide, selected on the basis of their proposals.

The UNI-SOL project aims at mobilizing the broad potential within universities to improve the health and well-being of the disadvantaged. This will be accomplished through a multidisciplinary approach involving coalitions between the participating universities, communities, local government and the health professions.

The UNI-SOL project expects to weave global links among universities that share the values and commitment outlined in the “Arizona Charter” (ratified at the WHO and UNESCO-sponsored global conference, “Universities and Health of the Disadvantaged”, held in Tucson, Arizona, USA, in July 1999). UNI-SOL will be a strong advocate to encourage the academic world to study and actively participate in both improving the health of the disadvantaged and in peace and social justice issues that support the design and implementation of international programmes.

Project features

UNI-SOL is interested in actively collaborating in university projects that meet the following four sets of criteria:

1. Targeting the disadvantaged

The university clearly indicates its focus on one or more targeted disadvantaged groups, such as street children; illiterate mothers; illegal immigrants; the chronically jobless; socially proscribed groups (for cultural, religious and other reasons); the handicapped; the lonely aged; people at war; and refugees.

The university should be in a position to justify its choice of target group(s), as well as its anticipated action. This involves demonstrating having considered the priority health and social concerns in the given national or local context, and opportunities to pursue the proposed action on a wider scale or with other disadvantaged groups.

In the selection process, priority will be given to a university that chooses one or more disadvan-
taged groups known for their vulnerability and their representativeness in the national context.

2. Multidimensional approach
The university gives evidence that it can mobilize several faculties or departments to study and act in favour of a particular disadvantaged group. Its activities vis-à-vis the disadvantaged are not restricted only to interventions of health sciences (medicine, nursing or public health), but incorporate inputs from other faculties or departments, such as political sciences, social sciences, economics, etc. The leadership of the project can rest with faculties or departments outside the health sciences.

Priority in the selection process will be given to a university that involves in its activities with regard to the disadvantaged a wide spectrum of faculties/departments beyond those of the health sciences.

3. Comprehensive approach
The university shows evidence of its contribution through education, research and service functions. For example, its students may be offered learning opportunities in real-life situations early and throughout their curricula, preferably in multiprofessional groups.

In research, activities could centre on situation analysis of a particular target group from a health and social perspective or on operational research, with assessment concerning the impact of intervention programmes.

In service, activities may be directed towards the planning and delivery of services, taking into account the main determinants of disadvantages and prejudices, with a particular emphasis on preventive measures from a health and social perspective.

Priority in the selection process will be given to a university that shows balanced inputs from and to education, research and services.

4. Institutional change and sustainability
The university has developed a strong relationship with local governments, communities and professions active in the health and social sectors, for the purpose of establishing a durable partnership in support of a particular disadvantaged group or of contributing to institutional change.

Action could be related to political lobbying, social advocacy, development of strategies for sustainable actions or establishing local, national or international networks. While the university plays the role of a catalyst, the major responsibility for execution of the work lies with other partners.

In the selection process, priority will be given to a university that shows evidence of its consistent commitment to institutional change in favour of the disadvantaged.

University commitment
The project should offer evidence of the university's commitment to the disadvantaged by meeting the following criteria:

- Institutional backing: The commitment of the university is confirmed by a letter signed by the president, vice chancellor or another representative of the university's leadership.
- Coordination mechanism within the university: A list of representatives of the different faculties and departments involved in the project is provided, as well as an indication of how coordination will be ensured.
- Coordination with partners outside the university: A list of representatives of partners outside the university is provided, as well as an indication of how coordination will be ensured.

Submission of proposals
A proposal of no more than three pages, presenting arguments relative to the above-mentioned four project features and three indicators of university commitment, should be submitted by 31 August 2000 to the following address:

UNI-SOL secretariat
WHO Collaborating Centre on Border and Rural Health Research
College of Medicine
University of Arizona Rural Health Office
2501 East Elm Street
Tucson, Arizona 85716
USA
(Telephone: +1 520 626 7862; Fax: +1 520 321 7763; E-mail: aclarihe@rho.arizona.edu).

Up to six universities will be selected by the UNI-SOL advisory committee. In return for a WHO contract and grant of up to USD 10 000, each selected university must pursue its project for two years and submit reports on progress in developing the project according to the proposed features and criteria. It is essential that all collaborating universities communicate with WHO headquarters in either English or French.

For further information on the UNI-SOL project and on the selection, please contact the UNI-SOL secretariat.

For contact with WHO on the UNI-SOL project:
Dr Charles Boelen, EIP/OSD
World Health Organization
1211 Geneva 27
SWITZERLAND
(Telephone: +41 22 791 2510; Fax: +41 22 791 4747; E-mail: boelencc@who.int).

For contact with UNESCO on the UNI-SOL project:
Mrs Christine von Furstenberg
United Nations Educational, Scientific and Cultural Organization
1 rue Miollis
75015 Paris
FRANCE
(Telephone: +33 1 45 68 45 16; Fax: +33 1 45 68 57 24; E-mail: c.von-furstenberg@unesco.org).
Working with the World Health Organization

In implementing its programme, WHO is looking forward to collaborating with institutions and individuals with recognized expertise and international experience in the following areas:

- Accreditation: accreditation or credentialing of educational institutions or programmes, primary health care services or health professionals.
- Family medicine/general practice: the contribution of family medicine or general practice to health system reform; family medicine/general practice and community health/public health; population-based approaches; primary health care teams.
- Integrated health services: integration of individual and community health at district level; innovative organizational patterns to support integrated approaches; competence and motivation of health professionals working in such settings.
- Changing roles of professions: methodologies to identify determinants for changing roles of health professions; adaptation to health system changes; reallocation of responsibilities and health professions mix; motivation and remuneration.
- Universities and the disadvantaged: strategies to mobilize a wide range of faculties and departments within a university in favour of health of the disadvantaged; coalitions between universities and civil society for sustainable action for health of the disadvantaged.

Collaboration may take several forms, but will not necessarily involve financial support from WHO. It is essential that collaborators be fluent in English or French. For further information, please contact: Dr Charles Boelen, EIP/OSD; World Health Organization; 1211 Geneva 27; SWITZERLAND.

Diary dates

- **Congrès National Annuel de la Société Marocaine des Sciences Médicales**
  
  **8–10 JUNE 2000, RABAT, MOROCCO**
  
  Le projet “Vers l’Unité pour la Santé” sera lancé à cette occasion.
  
  Pour de plus amples informations, prière de contacter le Dr Theo Lippeveld (Courriel: theo@elan.net.ma; tippeveld@sante.gov.ma).

  [On the occasion of the Annual National Congress of the Moroccan Society of Medical Sciences, to be held in Rabat, Morocco, 8–10 June 2000, a “Towards Unity for Health” project will be launched. For further information, please contact Dr Theo Lippeveld (E-mail: theo@elan.net.ma; tippeveld@sante.gov.ma).]

- **4th Rural Health Conference**
  
  **16–19 AUGUST, 2000, CALGARY, ALBERTA, CANADA**
  
  Convened by the University of Calgary.
  
  For more information, please contact Ms Irene Pullar, Continuing Medical Education, University of Calgary, 3330 Hospital Drive N.W., Calgary, Alberta, CANADA T2N 4N1 (E-mail: pullar@ucalgary.ca).

- **International Conference on Health Research for Development**
  
  **10–13 OCTOBER 2000, BANGKOK, THAILAND**
  
  
  For more information, please contact the Council on Health Research for Development c/o UNDP, Palais des Nations, 1211 Geneva 10, SWITZERLAND (E-mail: conference2000@cohred.ch).

- **Innovation in Health Professions Education and Community Orientation**
  
  **21–26 OCTOBER 2000, MANAMA, BAHRAIN**
  
  Convened by The Network: Community Partnerships for Health Through Innovative Education, Service and Research, in collaboration with the College of Medicine and Medical Sciences of Arabian Gulf University.
  
  For more information, please contact Ms Jolanda Koetsier, The Network Office, Faculty of Medicine, Maastricht University, PO Box 616, 6200 MD Maastricht, Netherlands (E-mail: secretariat@network.unimaas.nl).

- **International workshop: a primer on the Maastricht approach to medical education**
  
  **23–24 NOVEMBER 2000, MAASTRICHT, NETHERLANDS**
  
  This workshop will be held in November and March each year; the next dates planned are 22–23 March 2001 and 29–30 November 2001.
  
  For more information, please contact Ms Jolanda Koetsier, Workshop Secretariat, Office for International Relations, Faculty of Medicine, Maastricht University, P.O. Box 616, 6200 MD Maastricht, Netherlands (E-mail: j.koetsier@bibfdg.unimaas.nl).
Each year more than 10 million children in developing countries die before they reach their fifth birthday. About 70% of these deaths are associated with infectious diseases and inadequate nutrition. Among the children who do survive, many are still unable to grow and develop to their full potential. Doctors have an important role in improving this situation through the effective prevention and management of childhood diseases and malnutrition.

The WHO Department of Child and Adolescent Health and Development (CAH), together with its partners, is working to develop and introduce approaches to combat childhood illness and to promote healthy growth and development. These efforts have resulted in a new strategy that focuses on the child as a whole, rather than on a single disease or condition. It is called Integrated Management of Childhood Illness (IMCI).

Action is being taken to introduce the teaching of IMCI in medical schools to help ensure that future doctors:

- know proven methods for preventing and managing major childhood illnesses,
- have the skills needed to care for sick children in an integrated and effective manner,
- are able to work together with families,
- are able to support and follow national guidelines.

Yet numerous challenges must be overcome in a country before health professionals and teaching institutions are able to practise and teach the IMCI guidelines. These challenges include, for example, reaching consensus on health priorities in a country, preparing the health system to support IMCI-trained graduates, incorporating IMCI into already crowded teaching agendas, strengthening or even changing teaching methods and ensuring coordination between disease-specific programmes and between different teaching units.

What are the IMCI clinical guidelines and where should they be used?

The IMCI clinical guidelines use proven, practical measures for the prevention and cure of the most serious or lethal childhood illnesses. The guidelines promote standard assessment and treatment, using syndrome-based methods that support the rational, effective and affordable use of drugs. The guidelines are designed for use in outpatient clinical settings where health professionals have limited diagnostic tools, limited medications and limited opportunities to practise complicated clinical procedures. In addition, the guidelines include methods for teaching parents how to give treatments at home, for assessing a child’s feeding, for counseling parents to solve feeding problems and for advising parents about when to return to a health facility.

Why is IMCI needed in medical education?

Doctors play a key role in promoting the correct management of major childhood illnesses and in ensuring the best preventive interventions for children, families and communities. In many countries doctors are responsible for the in-service training or the supervision of other cadres of health workers. Yet doctors can give proper support only if they understand and agree with recommended procedures and if they apply them in their own practices on a routine basis. For this reason, appropriate training for medical students is a logical first step towards establishing scientifically sound practices among doctors and subsequently among other health professionals.

IMCI is relevant to medical education because it:

- encompasses basic elements of high-quality care
- ensures that sick children are thoroughly assessed and treated
- addresses the most frequent health problems of children
- provides additional skills in important areas such as nutrition counseling
- influences care-seeking behaviours
provides a link to real-life situations
- prepares doctors to manage sick children in outpatient settings
- combines preventive and curative care
- links different levels of health professionals and different levels of a health system
- rationalizes some outpatient procedures and emphasizes affordable interventions
- helps doctors recognize the severity of a child’s condition and take necessary action at times when a single diagnosis is difficult
- promotes rapid treatment and referral for severely ill children.

What are the challenges to introducing IMCI into medical schools?

Reaching consensus on health priorities: Introduction of the IMCI strategy in a country takes an important step towards tailoring pediatric teaching to the needs and demands of a society. During this process, agencies within the government, the academic community, professional societies and numerous other individuals and institutions work together to ensure that the IMCI clinical guidelines reflect national guidelines and policies, fit cultural and language differences and address the most serious childhood illnesses in a country. Reaching consensus among a broad group of individuals with various interests is a tremendous challenge.

Strengthening the health system to allow graduates to practise newly acquired skills: Teaching IMCI in medical schools will not ensure that students actually follow those guidelines after graduation. It is well known that a discrepancy exists between what is taught in medical schools and what is practised. Experience shows that students use case management guidelines when instructed to do so. Afterwards, when working as residents, however, they do not always follow those guidelines. Negative forces in the clinical environment, such as lack of supplies, lack of supervision or lack of skill reinforcement, influence practices. In order to encourage graduates to practise what they have learned, health facilities must be organized and equipped to implement IMCI and both professors and practitioners must use those procedures.

Reshaping the way paediatrics is taught: In essence, integrated case management is not something new. Because IMCI focuses also on outpatient management, its principles may not be fully compatible with hospital-based, diagnostic methods that are frequently used to teach paediatrics. For this reason, careful planning is needed to ensure that IMCI is incorporated into the overall paediatrics agenda. The same concepts should also be included in the formal evaluation of student knowledge and skills in order to reinforce the importance of the guidelines.

Giving priority to interactive and skill-oriented teaching: The introduction of integrated case management presents an opportunity to strengthen more dynamic learning processes. Students are helped to develop case management skills through supervised clinical practice with a variety of patients in outpatient settings. Ideally, students should learn clinical skills in an environment where integrated case management is being practised. Consequently, medical faculties will need to prepare appropriate clinical training sites and to train instructors and relevant clinical staff in the IMCI guidelines.

Ensuring coordination between disease-specific programmes and between different teaching units: The IMCI strategy encourages different agencies and institutions in a country to work together to identify child health problems and to agree on a common approach to those problems. This coordination requires careful planning as well as mechanisms for sustaining interaction. The introduction of IMCI in medical schools will require similar efforts to coordinate teaching among different academic departments and units.

Dr Lejnev is a Medical Officer and Ms Bailey is a Technical Officer, Department of Child and Adolescent Health and Development (CAH), World Health Organization, 1211 Geneva 27, SWITZERLAND (telephone: +41 22 791 3288; e-mail: lejnev@who.int).

Family medicine/general practice and health system changes: a new WHO/WONCA* collaborative project

The aim of this project is to produce a reference guide to help policy-makers with major decisions regarding the development and strengthening of family medicine/general practice in the wake of important health system changes in specific national contexts.

Chapters of the guide will focus on: opting for family medicine/general practice as a foundation for health services delivery; educating family physicians/general practitioners; organizing a professional association; conducting health system research, including in family medicine and general practice.

More information will be provided in the next issue of the TUFH newsletter.

*WONCA is the World Organization of Family Doctors.
The WHO Reproductive Health Library: A tool to incorporate evidence-based reproductive health into medical education and practice

A. Metin Gülmezoglu and José Villar, World Health Organization, Geneva

The WHO Reproductive Health Library (RHL) is an annually updated electronic review journal published by the WHO Department of Reproductive Health and Research since 1997. RHL includes systematic reviews of effectiveness of reproductive health care interventions relevant to important reproductive health problems in developing countries.

The systematic reviews are taken in their entirety from the Cochrane Database of Systematic Reviews published in The Cochrane Library. Each review is supplemented by a commentary prepared by an individual from a developing country or someone with extensive knowledge of conditions of those settings.

RHL is disseminated to health workers in developing countries on a free-subscription basis. RHL No. 3 will be published in early 2000 on three diskettes: 13,000 copies will be made available in English and 5000 in Spanish. In English, 3000 CD-ROMs will also be published.

RHL contents are arranged in four sections. The first section contains editorials relating to priority reproductive health problems, evidence-based medicine and methodological issues. Effectiveness summaries categorize in one sentence the evidence synthesized in the database according to the level of benefit or harm.

The Reproductive Health Database contains the Cochrane Reviews, commentaries and practical aspects documents. The latter two comment on the relevance of the review findings to under-resourced settings and are published after internal and external peer review. The Useful information section contains lists of funding agencies and nongovernmental organizations in reproductive health.

Challenge of changing behaviours

In the initial phase of the project our aim has been to disseminate RHL as widely as possible by means of WHO mailing lists, conferences, workshops and relevant e-mail discussion lists around the world. There are now RHL focal points in Argentina, China, Cuba, India, Indonesia, Mexico, the Philippines, South Africa, Thailand and Uruguay.

While these activities may have been very useful in raising awareness about RHL and providing access to many health care workers, more needs to be done towards getting the evidence presented into practice. There is now compelling evidence of the ineffectiveness of passive dissemination to affect behaviour change (1). Receiving RHL diskettes in the mail is therefore unlikely to make a big difference in practice, at least in the short term.

To evaluate this issue, we have initiated a cluster randomized trial to evaluate a programme of educational outreach using RHL in 40 district hospitals in Mexico, South Africa and Thailand. If effective, this strategy can be introduced on a wider scale to influence the practices at that level. The trial will be completed by end of 2001.

We believe that incorporating evidence-based practices as recommended in RHL will require action in undergraduate and postgraduate training as well in targeting practising health workers. RHL is currently included in the fourth-year obstetrics and gynaecology syllabus at the University of Pretoria, South Africa. The Royal Thai College of Obstetricians and Gynaecologists has recommended RHL to doctors undergoing specialist training since 1999. This is the beginning of a worldwide effort aiming at undergraduate and postgraduate education and clinical practice levels of the health system to incorporate evidence-based reproductive health into practice.

We look forward to collaboration with more medical schools around the world interested in using RHL in their medical curriculum.

Reference


Dr Gülmezoglu and Dr Villar are RHL Coordinating Editors, Department of Reproductive Health and Research, World Health Organization, 1211 Geneva 27, SWITZERLAND (e-mail: gulmezoglu@who.int; villarj@who.int).
Health personnel – a country priority: a viewpoint from Botswana

Teguest Guerma, WHO Representative, Gaborone

The objective of the WHO Global Strategy for Health for All is to enable each country to provide its citizens with all potentially useful health services. This will never be achieved without the development of skilled and appropriate human resources. A country’s capacity to implement public health programmes and ensure effective delivery of health care services to its people is determined by the extent to which its human resources development keeps pace with the requirements of health.

Human capital

In order to fulfil this important need, several developing countries have identified investment in human resources as their priority in health and have developed comprehensive policies and plans. Many of them have established their own training institutions in order to train their human resources locally because of political decisions, existing infrastructure or sometimes national pride. Others have opted not to establish local institutions, partly because of high training costs and partly because of easy access to suitable training institutions in neighbouring countries; Botswana was part of this group.

Over the years, however, Botswana has experienced an increasingly serious shortfall in the workforce needed to implement many of the public health programmes of national importance. The current pool of physicians in the country is 410, among whom 347 are expatriates, which means that only 15% are locals. Furthermore, all district medical officers of the country are expatriates. Faced with this shortage of local physicians, the government recently decided to establish a medical school in the country, but this is a long process that will take years to realize.

Deciding on priorities

Building capacity by offering fellowships to scientists in developing countries is an important part of the WHO programme. Several resolutions adopted by the World Health Assembly have reinforced this commitment in recent years.

A recent retreat organized jointly by the Ministry of Health of Botswana and WHO to set priorities for the coming five years’ technical cooperation identified human resources for health development as a top priority. This meant reducing the budget of other ongoing priority programmes in order to focus more on training.

This was not an easy exercise to go through, but after a comprehensive analysis of its merits the government upheld this decision.

WHO’s contribution is expected to serve as a catalyst for an intensified training programme of physicians by the Ministry of Education and other partners. The long-term objective of this decision is to increase the proportion of Batswana, or local, physicians to at least 40% by the year 2008. The cost-effectiveness of this investment appears evident when we consider the amount of the health budget currently spent to employ expatriates.

The development of human resources for health, although the basis of the health system, is often neglected by countries facing many other health priorities. The current moves of the government of Botswana to redress the imbalances are commendable and are worth emulating elsewhere in the African region.

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A five-star doctor for Africa: desirability and feasibility

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Providing health care for Nigeria’s 110 million people has never been seen as an easy task. With nearly one-quarter of the population of Africa and a largely rural-based agriculture-oriented population scattered over a varied geographical terrain, Nigeria has yet to achieve WHO’s dream of health for all by the year 2000.

Primary health care in progress
The evolution of the health care system as it operates today can be traced back to 1986, when primary health care (PHC) programmes were implemented as the baseline strategy for the development of national PHC services. With this approach, even though development was still centred around the local government areas, PHC programmes were now provided with the technical support to supervise and run the services.

In 1986, technical support was provided to 52 local government areas (LGAs) by various institutions such as the 12 colleges of medicine/university teaching hospitals where community health officers were trained. Other local government areas were supported by schools of health technology, and by 1990 almost all the LGAs had joined as “willing” LGAs.

The result of this system was better coverage of the population, with preventive and curative health services receiving adequate emphasis. Appropriate technology was being used, thereby reducing costs and making health care affordable. There was also better management and coordination of the activities of the nongovernmental and international organizations.

As in most countries, the system is organized into primary, secondary and tertiary levels. The primary level comprises health posts, health clinics, district primary health centres and comprehensive health centres. The secondary level comprises all general and district hospitals. The tertiary level comprises all specialist hospitals, such as those for teaching or for orthopaedic or psychiatric care.

Since 1990, however, successive governments have not provided an adequate level of funding to sustain these services, and this has resulted in Nigeria’s having among the highest infant and maternal mortality rates in the developing world. The basic three-tier structure is still in place, however.

A five-star MD for Nigeria
The five-star doctor, like a four-star general, has to be equipped to work at any of the three levels, and especially at the primary and secondary levels.

★ Community leader and motivator: He or she must lead by example and be able to both teach and motivate the community: to impart the habits of cleanliness and sensible preventive medical care; advocate the importance of child health, well-baby clinics and family planning services; and encourage involvement in appropriate community programmes.

★ Decision-maker: He or she must learn to make decisions on health matters that will be seen and proven to be in the best interest of the community, and must endeavour to convince and enlist community leaders.

★ Medical scientist: He or she must remember that as a doctor he or she is also a scientist, and that research can be done not only in a teaching hospital laboratory but also at the village level.

★ Health care manager: He or she must be able to efficiently manage resources and learn to improvise where necessary. Dwindling government resources in developing countries translate directly into dwindling health services budgets, which in any case have never been a priority.

★ Communicator: He or she must develop the ability not only to translate ideas into action but also to move freely between the primary, secondary and tertiary levels of care, as increasingly the general practitioner/family physician is being trained and equipped to look after patients holistically, and to acquire skills that hitherto were thought to be the exclusive preserve of the general surgeon or obstetrician.

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Essential service package in Bangladesh needs five-star doctors

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Country profile
Bangladesh is a country trying hard to overcome its health sector problems. The Health and Family Planning Programme has made remarkable progress over the last two decades. The fertility rate has declined and the immunization programme is successful.

Despite these advances, Bangladesh still has some major health problems. For example, the life expectancy at birth is lower for females than for males. Less than 40% of the population has access to basic health care. About 70% of mothers suffer from nutritional deficiency anaemia, and 75% of pregnant women do not receive antenatal care or assistance from a trained attendant at the time of childbirth, which indicates inadequate progress with respect to maternal mortality and morbidity. Other issues of concern are overall poor use of government services, as well as the cost-effectiveness, sustainability and quality of services.

The present structure of the health service delivery system has separate cadres at all levels for health and family welfare services. Therefore it is not cost-effective and its potential for increasing the range, quality and effectiveness of services is limited. The present service system does not allow clients to obtain services in basic health, reproductive health and family planning from a single service point, though recent studies of consumer preferences by a number of agencies have shown that the people of Bangladesh want “one-stop service”.

Essential service package
To satisfy the needs of the most vulnerable in the society—women, children and the poor—it has been decided to develop, in the Health and Population Sector Programme (HPSP) 1998–2003, an essential services package (ESP) for phased implementation. The ESP will be delivered through different levels of the primary health care system (community, union, thana and district). It is stipulated that the provision and use of ESP services will attain the HPSP objectives.

The ESP aims to maximize health benefits relative to per capita expenditure, meet felt needs of the clients, strengthen service delivery and improve system management. The elements of ESP are grouped into five major areas: reproductive health care; child health care; communicable disease control; limited curative care; and behaviour change communication.

The ESP delivery strategy is to establish community clinics that will provide one-stop community-level ESP services in a consistent location for easy access at the time of need. Thus, a much more comprehensive range of services can be provided. ESP is to be delivered on the thana [sub-district] level and below, with referral care at secondary and tertiary levels.

The ESP will be a client-oriented service. Client orientation will require a shift in attitudes from serving the system to serving the people for whom the system is designed. This change will motivate the behaviour of both the providers and the managers. Client focus cuts across several areas of concern: coverage and quality of services; cost-effectiveness; and accountability.

At the thana and below, the ESP delivery will be through a unified structure comprising health and family planning workers under a single manager, responsible for the overall management and administration of all activities.

Relevance of the five-star doctor
The doctor who will be the proposed thana manager should be a “five-star doctor”. The concept of the five-star doctor was proposed by Charles Boelen of WHO. According to Dr Boelen, the front-line doctor of tomorrow, who will serve the needs of all health systems and services, should play the following principal roles:

★ Care provider: who considers the patient holistically as an individual and as an integral part of a family and the community, and who provides high-quality, comprehensive, continuous and personalized care within a long-term relationship based on trust. To deliver ESP efficiently, the doctor should try to provide as much care as possible to his patient from one site.

★ Decision-maker: who chooses which technologies to apply, ethically and cost-effectively, while enhancing the care he or she provides. The doctor is the decision-maker in the case of ESP delivery, who decides whether he or she can...
Family practice and health system evolution

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Balance is important: Who would disagree with a balanced diet of animal protein, complex carbohydrates, leafy greens and yellow vegetables and fruit? A healthy lifestyle balances work, exercise, recreation, rest, and family life.

Health systems out of balance
Health care systems, too, need to be balanced. Many are, but some are seriously out of balance, focusing too heavily on hospital and specialist care, giving scant emphasis to front-line primary care.

In such health care systems, tertiary and secondary care consumes a large proportion of the resources, depriving the primary sector, although it usually caters for most of the population. This imbalance is seen even in some developing countries where most of the people live in rural areas and depend almost entirely on primary care. Achieving balance in such situations requires major enhancement of the primary care sector.

There are a variety of primary care providers, among whom family doctors comprise a large proportion. The World Organization of Family Doctors (WONCA) has 63 member organizations, the individual membership of which totals 140,000. Add to this the family doctors in countries where WONCA is not yet represented, such as in Central and South America and much of Africa and Eastern Europe, and the number rises to well over 200,000.

Family doctors, who provide primary care for people in community settings, are valued by the people and communities they serve, but often not to the same extent by academe, health planners and governments, who too often favour high-profile, high-tech hospitals and specialists. Hospitals are visible status symbols—monuments attractive to politicians. In contrast, family doctors provide low-tech care in modest settings that attract little attention. Yet this care is essential to balanced health care systems.

The need for family doctors
Family doctors need to be able to manage any problem that presents and therefore require a broad range of general knowledge and skills. Because some problems present frequently, such as respiratory

provide the care needed or to refer the patient.

Communicator: who is able to promote healthy lifestyles by effective explanation and advocacy, thereby empowering individuals and groups to enhance and protect their health. Behaviour change communication is a cross-cutting intervention that will use the facilities of the rapidly expanding communication networks in Bangladesh and the growing capacities for planning, designing and implementing comprehensive, highly effective communication programmes. To realize this component of ESP, the doctor should be a very good communicator.

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 actions on behalf of the community. Rural ESP will be delivered through community clinics. Community participation is essential to ensure the service, which means involvement and participation of the community in designing, planning, monitoring and helping to implement the programme. Here the role of the doctor will be that of community leader.

Manager: who can work harmoniously with individuals and organizations inside and outside the health care system to meet the needs of patients and communities, making appropriate use of available health data. ESP delivery depends on the teamwork of a team comprising personnel from the health and family planning sectors. The doctor is the manager of the team. For effective and efficient health services delivery, the doctor must execute this managerial role properly.

In Bangladesh today, clients want the health system to very efficiently deliver one-stop service in minimum waiting time with a harmoniously working health services team. They therefore expect the ESP delivery system to be staffed by five-star doctors.

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and cardiovascular problems, hypertension, diabetes, arthritis and psychological and family problems, they need knowledge in depth in these areas. Most people with these complaints are managed almost entirely by their family doctor.

People and their problems are managed in the context of the family and the community. The family context is central to the understanding and management of so many problems. Family doctors build up a relationship of trust and confidence with people and families that they use diagnostically and therapeutically. The doctor-patient relationship is central to family practice, and indeed to the whole of medicine.

Longitudinal care, too, is a central element of family practice. Many illnesses can be understood only over time. The high level of chronic illness now present in most communities demands continuing care for long periods.

Because family doctors provide care to a broad practice population, they are able to monitor the health of the populations they serve and take anticipatory action to improve it. They use the opportunities that exist in community practice for health promotion, preventive care, patient education and rehabilitation. They take an approach to health care that puts into practice the principles of systems theory, which expresses the interrelatedness of biological, psychological, family, occupational, social, economic, community and environmental factors.

Because in family practice a low-tech approach is the norm, the costs of providing care are modest. A study by Starfield published in 1994 showed that: ‘At least among western industrialized nations, a primary care orientation of a country’s health care system is associated with lower costs of care, higher satisfaction of the population with its health care services, better health levels, and lower medication use’ (Starfield, 1994).

The case of China

Family doctors have a central role to play in every health care system. Where they are not available, their absence results in overloading of tertiary and secondary care facilities, and high-cost care, which is often inappropriate for the problems that present. China is an example.

In China, the primary care sector, staffed by health workers with little training, is not highly regarded and is therefore bypassed by many for the secondary and tertiary sectors, where doctors provide most of the care. Realizing that this situation is too costly and not effective for many health problems, the health authorities in China have embraced the concept of family practice as the basis for their health care system for the 21st century. The consequent large number of family doctors needed is a huge challenge.

The Capital University of Medical Sciences in Beijing has already established a training programme in family medicine. In the provinces, where most of China’s population lives in rural settings, there is much interest in family practice, but the meagre resources make it difficult to train the doctors needed. Moreover, since the economic downturn in Asia there has been diminished central government support. In the meantime, there is interest in applying the above-mentioned concepts of family practice through the existing system of health care workers.

A guide for developing family medicine

Recognizing the need for a practical manual of guidelines to assist those who wish to introduce family practice into their evolving health care system or enhance its influence, WHO and WONCA have embarked on a collaborative endeavour to produce such a guide. After preliminary meetings where the content outline was developed, writing has commenced, with a view to publication in 2000. The guide will include not just the expected description of undergraduate and postgraduate education, training and assessment, but will cover the anticipated obstacles and ways of overcoming them, and the political aspects, so important to the numerous stakeholders. It will be designed to give practical help and advice at every stage.

There are three purposes for this guide:

- To help leaders improve people’s health by reorienting health systems towards the goals of quality, equity, relevance and cost-effectiveness.
- To help leaders understand the role of family practice in this effort to reorient the health system.
- To help leaders make decisions for the development of family practice in their country or region.

The guide is being designed to assist international consultants (organizations and institutions) who are responding to requests for family practice assistance, ministers of health and other policy-makers who want to reorient their health system, and pioneers/leaders who want to develop family practice as a means of reorienting the health care system.

It will be yet another step on the path of health for all through primary health care.

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Health care reforms in the Philippines: the contribution of family physicians

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Introduction

The decade of the 90s saw the introduction of health care reforms in apparent response to the failure of the health care delivery systems of several or nearly all countries to appropriately respond to the health needs of the people. Ranging from the provider/purchaser split in the United Kingdom to the Bamako Initiative, the user fees revolution and the rise of “managed care” in the United States, health reforms enveloped the whole globe. And the Philippines was no exception.

The idealism of their purpose and the difficulty of their implementation characterize health care reforms in the Philippines. From the devolution of primary health services to local government units (LGUs) in 1992 to the institutionalization of a national health insurance programme in 1995 and up to the present, the country’s health care system has been in flux as various stakeholders strive to identify new roles in the system. And in this flux, Filipino family physicians have played and should continue to play the role of drivers to make the reforms work.

The Filipino family physician and the family

The Philippine Academy of Family Physicians and the Department of Family and Community Medicine of the University of the Philippines led the development of the field of family medicine in the Philippines. The Academy organized continuing medical education for family doctors, introduced a system of evaluation and accreditation of members, and instituted a system of evaluating and accrediting residency programmes.

On the other hand, the Department pioneered residency training in family medicine. It also introduced various innovative curricular additions such as behavioural science, family systems theory, counseling, hospice care, evidence-based family medicine and family wellness.

Together, the Academy and the Department have guided the growth of Filipino family physicians towards not only taking care of the family but using the inherent strength of the Filipino family in addressing their health needs.

Indeed, the family continues to play a big role in the life of every Filipino. The family is not only the smallest unit of society and the centre of human development, but is also the top priority in the hierarchy of needs of Filipinos. With various challenges from urbanization, industrialization, increasing migration of Filipino workers, psychosocial problems, mental health concerns and the traditional scourge of infectious diseases and lifestyle-related diseases, Filipino families more than ever need the family care a Filipino family physician provides.

But this care should be made in consonance with the ongoing changes occurring in the country’s health care system. Family physicians should not just contribute to health reforms, but should be drivers of reforms. And as the five-star physician, as espoused by both the Academy and the Department, family physicians have contributed to health reforms.

The five-star family physician

Inspired by the five-star doctor described by the World Health Organization as a care provider, decision-maker, community leader, communicator and team member, five roles have been identified for family physicians. The roles and their corresponding responsibilities are as follows:

★ Health care provider: He or she provides family-oriented care. He or she provides promotive, preventive, curative and rehabilitative care and acts as the gatekeeper of health care. Conscious of the need for quality of care to be given to patients and their families, he or she participates in quality improvement projects.

★ Counselor: He or she listens, clarifies doubts, helps facilitate resolution of problems and reassures patients and their relatives.

★ Teacher/educator: He or she advocates a healthy lifestyle and ensures compliance through education. He or she not only disseminates information to patients but is also a role model to residents and medical students.

★ Researcher, scientist and lifelong learner: He or she practises scientific clinical decision-making. He or she is committed to continuing professional development and quality assurance. In essence, he or she is committed to continuing lifelong learning and the conduct of research.

★ Community leader: He or she goes beyond the four walls of the clinic and hospital by being involved in community issues such as environmental protection, the campaign against smoking, responsible parenthood, child survival and safe motherhood and other issues with an impact on the community. By moving people to support a worthy
cause, he or she becomes a social mobilizer.

And in these five roles, family physicians have contributed and will continue to contribute to health reforms in the Philippines.

Family physicians and health reforms

The devolution of health care services to local government units led to the need for new skills for both the rural health physician and the district hospital physician. Driven by the five-star philosophy, several graduates of the Department and the other family medicine residency training programmes nurtured by the Department have become rural health physicians. The Department also trains and enhances the professional growth of these doctors. And with the Academy, which has become a sort of mother professional association of these doctors, devolution has been sustained.

Devolution can fail if the service providers cannot provide the services expected from them. The five-star family physician has shown that they can fulfill the needs of devolution. The continuing challenge is for the family physician to be the health service provider or impart the five-star philosophy to the non-family medicine service provider.

The national health insurance programme is a recently implemented policy that is presently suffering growing pains. Before family physicians had played a major role in the programme, experience from other countries had shown the very crucial role of family physicians to the success of a national health insurance programme. The institutionalization of family physicians as gatekeepers should be strongly advocated.

The growing acceptance of traditional and/or alternative medical modalities in the country has led to the passage of a law giving them tacit admission. As the medical field that looks beyond the biomedical model and takes social and cultural considerations into account, family medicine can best lead the integration of traditional and/or alternative medicine. It is also in the position to prevent abuses that may accompany these modalities.

In the end, as family physicians grow into their roles as five-star physicians in the care of the Filipino family, they will contribute to health reforms in the country. They will be drivers of reform. Consistency with the five-star physician role will ensure that this contribution and impetus lead to a more responsive health care system for Filipinos.

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Coming soon

Available from May 2000 will be the seventh edition of WHO’s World directory of medical schools: xiv + 441 pages, ISBN 92 4 150010 7 (WHO Order No. 1157268). The Directory contains information on 1641 medical schools in 157 countries. Anticipated prices will be: CHF 45.00, USD 40.50; the price in developing countries will be CHF31.50. Addresses of national WHO distributors can be requested from <publications@who.int> or can be found on the WHO publications electronic catalogue Web pages: <http://www.who.int>.

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Medical meetings held throughout the world frequently produce voluminous proceedings that are widely distributed and infrequently read. When a meeting produces a document that is extraordinarily widely used and helpful towards meeting the original goals of the conference, there is reason to take note. A working paper of the World Health Organization and the World Organization of Family Doctors entitled *Making medical practice and education more relevant to people’s needs: the contribution of the family doctor* is such a document. Indeed, this document and the initiatives that have resulted from its publication have done more towards the development of the family doctor throughout the world than has any prior document.

**A historical event**

The preamble to the executive summary of this document includes the following statement:

To meet people’s needs, fundamental changes must occur in the health care system, in the medical profession and in medical schools and other educational institutions. The family doctor (general practitioner/family physician) should have a central role in the achievement of quality cost-effectiveness and equity in health care systems. To fulfil this responsibility, the family doctor must be highly competent in patient care and must integrate individual and community health care. The cooperation between the World Health Organization (WHO) and the World Organization of Family Doctors (WONCA) towards this vision is historic.

From November 6 to 8, 1994, WONCA and WHO convened a strategic action forum in London, Ontario, Canada, involving 60 government health officials, medical educators, family doctors and public representatives from around the world. The purpose of the meeting was to identify specific actions to make health care, medical practice and medical education more relevant to people’s needs, thereby contributing to the health-for-all goals.

The 100-page report of this meeting analyses challenges for health care systems, medical practice and medical education. It emphasizes a vision of changes in the health structures of all the countries in the world. The fifth and final chapter contains 21 specific and forceful recommendations for action to build a publicly responsive health care and medical education system. These recommendations contain suggestions for action by medical schools, medical associations, governments and many other relevant bodies.

**Global follow-up**

The planning and editorial committees that worked on this joint WHO/WONCA working paper determined from the beginning that this would not be a project or exercise that would become dormant in the near future. Strategies for implementing the 21 recommendations outlined in chapter 5 were developed, including additional key conferences, new initiatives, special reports and survey-related activities. A detailed explanation of progress related to these strategies was to be composed, and edited by Dr Mark Rivo of the USA.

The life of this document has been dynamic rather than dormant. Nearly 10,000 copies have been printed—in English, Spanish, Portuguese, Chinese and most recently in Russian. The document has been distributed to all ministries of health and all medical schools of all countries of the world. It has been used in personal meetings between representatives of family practice organizations throughout the world as they have met with ministries of health in discussions of health care reform and the role of the family doctor towards improvement of health for all. The individual recommendations have assisted health care planners and medical educators in the development of specific plans for the training of family doctors in many countries.

Following the original WHO/WONCA conference in the autumn of 1994, additional regional and “specific topics” conferences have been held in Argentina, Cuba, Korea, Switzerland and the United Kingdom. The conference in Argentina, entitled “Family medicine and health care reform in the Americas”,

**Dr Daniel J. Ostergaard**
resulted in the Declaration of Buenos Aires, which adapted many of the original 21 recommendations for appropriate use in Central and Latin America as well as the Iberian Peninsula.

In 1995 the World Health Assembly adopted resolution WHA48.8, “Reorientation of medical education and medical practice for health for all”, and called upon WHO and its Member States to undertake coordinated reform of health care and, necessarily, education of physicians and health care workers. This resulted in several reports, surveys and publications, most often coordinated by the WHO Department of Organization of Health Services Delivery (OSD).

A major survey currently under way is the “World survey of family medicine and general practice”, being undertaken by WHO and WONCA. This survey will assess development and status of general family medicine and its contribution to health development worldwide.

That a report written nearly five years ago has enduring and expanding impact is a tribute not so much to its framers but to the principles and philosophies it articulates and the recommendations it makes. Ministries of health, professional associations and medical education establishments throughout the world have used these principles and recommendations to define and refine their plans for health care system reform and change in medical education.

Perhaps eventually the original document will be lost in favour of the refinements, updated reports, translations into other languages and permutations tailored to meet the needs of specific countries. If so, all is well if there is continued progress towards encouraging the contribution of the family doctor in making medical practice and education more relevant to people’s needs.

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Making medical practice and education more relevant to people’s needs: the contribution of the family doctor is available in English on request from the Department of Organization of Health Services Delivery, World Health Organization, 1211 Geneva 27, SWITZERLAND or from the World Organization of Family Doctors, Locked Bag 11, Collins Street East Post Office, Melbourne, Victoria 8003, AUSTRALIA. For copies in Chinese, Portuguese, Russian or Spanish, please contact WONCA.

Seeking new ways to employ GPs:

Can an oil-spots strategy succeed?

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**Medical workforce mismatch**

Once again, the old story of imbalanced production of doctors was experienced in Iran, as in many developing countries.\(^1\) The number of medical faculties jumped from 9 in 1975 to more than 54 in 1995. Accordingly, the number of medical students rose from 6099 to 40 162. This represented a 10% growth rate in production of doctors per year. In 1998, more than 37 700 GPs and 18 300 specialists were working in the market; it is estimated that the total number of physicians will reach 70 000 by the year 2002.\(^2\)

The policy-makers’ primary goal was to produce enough doctors to meet health needs at the national level, but their target was only the raw index of one doctor per 1000 people, irrespective of the cultural considerations, socioeconomic factors, the inefficient health service system that cannot absorb the overflow of doctors and the future “changes”, etc. Studies have shown that the quality of medical education has been sacrificed to quantity. The medical faculties have sought primarily to produce more doctors, but many universities still lack the expert human resources to educate them.

Although the universities of medical sciences are also responsible for the delivery of health services to the people, they cannot employ their own products—the young GPs—even in their own vicinity. The labour market for GPs is being saturated even in the more deprived areas.

**General constraints**

Major factors leading to the above situation may be as follows:

- People do not have a regular personal physician they know and with whom they have sustained a relationship over time. They often approach any accessible doctor, whether a specialist or a general practitioner. Only a few patients are referred by doctors.
- The health of families is not addressed by both the health system and the family members themselves.
- People are not directed to the appropriate medical services, nor
are they well enough informed to approach the appropriate services on their own.

- The coming change in needs, which directly reflects the effective demand for health services, is overlooked.
- The economic factors affecting demand for health services are not noted, but these play an important role in determining the family's demand basket.
- Medical education is not yet sufficiently community-oriented.
- Health insurance organizations are not well enough engaged in medical and preventive services to support the demand.
- Doctors compete for patients to increase their income.

**Educating society**

The above facts were discussed within our university. It was concluded that the major problem in health is the cultural habits of the people. People should be encouraged to use doctors' services appropriately. But changing people's attitudes towards regarding GPs as family doctors is difficult and may not happen in the short run. Moreover, GPs have not been trained to function in the role of family doctors.

We must therefore act on both sides of the supply/demand equation:

- Develop family physicians.
- Change people's use of doctors.

But how can these be done? Our resources are limited and legal formalities constrain us.

We decided to use what might be called an oil-spot strategy: we would start in one place and spread out from there, much as an oil spot spreads on a surface.

With this strategy in perspective, we surveyed the communities in the Qazvin region—a developing city of 600,000—in order to find some areas we could influence. We also tried to identify competent young GPs to be trained as family doctors.

We decided to proceed cautiously. It is expected that the family doctors will be responsible for the health of whole families and will encourage family members to seek health services. We believe that word-of-mouth contact will be an efficient and effective means of influence, once people receive satisfactory services from the family doctors. We hope that by this strategy the GPs will be working in the right direction and that at the same time the demand for medical services will be reoriented appropriately.

How will these expectations be met? The future will tell us.

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**References**


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**Lessons learnt at WHO by a prospective US family physician**

Michael Coffey, University of Cincinnati College of Medicine

This article was contributed by Michael Coffey, who wrote it during a nine-month internship in the Department of Health Systems (now the Department of Organization of Health Services Delivery) of the World Health Organization. He is now finishing his fourth year of medical school at the University of Cincinnati College of Medicine.

As my internship at WHO draws to a close and I prepare to return to the USA to finish medical school, I find myself reflecting on all that I have learned this year. During the eight months I’ve spent here, I have come to recognize some important aspects of a model health care system and the ways in which WHO is trying to make this model a reality. My experience this year working on various projects and listening to visiting speakers has allowed me to compare the US system to this model, and to envision the type of system in which I hope to practise after I become a doctor.

Through my involvement in the “Towards unity for health” (TUFH) project, I have seen the need to link the health care of communities and individuals. TUFH seeks to study and promote worldwide efforts to create unity in health services organizations, particularly through the integration of medicine and public health. It also advocates the
formation of active partnerships between the different health care stakeholders. I agree with its tenet that governments, professional associations, academic institutions and provider organizations like health maintenance organization (HMOs) need to share a common goal to act on priority health concerns of individuals and populations.

I have also seen that the merging of individual and community care is an important component of community-oriented primary care (COPC), a health-planning process that blends primary care and preventive measures with epidemiology to determine factors that affect the health of the community. COPC aims to define the relevant issues facing a community, prioritize those issues, develop and implement strategies to address the priorities, and evaluate the strategies to continually make the process better and more cost-effective.

At my own medical school, this concept is taught and used in the Department of Family Medicine. Seeing the model’s success in a large university group practice has been an important part of my training and has helped me define the type of practice I want to have.

In studying health systems of various countries from around the world, I have seen the need for a balance between biomedical and social dimensions in health programming and practice. The US system already has a strong focus on biomedical dimensions, but its decision-makers in health care need to put more emphasis on the social ones. Physicians especially should not neglect these aspects, because there are many social problems—such as alcoholism, stress and depression—that have a great impact on a person’s well-being, particularly when one looks at WHO’s broad definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". My belief in the importance of social dimensions has, in part, inspired me to pursue a career in family practice.

By working with the social accountability model put forth by Dr. Charles Boelen, WHO, and Dr. Jeffery Heck, University of Cincinnati, I have seen that health care providers and organizers need to promote quality of care. Donna Shalala, the US Secretary of Health and Human Services, recently emphasized the importance of these two aspects when she spoke in a presentation at WHO about the Advisory Commission on Consumer Protection and Quality in the Health Care Industry. This commission, which brought together consumers, businesspeople, health plan managers, doctors and government officials to talk about quality, came to a consensus that the USA needs a “national commitment to quality improvement”. It also recommended that "steps should be taken to ensure that comparative information on health care quality is valid, reliable, comprehensible, and widely available in the public domain".

My internship at WHO has been both formative and instructive; I want to build on the research and health systems experience I have gained this year and become an academic family physician. I feel that in this type of position I can best practise the type of medicine I have come to view as ideal: one that embodies a balance of research, public health and high-quality patient care.

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Publications

The publications listed below are recommended as particularly relevant to the “Towards Unity for Health” initiative and to coordinating changes in health services and health professions practice and education. Some of them can be obtained free of charge.


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Dear Reader,

Towards Unity For Health: Coordinating Changes in Health Services and Health Professions Practice and Education is the World Health Organization newsletter that succeeds Changing Medical Education and Medical Practice, which was published from June 1992 through December 1998.

This new newsletter reflects an enlarged scope, consistent with WHO’s policy for developing new alliances and partnerships among educational institutions, health professions, health managers, policy-makers and communities to ensure sustainable improvement of quality, equity, relevance and cost-effectiveness in health interventions. Topics relative to health professions education and practice will continue to be addressed, along with other issues in health services development and health system changes.

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I hope this new WHO newsletter will be as well received as Changing Medical Education and Medical Practice, and that through topics of shared interest, collaborative links will be strengthened worldwide.

Yours sincerely,
Dr Charles Boelen
Editor-in-Chief, Towards Unity for Health

Please note: The newsletter Towards Unity for Health will systematically be sent to all WHO Representatives, WHO regional offices and WHO collaborating centres and to international NGOs in official relations with WHO. These recipients therefore need not confirm their wish to continue receiving the newsletter.

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For your urgent attention, please
Are Sri Lankan medical schools socially accountable?

Nimal D. Kasturiaratchi, Faculty of Medicine, University of Peradeniya

A n international meeting, “Towards Quality in Medical Education: Partnerships for Action”, was held in Kandy, Sri Lanka, to mark the 25th anniversary of the WHO Regional Teacher Training Centre (Medical Education Unit) at the Faculty of Medicine, University of Peradeniya. The Minister of Health of Sri Lanka used the opportunity to identify what he called “some of the issues in medical education that need consideration by the medical professionals in Sri Lanka”.

While complimenting the excellent technical training offered by medical schools in the country, the minister was critical of the medical profession for its lack of social responsibility. He referred specifically to the failure of the Post Graduate Institute of Medicine to formulate a policy regarding specialist requirements for the country, as well as to the reluctance of doctors to serve the underserved areas, compartmentalizing the health system by marginalizing the Ayurveda medical system and the inability of the educational system to recognize the pedagogical importance of non-university health personnel in the training of physicians. (1)

Such words from a person who is a politician—a representative of the lay public—and the person who bears considerable responsibility for the health of the nation should have attracted the attention of all Sri Lankan health professionals. The minister’s point was that physicians should ask themselves how they respond to people’s health needs. He was asking the medical profession to be creative, pragmatic, courageous and determined to venture outside the usual boundaries. (2)

The concept of social accountability

Venturing outside the usual boundaries can yield social accountability, a concept based on the four values of relevance, quality, equity and cost-effectiveness. (3) The minister’s plea was also a reference to a particular value portfolio in the country’s health scene.

In the scenario described by the minister, quality of care seemed to be preferred to equity of services rendered. And there was less concern with the cost-effectiveness of the services and overall relevance in planning human resources deployments. In sum, there seemed to be a bias in the overall accountability by the medical education system in responding to societal needs demonstrated by the skewed emphasis of certain values. The concept of social accountability as applied to medical educational institutions entails that service, research and education rendered by the institution incorporate the four values mentioned above. The traditional triad (education, service and research) of functions of a medical faculty should, in order to demonstrate social accountability, be evaluated by the extent to which they take relevance, quality, equity and cost-effectiveness into account.

All Sri Lankan medical schools are government-owned and are under the Ministry of Higher Education. However, they provide valuable service functions at assigned teaching hospitals, furnish expertise to the general health care scene and are involved in research and in undergraduate and postgraduate teaching. As institutions, however, the extent to which they move out of this traditional agenda to actively engage in issues of securing equity, promoting cost-effectiveness in the provision of health care to designated populations or are involved in sustaining and promoting quality is rather questionable.

Internal and external factors

This observable “closed” nature of medical schools is determined by many factors. Within medical schools two key features seem to perpetuate the lack of initiative to break away from the traditional teaching contexts and involve the students in more active service and research performed by the teachers within the social accountability paradigm.
One of these is the workload of undergraduate teaching resulting from increased intake of students without considerable expansion in trained human resources. The second is mostly attitudinal, in that most teachers shy away from engaging in collaborative work with external agencies that are also components of the national health system.

Similarly, many factors external to university environments limit the involvement of a given medical faculty with the regional and national level, servicing, planning, monitoring and evaluation of health care delivery. Placing medical faculties under the responsibility of the Ministry of Higher Education makes accountability beyond the patient care operating within the private space almost impossible.

Although the health care delivery system in Sri Lanka is decentralized to the provinces, the universities are national institutions. Although the health system has been decentralized, the teaching hospitals are not, and they come directly under the health ministry of the central government.

Public accountability for health in a given province where there is a medical faculty is therefore torn among the university, the provincial health authority and the Ministry of Health of the central government. Within this complexity, invitations for the university’s involvement in health as an accountable agency are unrealistic.

References

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Global issues for medical educators
Nancy E. Gary, Educational Commission for Foreign Medical Graduates, Philadelphia

After four years as President of the Educational Commission for Foreign Medical Graduates (ECFMG), I have had considerable opportunity to meet with medical educators and ministers of health and to attend international meetings on a variety of subjects. I have also visited several medical schools abroad and met with the administrators and faculty.

The diversity among schools in admissions processes, educational methodology and evaluation is quite interesting. I am also impressed by the commonality of medical educators’ concerns worldwide about the best preparation of those who will care for the ill members of society and prevent illness and injury to others. Faculties seem committed to enriching and enhancing their educational programmes to keep them contemporary.

Common issues for medical educators include the following:
- The careful assessment of the local, country or regional health needs of those whom medical school graduates will serve. The results of this kind of analysis can be translated back to the medical school and woven into the fabric of the undergraduate and postgraduate curricula.
- Preparing medical students for the environment in which they will practise as physicians. Some schools have included instructional experiences in remote, sparsely populated areas served by a district health officer, clinic or hospital far from the high technology and specialist-oriented university hospital. Delivery of health care to people residing in densely inhabited urban locations is part of the educational experience in some medical schools.
- Another topic under discussion is how the medical school can best serve its immediate community. Most schools provide care to the sick and injured. Attention by the academic faculty to illness prevention and public health may require collaboration with local officials in government, health and education.
The faculty’s conduct of biomedically relevant research can also yield results that will benefit not only the local community but also the world’s population.

Internationally, medical educators are working to enhance the evaluation of students’ acquisition of knowledge, clinical judgement, behaviour and skills to better assure their preparation to be physicians.

Finally, I have observed a worldwide interest in discussion of the matter of globalization of medical education, perhaps through the setting of some international standards or an accrediting process that would require establishment of standards for the educational programme. The diversity in medical education and differences among countries, regions and hemispheres would have to be taken into account. Most importantly, the needs of the people to be served must be paramount. Several countries have been enhancing their systems for accreditation in recent years. The ECFMG has provided consultation to Malaysia to assist that country as it worked towards enhancing its system of health professional school accreditation. Perhaps it is time to formalize these discussions about international standards and accreditation through conferences with global representation.

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Quality assurance and accreditation: Where do they meet?
Alistair Stewart, University of Dundee

Introduction
Accreditation has been an issue in medical and other health professions education for longer than that of quality assurance, and continues to be very important, particularly as ideas in global accreditation and standards are explored. Quality assurance has assumed a new importance in recent years as governments around the world have held health professions schools accountable for the quality of preparation of doctors, nurses and others [endash] particularly those who, it is claimed, are being trained to meet the health care needs of the society they will serve.

The processes of accreditation and quality assurance are similar, and many institutions object to what appears to be duplication of effort in satisfying the requirements of both. Surely it must be possible to develop a model that would allow both processes to be undertaken and the requirements of each to be met, without duplication of effort?

The accreditation process
In many countries accreditation of courses and, by implication, professional standards for health professionals are, by statute, the responsibility of the respective professional bodies. Professional bodies tend to be concerned primarily with the maintenance of standards, since the reputation of the profession as a whole is at stake.

To be able to assess standards, professional bodies must, of course, concern themselves with the curriculum, the teaching and learning environment, and the assessment of students. With respect to the curriculum, they will want to assure themselves that it is up to date, but the criteria for determining this could be quite subjective. With respect to the teaching and learning environment, they will want to assure themselves that the facilities are good, that the student/staff ratio is acceptable, and that opportunities for learning extend beyond the confines of the institution, particularly to clinical settings. With respect to the assessment of students, they will want to assure themselves that the pass marks are not too low and that the pass rate is of an acceptable level.

The quality assurance process
Quality assurance has connotation of “fitness for purpose”, so it is appropriate to ask whether the teaching and learning in an institution are equipping the students to meet the requirements of their future
employment. In other words, as far as medical and other health professions education is concerned, are these students going to be able to deliver the kind of health care that society needs and expects?

The quality assurance process is therefore concerned not only with teaching and learning; it is concerned with an institution’s approach to what is being learned, how it is being learned, and whether it has been learned. The QA process is concerned with the curriculum and the procedures that are gone through in determining what that curriculum should be; with the teaching and learning environment and how the learning opportunities provided will enable the student to acquire the knowledge, skills and attitudes that underpin the competences required for the performance of health care tasks in professional practice; and with the assessment of students to ensure that they are, in fact, able to use these competences in practice for the benefit of society.

In the process of quality assurance, an institution must be able to demonstrate that it has an organizational structure conducive to the ongoing monitoring and evaluation of its courses; analysing performance indicators; obtaining feedback from students on their learning experiences; obtaining feedback from the employers of graduates on the appropriateness of the training received; analysing external examiners’ reports; accepting and responding to external inspection from relevant professional bodies; and, within a framework of staff appraisal and development, offering training to staff in educational issues.

So what’s the difference?
The processes of accreditation and quality assurance are very similar. Each is concerned with the curriculum, with teaching and learning, and with assessment. The difference is essentially in the perspective from which these issues are analysed and evaluated. Accreditation is concerned primarily with standards—but standards in relation to what? Quality assurance is concerned, inter alia, with fitness for purpose—but what purpose? This is where the respective perspectives come in. They can be quite different, but they need not be. Is it beyond the ingenuity of man that what a professional body is looking for and what a society is looking for can be reconciled?

Active response
At the Centre for Medical Education in the University of Dundee, staff and doctoral students are currently exploring the relationship between curriculum evaluation and quality assurance, including total quality management, and accreditation and credentialing. They are building up expertise that could be of crucial interest to health professionals around the world at a time when issues such as global accreditation are fairly high up on the agenda.

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Credentialing for the health professions: an international nursing perspective

Fadwa A. Affara, International Council of Nurses, Geneva

The role of the International Council of Nurses (ICN) in regulation

As a global advocate for nursing and health care, the International Council of Nurses has, from its inception in 1899, defined an important role in promoting effective regulatory systems. In the early 1980s, ICN developed and widely disseminated its position on regulation. The position and accompanying guidelines addressed the broad issues of professional regulation, including standards and models for regulating nursing education, practice and services (ICN, 1986). In 1996 the position was updated to take account of the changing health care environment.

For ICN the term regulation refers to “all of those legitimate and appropriate means—governmental, professional and private—whereby order, consistency, identity and control are brought to the profession. The profession and its members are defined; the scope of practice is determined; standards of education and of ethical and competent practice are set; and systems of accountability are established through these means” (Madden-Styles and Affara, 1997). Thus, the concept of credentialing is encompassed within this definition as it constitutes one major category of regulatory mechanisms, including registration, licensure, accreditation and certification.

Current credentialing challenges

As for all health professionals, lifelong learning and verified continuing competence are necessary to equip nurses for the ever-changing knowledge bases, technologies, roles and settings that characterize
today’s health care environment. Therefore, credentialing models must go beyond ensuring initial competence. They must also assess continuing, advanced and specialized competence. Moreover, in countries with advanced practice programmes, which prepare nurses for expanded and more autonomous roles, credentialing can be and is used to acknowledge and sanction these enlarged dimensions of practice.

In response to these new demands and to the dramatic new changes in nursing practice, various governmental forms of credentialing are being supplemented with credentialing developed by the nursing profession itself. For example, the American Nurses Credentialing Centre (ANCC), a subsidiary of the American Nurses’ Association, provides a range of accreditation and certification services. These include accreditation of continuing education providers, and recognition programmes for excellence in nursing services. According to the ANCC, it has certified 130,000 nurses in specific fields of nursing practice.

In the future, health care providers will increasingly work across traditional job and hierarchical boundaries. For the nursing profession, the growing demand to practise more autonomously and function within multidisciplinary and interdisciplinary environments presents new educational and regulatory challenges, including preparation for evolving and less restricted scopes of practice that may even overlap with those of other health professionals. Health professionals need to explore together the credentialing policies and practices that will respond to the changing face of all health practice, and create credentialing frameworks that promote collaborative practice.

The trend to globalization of the economy also presents challenges for professional credentialing. Regional treaties, and organizations such as the World Trade Organization, facilitate cross-border movement of persons and services as well as of goods. This development may raise standards in some jurisdictions, or lower standards or impose in appropriate ones in others. In addition, progress in telecommunication and information technologies is accelerating the growth of transborder education and health care services. Programme accreditation and jurisdictional issues such as recognition of qualifications, right to practise and legal liability are emerging and need to be addressed as globalization takes further hold and advanced technologies spread.

Questions related to what standards and whose standards will be applied, need to be resolved so that the free movement of health professionals and health services does not have a negative impact on the quality and safety of health care services. Broadly recognized credentials may become more important in facilitating the transfer of “expert authority” and practice rights from place to place. ICN believes that the globalization of services is an opportunity for health professionals to collaborate in developing accreditation frameworks and mechanisms for internationally provided education and health care services.

Future directions for credentialing: an ICN perspective

Current credentialing models need to evolve to remain pertinent. They will need to demonstrate a number of characteristics, including:

- the capacity to ensure continued competence, maintenance of safe health care practices and ongoing relevance and quality of education;
- the ability to provide opportunities for health professionals to demonstrate advanced areas of expertise with transferable credentials;
- an open-ended and dynamic structure able to adapt to the changing health care environment;
- the capacity for a direct role in credentialing for the professions;
- support for international credentialing services.

ICN is committed to moving in this direction. If populations are to receive skillful and knowledgeable health care, this must be done in partnership—within the nursing profession itself, with other health professionals, with private and public health care and educational agencies and with governments.

References


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A student’s view on social issues in medical education

Thiago Monaco, International Federation of Medical Students’ Associations

It is generally thought today that medical education is not meeting the expectations of students. The medical profession is influenced by the constant questioning of the role of the modern doctor in society. Students are not well-oriented when they start their studies, and, as a result, they are often not clear as to what they want from the profession, which now is more specialized than ever. At the same time, the need for general practitioners has increased sharply to meet social and community needs. Despite this dilemma, a good number of students remain idealistic about their medical studies, which is fortunate.

But the unmet expectations are important, given the diverse reasons that motivate people to study medicine and the costs involved. It is true that the medical labour market is not as empty as it was 40 years ago and many young doctors have problems finding a stable and well-paid job. Once into their studies, idealism can be blunted by the practical aspects of the profession, including the need to understand the reasoning of national health care systems—and we should not forget that, in time, responsibility for public health systems will be assumed by today’s students.

Medical education must also prepare doctors for health care delivery, to train future professors of medicine and to ensure lifelong learning opportunities for health professionals. The search for the best methods of education to meet social needs will ensure that medical education will be relevant.

Undergraduate medical education should prepare doctors through the traditional acquisition of academic knowledge, through the application of this to everyday practice and through training in medical ethics. Social values and responsibilities must underpin all medical studies, but even the best faculties and schools could do more in this area.

Often medical ethics is not taught at all, and there is strong emphasis on the biological sciences but little attention is paid to social medicine. Moreover, students today have to acquire a huge amount of specialized knowledge that is changing all the time. Thus, the curriculum and teaching methods must be constantly assessed and updated to keep pace with these developments.

For this and other reasons, students should participate actively in the governance and policy-making structures of their institutions. Students are usually aware of the issues affecting their education and of the trends in their chosen field. They also bring the perspective of youth to social questions, which should be recognized as an important input by institutional leaders.

Medical education should be much more attuned to the actual needs of society—that is to say, it should be problem-based, with early and regular contact with real patients. This implies a new role for the medical teacher, who would become more of a tutor or counselor in the future.

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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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