Health professionals meeting people’s needs: the example of the Janus Project
Highlighting the role of family physicians

Nick Busing, University of Ottawa, and Steve Slade, College of Family Physicians of Canada, Mississauga, Ontario, Canada

Adapting to diversity

The Canada Health Act, guided by its five basic criteria (public administration, comprehensiveness, universality, portability and accessibility), has helped foster a comprehensive and diversified health care system in Canada made up of physicians and other health care professionals. Canadians benefit greatly from the care they receive from family doctors, specialist physicians, nurse practitioners, midwives, dieticians/nutritionists, occupational therapists, chiropractors and others within the health system.

While the benefits of a diversified health care system are enormous, there are challenges in ensuring it works for the individual and the community. The roles played by health care providers can change over time and across space, accord-
Refocus

Charles Boelen, World Health Organization, Geneva

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hich issues are most likely to inspire those responsible for developing and strengthening health services delivery systems for improved quality, equity, relevance and cost-effectiveness? Trying to suggest an answer that would be universally applicable despite the wide diversity of socioeconomic and cultural contexts makes this exercise even more complex and risky.

The last three decades have witnessed the emergence of the notion of social justice in health service provision and advances in science and technology, a better-informed citizenry, and improved democratic governance and global communication. Now perceived is the need to refocus on what is of prime importance to effectively and sustainably respond to people’s priority health concerns.

In this context, instead of the question: “What is the only book you would take with you if you were to spend a year on an island with no contact with the outside world?”, we might ask: “Which are the only three areas of work on which you would concentrate in order to move furthest towards an efficient and equitable national health service organization?” If I were asked the question, my answer would be:

- Efficient primary health care services
- Mechanisms to meet standards
- Productive partnerships with key stakeholders

My guiding principle in pursuing all these would be that research and development would serve as both the search for evidence and for applicability to benefit a population.

Efficient primary health care services

It is probably fair to say that the expectations raised by the unparalleled worldwide commitment to the health development approach epitomized by “primary health care” have not been matched by results. One of many reasons is that the generosity and enthusiasm of those embracing the cause have not been sufficiently backed by strong organizational methodologies.

I would nowadays favour two streams of action: proper management of information for continuous assessment of needs and the effects of interventions on a population at decentralized level, and approaches to warrant optimal use of human resources in primary health care functions.

As I see it, investing on family medicine would be a priority, in as much as it favours working in multiprofessional health teams, is dedicated to individual health, is willing to widen its scope to population health and supports initiatives towards cost-effective and equitable services.

Family medicine as a discipline with its academic references is committed to methodological rigor in determining the most appropriate approaches to primary care practice in the wider context of health system development.

Mechanisms to meet standards

In a culture that increasingly recognizes the values of transparency, returns on investment, mobility of people and goods, and threats and opportunities of globalization, claims for excellence come from governments as well as from individuals.

An inventory of standards used by various national or international agencies should be compiled, followed by the promotion of standards recognized as best meeting the needs of societies.

Educational institutions should be accredited according to these standards, and mechanisms should be set up to assist these institutions to attain the highest possible level of excellence. Similar endeavours should be undertaken for health service organizations and for health professions.

To the extent that the specific health needs of countries are protected, standards and accreditation systems could be recognized internationally, and information on positive results of quality assessment widely disseminated.

Productive partnerships with key stakeholders

Because health has multiple determinants, it is obvious that sustainable health services will be achieved only through the active contribution of important stakeholders operating on the national health scene. Integration of services to better meet individual health needs and coordination with population health activities require that the different actors involved share a common vision and agree on a collaborative mode of work.

Policy-makers, health managers, the health professions, academic institutions and civil society, for instance, have their own references and work agendas. Each of them—to best use their potential to meet the needs of a given population, such as in the context of a primary care oriented-health system—will have to consider adjusting their scope of responsibilities.

New challenges but also new opportunities emerge, which require appropriate methodologies for reallocation of roles and negotiation, again in a spirit of research and development. The “Towards Unity for Health” approach is one of those.
TOWARDS UNITY FOR HEALTH, APRIL 2001

Informing the prevailing mix of health professionals. Diversified health care systems demand effective coordination. When such coordination is lacking, when roles and responsibilities are unclear and/or during times of health care reform, service delivery gaps can arise that lead to unmet health care needs.

Family doctors are key participants in Canada’s health care system. They comprise half of the physician workforce in the country (1) and most Canadians (78%) will visit a family doctor at least once a year. (2) No other health care provider group is so omnipresent on the health care scene. Through regular visits, and as the point of first contact, family doctors play a pivotal role in the delivery and coordination of health care services to Canadians.

**Information needed**

Yet the lack of information on how family doctors help to meet the health care needs of Canadians is striking. Comprehensive, national-level data describing family medicine practice has simply not been available to health care planners. As health service coordinators and because they usually live within the communities they serve, family doctors are well-placed to develop and implement innovative programmes that respond to community needs. This potential strength must become the focus of a national programme that supports family doctors in their efforts to address community-based needs.

In 1997 the College of Family Physicians of Canada began to address the need for better data and to support family doctors in responding to community needs by continued page 4

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**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.
launching the Janus Project: Family Physicians Meeting the Needs of Tomorrow’s Society. The two main thrusts of the project are the Janus Project Scholarship Programme and the National Family Physician Survey.

Janus scholarships support community-based family doctors in pursuing research projects or educational activities to help them better meet the changing needs of their patients and communities. Since 1998, Janus Project scholarships have been awarded to 16 family physicians from across Canada.

Many community health issues have been addressed, including appropriate antibiotic use and prescribing, family medicine education for complementary and alternative therapies, and the identification and removal of barriers in the recruitment of community-based clinical preceptors. An endowed fund, with a number of major contributors, has been established to ensure that family doctors are able to make a sustained contribution to the Canadian health care system for years to come.

Shaping policies

The National Family Physician Survey is designed to guide improvements to the health care system through the provision of relevant, up-to-date information on providers and patients needs. Survey data were first gathered in 1997/98 on a random, stratified sample. The resulting database is the first of its kind and contains data supplied by 3004 family doctors. Data elements include:

- Regular and on-call work hours in various clinical settings (e.g. private office, walk-in clinics, hospital emergency rooms)
- Service delivery within broad medical areas (e.g. obstetrical/maternity care, palliative care, HIV/AIDS care)
- Performance of specific clinical procedures (e.g. Pap smears, casting/splinting, anaesthesia)
- Patient populations served (e.g. aboriginal, elderly, inner-city and substance abuse populations).

The survey is being repeated in 2001. It will build on the earlier study by gathering information that will allow for direct comparisons of how practice patterns have changed since 1997/98. The 2001 National Family Physician Survey will also probe more deeply into areas that directly measure primary health care system performance. For instance, family doctors will be asked to report on:

- the extent to which their practices are open/closed to new patients.
- the ability of patients to gain access to a broad range of health care services, including specialist physicians, hospital beds, community care and diagnostic services.
- the extent to which family physicians deliver coordinated health care services to Canadians through facilities that are shared with specialist physicians, nurses and other health care providers.

As in the “Towards Unity for Health” (TUFH) project, the Janus Project seeks to find synergy between people’s needs and providers’ skills and help family doctors respond to community needs, with a goal of improving the quality of health care for all Canadians through a cost effective, rational system.

The CFPC has established specific goals that will make the 2001 survey more relevant to all of its potential users. First, all family doctors in Canada, rather than a sample, will be included in a census study that will map respondents to standardized regional health planning areas. Secondly, external databases will be used to produce population health indicators for those same health planning areas.

With these data we will, for the first time, be able to draw comparisons between community-level primary care services and the health status of Canadians. This new information will help to inform the work of policy-makers, health managers, health professionals, academic institutions and communities.

References


Nick Busing, MD, CCFP, FCFP; is the Chair, Janus Project Coordinating Committee; College of Family Physicians of Canada. He can be reached at the Department of Family Medicine, University of Ottawa; 43 Bruyère Street, Suite #375, Floor 3JB; Ottawa, ON K1N 5C8, CANADA (Telephone: +1 613 562-4262 ext.1610; Fax: +1 613 562-6336; E-mail: nbusing@scsos.on.ca). Steve Slade, BA, is the Janus Project Coordinator. He can be reached at the Department of Family Physicians of Canada; 2630 Skymark Avenue; Mississauga, ON L4W 5A4, CANADA (Telephone: +1 905 629 0900, ext. 289; Fax: +1 905 629 0893; E-mail: sas@cfpc.ca).
**Towards Unity for Health**: status report

**TUFH field projects**

A first set of 12 TUFH field projects was selected in January 2001, based on their potential and plans to adhere to pre-established criteria. Other TUFH field projects may enlarge this sample, on recommendations from the ad hoc international selection committee.

Selected TUFH field projects have received a WHO grant and will submit progress reports twice a year, according to a predetermined format. Lessons learnt from the analysis of these reports and from ongoing exchange of information among field projects will contribute to improving the body of knowledge and develop appropriate methodologies for creating unity in health, from the standpoint of policy as well as operationally.

A briefing seminar of 12 TUFH field project managers is scheduled to be held at the University of Illinois College of Medicine at Rockford, Rockford, Illinois, USA, 7 to 9 May 2001, to agree on a list of indicators to measure achievements and a standardized procedure for reporting progress. Fifteen resource persons will also attend, to help develop an evaluation kit for TUFH.

**Education on TUFH**

Learning modules relative to the TUFH approach will be developed, targeting specific categories of health personnel. Four areas will be emphasized:

- **Fragmentation in the health service delivery system: assessment, implications, opportunities for change**;
- **Creating unity: organizational patterns of services integrating medicine and public health; a comprehensive health information management system**;
- **Knowing the partners: strengths and weaknesses of the main**

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<tr>
<th>Region and country</th>
<th>Title of project</th>
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<tr>
<td><strong>AFRICA</strong></td>
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<tr>
<td>Kenya</td>
<td>Project-linked innovative management by integrative-participatory research approach (PIMIRA)</td>
<td>Dr Solomon M. Nzioka, Faculty of Health Sciences, Moi University, Eldoret, KENYA (E-mail: <a href="mailto:nzioka_sm@yahoo.com">nzioka_sm@yahoo.com</a>; <a href="mailto:medfaclib@net2000.ke.com">medfaclib@net2000.ke.com</a>).</td>
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<tr>
<td>Nigeria</td>
<td>Community empowerment for health financing and co-management</td>
<td>Dr Akin Osibogun, College of Medicine of The University of Lagos, Lagos, NIGERIA (E-mail: <a href="mailto:akinosibogun@excite.com">akinosibogun@excite.com</a>).</td>
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<td><strong>AMERICAS</strong></td>
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<tr>
<td>Brazil</td>
<td>Rural Internship and Family Health: A compromise for “Towards Unity for Health”</td>
<td>Dr Francisco Campos/Professor Geraldo Cunha Cury, Faculty of Medicine, Federal University of Minas Gerais State, Belo Horizonte, Minas Gerais, BRAZIL (E-mail: <a href="mailto:camposfr@medicina.ufmg.br">camposfr@medicina.ufmg.br</a>; <a href="mailto:gcury@medicina.ufmg.br">gcury@medicina.ufmg.br</a>).</td>
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<tr>
<td>Brazil</td>
<td>A strategy for integrating education and services in family health</td>
<td>Professor Ellen Marcia Peres, Rio de Janeiro State University, Rio de Janeiro, BRAZIL (E-mail: <a href="mailto:ellenperes@openlink.com.br">ellenperes@openlink.com.br</a>).</td>
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<tr>
<td>Canada</td>
<td>Integrated cardiovascular health programme: a commitment for “Towards Unity for Health”</td>
<td>Dr Paul Grand’Maison, Faculté de Médecine, Université de Sherbrooke, Sherbrooke, Québec, CANADA (E-mail: <a href="mailto:pgmaison@courrier.usher.ca">pgmaison@courrier.usher.ca</a>).</td>
</tr>
<tr>
<td>United States of America</td>
<td>Towards unity for health in the Greater Rockford area</td>
<td>Mr Raymond W. Empereur, Rockford Health Council, Rockford, Illinois, USA (E-mail: <a href="mailto:RayEmp@aol.com">RayEmp@aol.com</a>).</td>
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<td><strong>EASTERN MEDITERRANEAN</strong></td>
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<td>Morocco</td>
<td>Towards unity for the health of diabetic children</td>
<td>Dr Amina Balafrej, Rabat, MOROCCO (E-mail: <a href="mailto:vxakir@elanonline.net.ma">vxakir@elanonline.net.ma</a>; <a href="mailto:mktiri@cms.org.ma">mktiri@cms.org.ma</a>).</td>
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<td><strong>EUROPE</strong></td>
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<tr>
<td>Czech Republic</td>
<td>Integrated community health care in the Czech Republic</td>
<td>Dr Jana Zrej_ková, Institute for Postgraduate Medical Education, Prague, CZECH REPUBLIC (E-mail: <a href="mailto:krejkovak@dpzc.cz">krejkovak@dpzc.cz</a>).</td>
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<tr>
<td>Italy</td>
<td>Towards unity for health in Sicily</td>
<td>Dr Pina Frazzica, Centre for Training and Research in Public Health; Caltanissetta, ITALY (E-mail: <a href="mailto:frazzica@ceu.its.it">frazzica@ceu.its.it</a>).</td>
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<tr>
<td>The Netherlands</td>
<td>“Hartslag Limburg”: Community-based prevention of cardiovascular disease integrated with a high-risk group approach in general practices and in the hospital</td>
<td>Dr Erik C. Ruland, Maastricht, The Netherlands (E-mail: <a href="mailto:E.Ruland@uzl-ggd.nl">E.Ruland@uzl-ggd.nl</a>).</td>
</tr>
<tr>
<td>Spain</td>
<td>Towards unity for health: Barcelona’s project. A population approach in a district of Barcelona</td>
<td>Dr A, Oriol Bosch, Institut d’Estudis de la Salut, Barcelona, SPAIN (E-mail: <a href="mailto:institut@ies.scs.es">institut@ies.scs.es</a>).</td>
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<td><strong>SOUTH-EAST ASIA</strong></td>
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<td>Indonesia</td>
<td>Towards a healthy city in a decentralized health system: a partnership model for medical school accountability</td>
<td>Dr Sorenato Sastrovijoto; School of Medicine; Gadjah Mada University; Yogyakarta, INDONESIA (E-mail: <a href="mailto:anis@desentralisasi-kesehatan.net">anis@desentralisasi-kesehatan.net</a>).</td>
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stakeholders (policy-makers, health managers, the health professions, academic institutions, communities) and adjustments to become more socially accountable;

- Partnership and leadership: negotiating and contracting, creating a momentum and sustaining it, from project implementation to policy development, advocacy.

A preliminary plan of work is being drafted. A working group is being set up to implement the project. Collaboration is being sought for the development and field-testing of the learning modules.

**TUFH and the health professions**

This activity refers to the relationship of the health professions and the TUFH approach. The health professions possess great potential to implement approaches that promote a more unified approach to health service delivery. What are the new challenges and opportunities for the health professions?

WONCA (the World Organization of Family Doctors) is holding a consultation on the TUFH approach in Durban, South Africa, on 17 and 18 May 2001.

**TUFH and health information**

The importance of a comprehensive health information management system is emphasized in the TUFH approach. The systematic collection and use of essential health data on a given reference population by major stakeholders should serve as a “glue” and provide a solid foundation to create coherence and unity in decision-making and action. A working group is being set up to propose concrete interventions.

Collaboration is being sought.

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**Global networking**

Collaboration among selected international nongovernmental organizations (NGOs) is being developed to contribute to the TUFH approach. Alliances and joint projects among organizations with similar interests will be enhanced.

A web site is being established featuring the various action programmes of participating NGOs consistent with the components of TUFH. An international consultation with these NGOs is scheduled for Londrina, Brazil, 18 to 19 October 2001.

**Regional consultations**

Consultations with representatives of different countries were held in Barcelona, Spain, in November 2000 (for the European Region) and in Dharan, Nepal, in February 2001 (for the South-East Asia Region).

Regional consultations will be held in Miami, Florida, USA, 1–3 August 2001 (for the Americas); in Egypt in the summer of 2001 (for the Eastern Mediterranean Region); and in Dakar, Senegal, in the autumn of 2001 (for the African Region).

The aims of the consultations are to examine how the TUFH approach can strengthen partnerships to facilitate implementation of primary health care-oriented systems and assist in developing TUFH field projects in selected countries.

**Advisory Committee**

An Advisory Committee of 30 members, half from WHO and half with other affiliations, has been established to provide guidance in the development of the TUFH approach worldwide. A meeting of the Advisory Committee is being planned to take place at the WHO Office for Integrated Care, in Barcelona in October 2001, to review the achievements of the TUFH project and plan a future course of action.
UNI-SOL: the next steps

Charles Boelen, World Health Organization, Geneva

To help implement the recommendations in the “Arizona Charter” reproduced in this newsletter, participants in the global conference “Universities and the Health of the Disadvantaged” unanimously adopted the proposal to create a project called “UNI-SOL,” an acronym for Universities in Solidarity for the Health of the Disadvantaged.

UNI-SOL aims to develop a global network of universities and people committed to supporting reflections and actions leading to improved well-being and health of disadvantaged individuals and groups in societies worldwide. To give birth to UNI-SOL and develop it, the following steps are proposed:

Setting up a central office: A secretariat hosted in a university actively involved in improving the health of the disadvantaged will be established. Its functions will be to transmit information and provide support to initiatives that develop over the years in the UNI-SOL project.

For the years 2000–2001, the World Health Organization will provide a grant to the University of Arizona, based in Tucson, Arizona, USA, to assume the functions of the central office. Regional offices will also be established to provide support more readily to national and subregional activities.

Being advocates: A monograph will be made available to international and national agencies for further dissemination to universities and other concerned institutions and organizations in countries. A brochure outlining the objectives and expected outcomes of the UNI-SOL project will be published in English, French and Spanish—and, it is hoped, in other languages—and widely distributed. The Arizona Charter will be translated into all the official languages of the United Nations system (that is, Arabic, Chinese, English, French, Russian and Spanish) and made widely available.

Sharing information: A web site will be created at the University of Arizona and a database of experts, projects and references by country and main areas of work will be set up and maintained. Opportunities will be reviewed to organize a global conference in 2001 to take stock of new developments and strengthen international collaboration. WHO and UNESCO will provide regular updates through newsletters and other vehicles.

Steeringship: An international council will be established, with about 15 members representing different parts of the world to advise on the development of the UNI-SOL project. Members of the council will head a number of specific task forces regarding issues such as: technical support to country field projects; advocacy and international collaboration; information and publications; and fundraising. Members of the council will be linked through quarterly conference calls.

Research and development: During the period 2000–2001, contracts and grants will be offered by WHO on the basis of competition to at least six universities interested in developing a research and development project consistent with a set of pre-determined criteria. In return, these universities will submit reports twice a year to show progress in mobilizing multidisciplinary talents and resources in favour of the health of a disadvantaged group and in creating coalitions with local governments, the health professions and communities to ensure sustainability in action. A monograph of the most striking achievements of the “model” universities will be published.

Dissemination: A special endeavour will be made to enlarge participation in the UNI-SOL project to United Nations agencies and other concerned international and national organizations. Regional chapters of the UNI-SOL project will be established. In the 2000–2001 period, at least two regional chapters will be set up: one in Africa and one in Asia. National focal points should be designated in at least five countries of each of the six WHO regions (Africa, the Americas, the Eastern Mediterranean, Europe, South-East Asia and the Western Pacific).

Création du reseau UNI-SOL: “Universités en Solidarité pour la Santé des défavorisés”

Douze projets présentés par des universités ont été sélectionnés par l’OMS pour la mise en oeuvre de stratégies visant à améliorer la santé de groupes de population vivant en situation d’exclusion ou de précarité. Pour plus d’informations, prière de contacter l’OMS.
The WHO-UNESCO-sponsored UNI-SOL project (“Universities in Solidarity for the Health of the Disadvantaged”) aims to mobilize the widest possible spectrum of talents within participating universities to further the well-being and health of the disadvantaged.

Projects from 12 universities worldwide have been selected for their intention and potential to do the following:

- target a disadvantaged group that is highly representative of the national context;
- use a multidimensional approach involving several faculties and departments beyond those in health sciences;
- use a comprehensive approach, with educational, service delivery and research interventions;
- develop sustainable coalitions between universities, local governments, professional associations and civil society.

These universities have received a WHO grant and will submit progress reports twice a year, highlighting their efforts to meet these four criteria, with reference to pre-established indicators. Lessons learnt from these field projects will be analysed and made available to further refine strategies and methodologies to help universities optimally use their potential in favour of the disadvantaged. The 12 selected universities and their projects are described in the table.

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**Universities and the health of the disadvantaged**

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<tr>
<th>University</th>
<th>Description of project</th>
<th>Contact Information</th>
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<tbody>
<tr>
<td>1. University of Sydney, Australia</td>
<td>The Dream Run Travelling Rural Seminar Programme and Relay Initiative, focusing on disadvantaged rural young people of the Aboriginal population</td>
<td>Ms Wendy Jopson (E-mail: <a href="mailto:w.jopson@cchs.usyd.edu.au">w.jopson@cchs.usyd.edu.au</a>).</td>
</tr>
<tr>
<td>2. Moi University, Eldoret, Kenya</td>
<td>Establishing an academic health care services research centre of excellence targeting street children in Eldoret</td>
<td>Dr David Ayuku (E-mail: <a href="mailto:Muhs@net2000ke.com">Muhs@net2000ke.com</a>).</td>
</tr>
<tr>
<td>3. Kyrgyz-Russian Slavic University, Bishkek, Kyrgyzstan</td>
<td>Focusing on health and education problems of an isolated and disadvantaged population</td>
<td>Professor V. Nifadyev (E-mail: <a href="mailto:ofr@krsu.edu.kg">ofr@krsu.edu.kg</a>).</td>
</tr>
<tr>
<td>4. Koirala Institute of Health Sciences, Dharan, Nepal</td>
<td>A multidimensional approach to integrating a seriously disadvantaged group into the mainstream of development</td>
<td>Dr Paras Pokharel (E-mail: <a href="mailto:maniparas@hotmail.com">maniparas@hotmail.com</a>).</td>
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<tr>
<td>5. Aga Khan University, Karachi, Pakistan</td>
<td>Empowering families, communities and local health care providers to improve the health status of women and children, focusing on selected health and social sector initiatives</td>
<td>Dr Fauziah Rabbani (E-mail: <a href="mailto:fauziah.rabbani@aku.edu">fauziah.rabbani@aku.edu</a>).</td>
</tr>
<tr>
<td>6. Makerere University, Kampala, Uganda</td>
<td>Promoting research on forced migration, and integration of refugee health services into the national health system</td>
<td>Dr Christopher Garimoi Orach (E-mail: <a href="mailto:cgorach@hotmail.com">cgorach@hotmail.com</a>).</td>
</tr>
<tr>
<td>7. University of Transkei, South Africa, and University of Illinois at Chicago</td>
<td>Behavioural change and education of vulnerable populations, especially women</td>
<td>Dr Joseph M. Harrington (E-mail: <a href="mailto:jharrington@rush.edu">jharrington@rush.edu</a>).</td>
</tr>
<tr>
<td>8. University of Central Lancashire, Preston, United Kingdom</td>
<td>Promoting the health and well-being of disadvantaged minority ethnic communities</td>
<td>Dr Mark T. Dooris (E-mail: <a href="mailto:m.t.dooris@uclan.ac.uk">m.t.dooris@uclan.ac.uk</a>).</td>
</tr>
<tr>
<td>9. University of North Carolina, Wilmington, North Carolina, USA</td>
<td>Reducing health, economic and social disparities and enhancing the strengths of the Waccamaw-Siouan community of Native Americans</td>
<td>Dr Robert Blundo (E-mail: <a href="mailto:whitlock@uncwil.edu">whitlock@uncwil.edu</a>).</td>
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<tr>
<td>10. Université Libre de Bruxelles (Brussels) and Universiteit Antwerpen (Antwerp), Belgium</td>
<td>To improve health care for vulnerable populations and reduce the burden on emergency services</td>
<td>Professor Vranken (E-mail: <a href="mailto:isabelle.bergeret@chu-brugmann.be">isabelle.bergeret@chu-brugmann.be</a>; <a href="mailto:berisa@chu-brugmann.be">berisa@chu-brugmann.be</a>).</td>
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<tr>
<td>11. University of Ottawa, Ottawa, Ontario, Canada</td>
<td>Linking service and research to address homelessness in Ottawa-Carleton</td>
<td>Dr Jeffrey Turnbull (E-mail: <a href="mailto:jturnbull@uottawa.ca">jturnbull@uottawa.ca</a>).</td>
</tr>
<tr>
<td>12. Border Vision Fronteriza Initiative, USA-Mexico Borderlands</td>
<td>Bringing together universities and community health worker programmes to promote an exchange of best practices in addressing health and human services needs of disadvantaged communities at the USA-Mexico border</td>
<td>Ms Eva M. Moya (E-mail: <a href="mailto:moyae@elprr.com">moyae@elprr.com</a>).</td>
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WHO and WONCA tackle rural health

In developing countries, 60% to 70% of the people live in rural and remote areas. Many are caught in the poverty/ill-health/low productivity downward spiral. Recognizing that good health is a way out of poverty, WHO and WONCA, the World Organization of Family Doctors, have agreed to work together on a Rural Health Initiative.

The WONCA Working Party on Rural Practice, which began in 1992, has been successful in drawing national and international attention to major issues of concern in rural health and rural practice. Since 1996, there have been four World Rural Health Conferences, bringing together rural family practitioners from all corners of the globe. These conferences have provided a forum for the exchange of ideas and development of recommendations that form the basis of a series of WONCA policies on rural practice and rural health.

The Second World Rural Health Congress, in Durban, South Africa, adopted “Health for All Rural People: The Durban Declaration”, which presented a Call for Action renewing the “Health for All” initiatives and calling on international and national bodies to work with doctors, nurses and other health workers towards improving the health and well-being of people in the rural areas of the world.

In order to carry this further, WHO and WONCA have agreed to co-sponsor a major WHO–WONCA Invitational Conference on Rural Health in April 2002. The conference will address the immense challenges for improving the health of people in rural and remote areas and develop a specific action plan—the Global Initiative on Rural Health—which integrates the individual and population health approaches. Outcomes of the Global Initiative on Rural Health will be expressed as global targets and country-specific targets that participating nations will pledge to meet.

In addition to the action plan in the Global Initiative on Rural Health, the invitational conference will provide the impetus for a series of demonstration projects on rural health development around the world. These demonstration projects will, in turn, provide the opportunity to test aspects of the Global Initiative and so facilitate development towards achieving its targets.

UNI-SOL field projects

For further information, please contact the UNI-SOL secretariat, in Tucson, Arizona, United States of America: The University of Arizona Rural Health Office; 2501 East Elm Street; Tucson, Arizona 85716, USA (Telephone: +1 520 626 7946; Fax: +1 520 326 6429; E-mail: aclarihe@rho.arizona.edu; http://www.unisol.arizona.edu) or Dr Charles Boelen, WHO, Geneva.
Improving health systems with the contribution of family doctors

Cynthia Haq, University of Wisconsin Medical School, Madison, Wisconsin, and Vincent Hunt, Brown University School of Medicine, Providence, Rhode Island

The World Health Organization and the World Organization of Family Doctors (WONCA) have joined forces to improve primary health care. An international steering committee, including members of both groups, is developing a guide: *Improving health systems: the contribution of family medicine*. This guide will expand on the ideas in this article, describe how family medicine can enhance health systems, and provide strategies for development of the discipline. It will be available through the WHO and WONCA by early 2002.

In every part of the world, when people fall ill, they look for someone to listen, to understand and to address their suffering. If these needs cannot be addressed within the family, people look for health care in their community. Access to essential primary health care (PHC) remains a dream beyond the reach of many communities. (1,2)

Characteristics of family medicine

As partners in PHC, family doctors are eager to contribute to improving health systems. (3) Health systems in which family doctors provide PHC services achieve better health outcomes, at lower costs, with more equitable distribution of health services. (4)

As health providers, family doctors provide first-contact care and address the majority of health care needs for people of all ages from womb to tomb. Person-centred and family-centred care allow family doctors to establish long-term relationships, engendering trust and enhancing effectiveness. Continuity of care provides valuable information regarding individual and community strengths and vulnerabilities.

Acting as both coordinators and team members, family doctors integrate individual and community health care services, and primary to tertiary care. When family doctors are prepared to serve as leaders, they can improve the quality and outcomes of community health efforts.

Uniting stakeholders

While family medicine can improve health systems, its development varies throughout the world. Roughly one-third of all nations have established training for family doctors, who provide substantial health care services; another one-third are in the process of establishing training programmes; and the remaining third have no plans to train family doctors. Towards Unity for Health provides strategies for countries that wish to establish or strengthen family medicine. (5) Leadership is required to unite stakeholders around the vision of providing everyone with equitable, relevant, cost-effective, high-quality PHC delivered by teams including family physicians. Government health officials, academic institutions, health professionals, health managers and community members may each contribute to collaborative efforts necessary for planning, mobilizing resources, and implementing family medicine programmes.

Primary health care teams

Family medicine development requires delineation of the role and responsibilities of family doctors as interdependent primary health care team members. Synergistic teams, which may include office staff, nurses, community health workers, health educators, social workers and family doctors, can provide care greater than the sum of each member’s contributions. When team members share a common purpose, understand their own roles and the roles of others, and pool resources, effectiveness is increased. (6) As team members, family doctors can enhance the capacity for comprehensive PHC at the community level.
Continuum of education

Family medicine is strengthened through a continuum of education that prepares family doctors with the knowledge, attitudes and skills necessary to meet the needs of communities they serve. The skills required vary, depending on local disease patterns and availability of other health resources.

Ideally, this education begins in medical school, when family doctors teach students the basics of comprehensive patient care, communication, management of common problems, health promotion, disease prevention, and how to work with families and communities. A period of vocational training, usually lasting three years, prepares family physicians for leadership and improves skills to provide comprehensive care for individuals, families and communities.

Many countries have established successful programmes to retrain practising physicians to become family doctors. (7) Continuing medical education allows family doctors to participate in lifelong learning and to incorporate new developments into their practice.

Supportive practice environment

While education prepares physicians for practice, meaningful and supportive practice environments are necessary to attract doctors to family medicine careers, particularly in medically underserved areas. Opportunities to promote health and alleviate suffering on the front lines provide health professionals with a great sense of satisfaction and meaning.

Supportive environments include attractive career opportunities with competitive salaries. Primary care research and practice networks provide opportunities to participate in the discovery of new information. Professional associations establish and maintain standards, and promote quality-improvement efforts that allow teams to assess outcomes and continually improve their performance.

Networking

National and international health associations provide opportunities for health professionals and other stakeholders to collaborate for health system improvements. The WHO–WONCA collaboration is an example of such an association. (8, 9) The fruits of these collaborations are urgently needed to address the health care needs of people in every part of the world who will benefit from access to essential health care.

References

8. World Health Organization URL: http://www.who.int/
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Dr Cynthia Haq is Associate Professor and Director of Medical Student Education, Department of Family Medicine, University of Wisconsin–Madison. She served as a consultant to WHO and WONCA to assist with development of the guidebook, and can be reached at 777 S. Mills St., Madison, WI 53715, USA (Telephone: +1 608 263 6546; Fax: +1 608 263 5813; E-mail: chaq@fammed.wisc.edu).
Dr Vincent R. Hunt is Professor and Chairman Emeritus, Department of Family Medicine, Brown University School of Medicine. He can be reached at 8 Blaisdell Avenue; Pawtucket, Rhode Island 02860, USA (Telephone: +1 401 722 2969; Fax: +1 401 729 2923; E-mail: vinrhunt@aol.com).
Can academic family medicine help?
A view from Latin America

Julio Ceitlin, University of Buenos Aires Medical School

Health care system reform in Latin America

Profound changes in health care delivery systems are occurring in most Latin American countries under the umbrella of health care reform, as recommended by international bodies such as the World Bank and the Inter-American Development Bank. Suboptimal managerial practices and a shortage of funds for health services have resulted in inefficient administration and the provision of poor and inequitably accessible services that are not cost-effective. This is an extremely critical time.

Bankruptcy of the health care systems of many Latin American countries triggered the promotion of health care reform as part of a bigger package of state reform in many countries. One important decision in revitalizing health care systems was the inclusion of family medicine in local health care services, with the implication that this will require the whole system to be re-engineered, creating a broad base of primary care centres, staffed by qualified family physicians, where the principles and tools of family practice may be applied. It also corresponds to people’s demands.

Cost-effectiveness and efficiency, which were primarily by-products rather than conscious goals of family medicine, are now being taken into account as a primary contribution of family medicine to the new approach. In recent years the goals and values of family medicine and health care reform have converged and reinforced each other with the aim of achieving greater efficiency, cost-effectiveness and productivity in health care.

Family medicine is recognized as a valued specialty in most of the health care organizations in Latin America. Even in countries with different social, political and economic characteristics, family medicine has been able to adapt to each unique situation as an efficient health care delivery model.

One important issue is to increase the proportion of generalists vis-à-vis specialist physicians in the health care system. Despite the significant number of residency programmes of family medicine created during the last 20 years, Latin American countries have not made significant progress. Hence the effort to “convert” physicians from other specialties into family practitioners.

Hopes for academic family medicine?

Ten years after recognition of the specialty of family practice, three out of four medical schools in the United States of America had departments or divisions of family medicine, and in Canada all the medical schools have departments of family medicine. In Latin America, the response of medical schools has been inadequate.

In 2000 a survey, conducted among the 100 medical schools of Argentina, Colombia, Mexico and Panama, showed that of the 65 schools that responded, 83% teach family medicine in the graduate curriculum, while 17% of medical schools teach family medicine in postgraduate courses only. In 26 medical schools (76%) of the 34 schools that have family medicine in the graduate curriculum, the course is mandatory for medical students; in 25 schools, it takes place during the rotating internship. Six medical schools reported having qualified family physicians as teachers. Ten schools reported having departments of family medicine.

It is hoped that Latin American countries will give appropriate emphasis to developing the quantity and quality of family physicians and to increasing the incentives to practise family medicine as a contribution to improving the performance of health systems. Obviously, establishment and reinforcement of partnerships among main stakeholders, as exemplified in Towards Unity for Health, are critically needed.

Information sources


Julio Ceitlin, MD, MPH, is Professor and Chairman, Department of Family Medicine, University of Buenos Aires Medical School, Paraguay 2155, Buenos Aires, ARGENTINA, and leader, Group of Panama task force for the development of academic family medicine (E-mail: jceit@intramed.net.ar).
Improvement of medical practice in social context

Ray Lewkonia, Calgary, Alberta, Canada

Who assesses what?

In many countries the right of self-regulation permits the medical profession to determine the content and duration of education and training for different medical roles in society, and to decide how these roles are to be maintained and revaluated. Self-regulation is usually governed by medical authorities with legislated power to determine criteria for registration or licensure, standards for practice and conduct, and sanctions or discipline for their members who fail to meet acceptable standards. In recent years there have been expressions of public and governmental concern in several countries, with consequent pressure on the profession to demonstrate that continued self-regulation is justified, particularly with regard to socially acceptable practice and possible substandard performance of individual doctors.

In looking at potential sources of variance in medical practice it can be useful to consider competence, performance and quality as contiguous attributes. The concept of health care quality places values and expectations on both competence and performance. The locus of responsibility differ for initial certification of competence and for ongoing assessment of the three major attributes, as shown in the table.

Engaging in a consultative process

The College of Physicians and Surgeons of Alberta (CPSA) is the medical licensing authority in one of Canada's western provinces; it regulates approximately 5000 generalist and specialist doctors. In partnership with the two Alberta medical schools it has established an innovative system for formal assessment of medical performance. This system differs from most comparable programmes set up elsewhere to detect and deal with a very small proportion of poorly performing doctors.

The primary purpose of the Alberta programme is to promote practice quality improvement for all doctors. This is done in a structured educational protocol in which each doctor asks his or her patients, medical colleagues and health care system co-workers (e.g. nurses, pharmacists, secretaries, therapists) to complete performance-related questionnaires, and also complete a self-evaluation survey.

After the data are processed by a central agency, a confidential feedback report is provided to the doctor, referenced to performance ranges and means for peers. The Alberta programme is called the Physician Achievement Review (PAR), a name intended to suggest a positive outlook rather than a policing process.

A 1998 pilot project with 308 volunteer doctors, predominantly general and family physicians, has been published. (1, 2, 3) In a follow-up study, 83% of respondents said that the PAR feedback information had stimulated them to contemplate practice change and 65% said they had initiated change, most often in the area of information and support for patients. Listed below are the numbers of questionnaires to be distributed by primary care doctors to each category and the major feedback domains identified by factor analyses as most significant for medical performance:

- 25 patients (44 questions): patient interaction and provision of information, practice staff functions, telephone communication and appointment systems

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Table. Categories of medical competence, performance and quality assurance and responsibilities for assessment

<table>
<thead>
<tr>
<th>Attribute:</th>
<th>Competence</th>
<th>Performance</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process:</td>
<td>Attaining objectives, goals and skills</td>
<td>Service delivery</td>
<td>Continuous, cyclical audit</td>
</tr>
<tr>
<td>Schematic:</td>
<td>&gt;&gt;&gt;</td>
<td>&gt;&gt;&gt;</td>
<td>&gt;&gt;&gt;</td>
</tr>
<tr>
<td>Basic questions:</td>
<td>Can they do it?</td>
<td>Do they it?</td>
<td>How well do they do it?</td>
</tr>
<tr>
<td>Responsibility for formal assessment and appraisal:</td>
<td>Medical schools, universities, national colleges for medical roles and specialties</td>
<td>Medical licensing authorities, professional associations and societies, employers</td>
<td>Health systems, organizations, hospitals, services, clinics</td>
</tr>
<tr>
<td>Routine or informal assessment of functions:</td>
<td>Teachers and instructors</td>
<td>Self (professional), Patients, Service peers, health care co-workers</td>
<td>Groupings of service providers – colleagues, teams, managers, planners</td>
</tr>
</tbody>
</table>

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Ray Lewkonia
8 Health co-workers (17 questions): patient interaction, co-worker collegiality, co-worker communication

8 Medical colleagues (26 questions): clinical competence, patient interaction, professional self-management, psychosocial care of patients, communication in medical consultations.

With good technical results in the pilot project, provincial legislation was enacted requiring participation in PAR by all registered doctors every five years. By early 2001 approximately 40% of doctors in Alberta had been involved in PAR, with questionnaires having been adapted and developed for different groups such as surgical specialists and anaesthetists.

Results of PAR surveys are monitored by a committee that includes public representation and that takes care to protect confidentiality. When there is concern about performance, the doctor is telephoned by a member of the committee to discuss the PAR process and possible systemic or other problems affecting performance. If concern persists, a structured peer practice visit is arranged and the doctor may receive further advice, recommendations or requirements for practice improvement and subsequent reassessment.

Relevance to TUFH

In health care systems the bulk of resources are committed to illness and disease, although it is recognized that preventive health measures for all are preferable and less costly. By analogy the complaints and disciplinary activities of the CPSA continue and are separate from PAR, but the latter could be thought of as a preventive health programme for good medical practice.

PAR induces doctors to consider the views and opinions of their patients and other professionals in their health care environment by use of a scientifically validated process. In this way the authority of the licensing body is deployed in a constructive manner to promote social sensitivity in medical practice at the level of the individual doctor, with the aim of influencing the routine practice of all doctors in its jurisdiction.

Further operational details of the PAR programme and some of its instruments and tools are available on the web site of the College of Physicians and Surgeons of Alberta at http://www.cpsa.ab.ca/.

References


Ray Lewkonia is a professor of Medicine and Pediatrics, University of Calgary, Canada, and Visiting Professor, Department of Health Care Education, University of Liverpool, Liverpool, United Kingdom, and Chair of the Assessment Committee in the Alberta PAR programme. He can be reached at the University of Calgary Health Sciences Centre, 3330 Hospital Drive NW, Calgary, Alberta T2N 4N1 CANADA (Telephone: +1 403 220 4258; E-mail: rlewkon@ucalgary.ca).

The Arizona Charter: Mobilizing universities in favour of the disadvantaged

We call for Universities to:

- Recognize and respect the legitimacy and dignity of disadvantaged populations.
- Take responsibility and accept accountability for addressing the health and welfare needs of disadvantaged populations.
- Give priority to research on the special problems of disadvantaged communities, on understanding the underlying determinants of poverty and inequity, and on approaches to reducing the disparity in health status.
- Mobilize and coordinate the activities of all appropriate academic disciplines, and not just those in the health sciences, to address the complex issues associated with the health of the disadvantaged.
- Ensure students are motivated and appropriately equipped to serve disadvantaged populations, to be community-responsive citizens and to function as agents of social change.
- Influence the development of public policy and the implementation of programmes to improve the health and well-being of the disadvantaged.
- Diversify university faculties and student bodies by increasing recruitment of faculty and matriculation of students from disadvantaged populations, including specific efforts to strengthen the pool of disadvantaged applicants.
- Create a forum (network) that promotes social accountability of academic institutions and supports their efforts to improve the health of advantaged populations.

Extracted from the Arizona Charter, “Universities and the Health of the Disadvantaged”. 

HEALTH PROFESSIONS PERFORMANCE
Health reforms in eastern Europe: my feelings about the project “Towards Unity for Health”

K. Tchamov, Medical University–Sofia, Bulgaria

Reform patterns

In the countries of central and eastern Europe (CCEE), health system reforms are taking place against a background of rapid general political and social change designed to build and strengthen new democratic, consumer-oriented and more effective structures. Pressures for change in the financing, organization and management of the health sector are coming from all parts of the society: providers, consumers, public and professional organizations. A changeover to a health insurance system has been introduced in Bulgaria, the Czech Republic, Hungary, Slovakia, and Slovenia.

The reform patterns in the CCEE are aimed at achieving better integration of health services, equity of access, consumer choices, improved health outcomes, patient satisfaction and provider autonomy. In response to the request for introduction of market mechanisms, decentralization and public competition, the CCEE have developed a variety of implementation strategies. (1, 2)

Reform intentions and realities

A renewed role for primary health care as defined in the Declaration of Alma-Ata (1978), including “promotive, preventive, curative and rehabilitative services”, has been widely accepted in the CCEE reform strategies. Measures to strengthen the PHC through the introduction of a system of general practitioners, or family physicians, have been taken in the CCEE. It is a general trend in both publicly operated health systems (in Latvia, Poland and Romania, for example) and social insurance-based health systems (as in Bulgaria, the Czech Republic, Hungary, Slovakia and Slovenia) to integrate certain preventive and health-promotion functions formerly carried out by vertical PHC programmes.

Analyses of reform outcomes show that many of the current reform problems are caused by a weak integration between medicine and public health, and by an increasing autonomy of primary, secondary and tertiary care. (3) The innovative but incomplete legislation and normative basis have affected the integrative mechanisms of the system.

The hospital sector restructuring has started with a reduction of beds as part of cost-containment policies. Disappointment with large, centralized and bureaucratic institutions (hospitals and polyclinics) is widespread due to their low efficiency, slow pace of change and inappropriate management. (4)

The health sector reforms have specific characteristics that make bridging the gap between policy intent and successful action particularly difficult. Factors such as economic recession, substantial increases in expenditure, structural deficits and higher labour costs have led to a multitude of implementation problems.

Need for new models of integrated care

Health policy analysts find that present health services in the CCEE are fragmented, both horizontally and vertically. Instead of being organized around the concept of comprehensive and horizontally integrated services provided by multiprofessional teams, health care is often split among a multitude of singlehanded medical specialists. The development of innovative management tools for intersectoral collaboration in the

Reform strategies is still lacking. (5) Improved coordination of the health services is needed to deal effectively with national and international challenges to public health. (6)

For improved performance of health systems, new models of integrated care will have to be developed alongside attempts to remove the barriers between the promotive and preventive services, PHC, long-term care and hospital care. Innovative integrated health services designed to provide comprehensive, appropriate and coordinated care should have the potential to meet this challenge. In Europe a clear statement in the direction of a better integration of health services was put forward by the WHO Regional Office for Europe with the adoption of the “Ljubljana Charter on Reforming Health Care in Europe” (1996).

The TUFH project

In this respect the project “Towards Unity for Health” (TUFH) is a step towards the development of integrated care models. It is designed to “study and promote efforts worldwide to foster unity in providing services based on people’s needs, particularly through a sustainable integration of medicine and public health”. (7) The philosophy and the practical steps of this project are concentrated on the elaboration of criteria, conditions, support and integrative mechanisms for the development of:
The following reasons:

- innovative patterns of services for integrating medicine and public health;
- implications for health professionals;
- essential and sustainable partnerships;
- evidence of impact.

The pursuit of evidence-based integrated care services should be focusing on three essential features: reference population in a defined geographical area; organizational models supporting the integration processes; and the availability of a comprehensive information management system.

The ideas incorporated in the TUFH project are aimed at achieving equity, better health outcomes, responsiveness to public-health problems and those of individuals, and effective use of resources. This is an attempt to put most, if not all, of the pieces of a health system together, shifting the conventional responsibility for only delivered care to responsibility for the public health of the served population. In this respect the participation of some CCEE countries in the TUFH project would be appropriate for the following reasons:

- the health reforms in the CCEE are recent and the reformed systems are still relatively immature, i.e. appropriate for testing the philosophy and innovative practices of integrated care;
- CCEE have historical experience with different models of integrated medical care;
- similar studies, empirical research or intervention projects such as TUFH have better starting and survival chances within health systems in transition than in well-established and traditionally rigid systems.

References


K. Tchamov, PhD, MPH, is Assistant Professor, Medical University–Sofia; Chair of Social Medicine and Health Care Management; Hospital “Tsariza Joanna”; B, Bjalmore str.; 1527–Sofia, BULGARIA (Telephone: +359 2 434 4416; Fax: +359 2 432 375/442 388; E-mail: tchamov@bulinfo.net).
Challenges for an emerging nation: the case of Kosovo

Robert N. Hedley, European Agency for Reconstruction, Kosovo

Setting the stage

Kosovo has a very young population: 52.7% are under 20 years of age, and only 1.5% are over 75. Many adults are working temporarily in other European countries, and refugees are still scattered around the world. This territory has the highest infant mortality rate in Europe, estimated at 51.2 deaths per 1000 in 1989. Official statistics from the last ten years have not accurately reflected the situation, since much of the population seeks medical help outside the government system.

Tuberculosis is a major cause of concern at the moment, with 60 to 70 cases per 100,000. The major causes of death in the under-fives are perinatal conditions, respiratory-tract disorders, gastrointestinal-tract disorders and congenital anomalies. Major causes of death in adults under 65 are heart disease, chronic lung disorders and respiratory-tract neoplasms. This is not surprising when almost everyone, including doctors, smokes—where children no older than eight and nine sell and smoke cigarettes. Cigarettes are very cheap: the equivalent of GBP 0.30 for a pack of 20. This is a big challenge for health education.

Apart from this there has, of course, been a disruption of the whole infrastructure in Kosovo as a result of the war and the conditions prevailing for the 10 years before that. Nobody can tell you the exact size of the population of Kosovo. The best estimate is probably two million. There are no pensions and only minimal social support payments, and these according to strict criteria.

At the moment health care is fragmented. Within the government health system, patients choose whether to go to a general practitioner or to a hospital. There are also many private doctors and clinics.

The hope for unity

In an effort to rationalize the health care system in Kosovo, the UNMIK (United Nations Mission in Kosovo) administration, through WHO, developed health policy guidelines (1) that included the recognition of family medicine as a new specialty.

A consortium was set up to advise on the development of education and training for three components: family medicine, hospital specialties and health service management. In its work the consortium is forging partnerships with WHO, the Department of Health and Social Welfare, the Ministry of Education and the Medical Faculty of Pristina University. There are also regular consultations with the consumers (doctors and managers).

The importance of close cooperation with all the above players cannot be over-emphasized, to achieve acceptance and local ownership of planning so that procedures can be set in place that will be implemented. Local ownership has been further strengthened by the appointment of “Counterparts”: Kosovars who “shadow” and work with the heads of the three components.

WHO took the lead in setting up a Continuing Professional Development programme that is financed by several donors. This programme is nearing completion with the first cohort of 100 general practitioners. There was also very strong collaboration with the Association of General Practitioners of Kosovo. The first lessons learnt here concerned the importance of collaboration, integration and coordination.

The “fast track” family medicine curriculum is based on the specific health needs in Kosovo and on the general principles and content of family medicine, which ensures the relevance and quality of the education and training. Health promotion and disease prevention by the family doctor in the context of a registered population list, together with the collection of health data in family-medicine centres, emphasizes the doctors’ public-health role. Their “gatekeeping” function will aid unity, adding to the cost-effectiveness of the health care system and at the same time ensuring equity.

The other partnership for the effective development of a health care system is of course with the population served. The concept of family medicine is new to Kosovo and the basis of family medicine—which involves registration of patients with a doctor, gatekeeping and health promotion, in addition to treating disease—has been explained through television and radio, as well as via a newsletter produced by WHO Pristina.

In summary, we are aiming for quality, equity, relevance and cost-effectiveness through a system driven by family medicine and...
forged by a partnership between professionals, government, WHO, various nongovernmental organizations and the European Agency for Reconstruction.

**Reference**

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**Peace villages in south Sudan**

Asim Abdelmoneim Hussein, Africa International University and Medical Director, Benevolence International Organization, Khartoum

**Our world**

Benevolence International Foundation (BIF), a leading voluntary agency, is conducting health and social development activities through partnership with the State Ministry of Health of South Kordofan, one of Sudan’s 26 states. South Kordofan State, which lies in the southern part of central Sudan, has had to cope in recent years with such challenges as a destroyed infrastructure, a weak official governance and the need to bring back and resettle disadvantaged people and those displaced by war.

BIF is implementing “Primary Health Care and Community Development” (PHC and CD) projects in 18 of the most difficult locations in Kadogli Province. These areas, which are referred to as “peace villages”, host the most war-affected and disadvantaged populations, who constitute 28% of the people living in the province (some 86,000 men, women and children). The BIF strategy was not merely to provide relief to those communities, but to induce comprehensive development through a detailed needs-based community diagnosis.

**Our challenges**

Though the programme is not yet five years old, it has shown some remarkably positive indicators. Many of the PHC components were implemented with reasonable coverage rates. We are still poor in certain areas, such as the provision of proper nutritional and feeding programmes, which accounted for a coverage of less than 15%.

The real challenge, however, is the social and developmental impact of the project. Four aspects were targeted as priorities for community development: initiation of pre-school education, women's development activities, literacy lessons and community participation. These all had to be linked to the health care programmes as an innovation and an addition to the PHC package.

A real breakthrough worth noting was the high rate of participation of the local communities in 79% of the localities. Participation was considered positive when people either contributed towards building the health centre or classrooms or buying furniture or simple equipment for the clinics, or participated in campaigns for cleaning the village regularly with the involvement of different sectors of the community, usually led by community leaders.

**“Towards Unity for Health” and us**

We see that the BIF PHC and CD project in South Kordofan has many similarities to the goals and actions of the TUFH projects. It targets displaced communities, being of the most needy, aiming at establishing a health care delivery system that is most relevant to that community’s needs as well as trying to reduce fragmentation between individual and community health, preventive and curative services and the social and economical aspects of health.

PHC and community development are incorporated and integrated to function as one package, and community participation is proposed to act as an essential vehicle for the success of the project. It is through partnership between key stakeholders at the level of the peace villages, who are in our case the state government and its ministry of health, an NGO (BIF) and the local communities living in those areas, that a sustainable social and economical development will, we hope, be encouraged and achieved.

Dr Asim Abdelmoneim Hussein is Assistant Professor, Community Medicine and Public Health, Africa International University, and Medical Director, Benevolence International Organization, PO Box 1937, Khartoum, SUDAN (Telephone: +249 11 228 859; Fax: +249 11 225 989).

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Robert N. Hedley, B.Sc M.B. DRCOG FRCGP, was the coordinator of the WHO Programme for Family Medicine, Kosovo, and is now Advisor in Family Medicine, European Agency for Reconstruction, Kosovo; Hopwell House, Ockbrook, Derbyshire DE72 3R, UNITED KINGDOM (Telephone and Fax: +44 1332 872294; E-mail: RNHedley@cs.com).
How good are they?

Often forgotten in the global quest to improve our health care systems is any serious assessment of the quality and goals of the medical schools that train physicians to serve the needs of the world. While it is generally accepted that formal medical education is one of the cornerstones of world health, many tend to take the quality of our medical schools for granted.

Everyone assumes that the world must have medical schools; by last count there were more than 1700 schools worldwide, with over 50% of them created since 1980. Everyone also assumes that most medical schools are “good” but knows that—by some ill-defined yardstick—certain medical schools may be “better” than others.

The public is now asking for better definitions of “good” and “better”. They need to have a better understanding of how we evaluate medical schools and whether society is getting value for money from these educational institutions.

Standards, yes . . .

What makes a good medical school, and why is one school perceived to be better than the next? It is obvious that what is good in one part of the world may not be good in another, but given the changes in the causes of illness over the past decades, many want to know whether we are preparing physicians well for the health problems of today.

The question of whether a given medical school is good or not can, of course, be answered in a variety of ways and, as always, the questioner must also ask: “Compared to what?” Does the medical school in question meet standard criteria that all educational institutions should have: a coherent, fair admissions policy; a relevant, up-to-date curriculum of good quality; dedicated and competent instructors and an unbiased accreditation process.

Everyone agrees that one measure of a medical school’s quality is a variously defined composite of the institution’s prestige, the intelligence and motivation of its students, the quality of its curriculum, the use of new teaching methods, the reputation of its faculty, the quality of its research programmes, the ability of its students to pass examinations and get jobs, its placement of graduates and a number of other factors that deal primarily with the form of medical education. Any list of quality based on these factors can be drawn up fairly easily.

What are these standards for?

But there is another measure of quality that is receiving more attention. This comparison results in a list of medical-school “goodness” that deals primarily with the extent to which the medical school in question is serving the health needs of people.

This definition of “goodness”—while still concerned with the issues of quality outlined above—also addresses the factors related to the mission of the school in relation to public needs. This definition is concerned with the content or relevance of the institution and its educational programmes: To what extent is the medical school socially accountable? Does it educate professionals who care for the health priorities of people? Do its teaching and research programmes deal with the concerns of the community? Do its graduates work well with other caregivers? Does it combine the teaching of technical skill with imparting community leadership, management and communication abilities? Does it teach an integration of community wants with individual care into a larger view of health? Is it suitably evaluated so that it meets standards concerning both its curricular quality and its fulfilment of a social mission?

As a step towards understanding these issues and the kinds of problems facing medical schools worldwide, WHO has initiated a study investigating both the quality and the relevance of today’s medical schools. Due for completion this year, the report provides an overview of world medical schools today and also makes recommendations on how medical schools...
might improve their roles in contributing to better world health. Coupled with assessments from other stakeholders, the report provides information that may prove useful in re-evaluating medical education worldwide.

All of us want teaching institutions that educate professionals to serve both individual health needs and community requirements. For decades, most of us accepted that our medical schools were training “good” caregivers. Today’s health needs call for a reassessment of some of our long-held beliefs about today’s medical education process. The world is entitled to global health systems that best serve the health of the public; a hard look at what our medical schools are currently doing is an important part of this effort.

Markley H. Boyer MD, DPhil, MPH; Professor of Family Medicine and Community Health; Tufts University School of Medicine; 136 Harrison Avenue; Boston 02111 MA, USA (Telephone: +1 617-636-5442; E-mail: mboyer@granit.tufts.edu; mark.boyer@tufts.edu).

Accrediting educational institutions for their social accountability

A national need, a global expectation

Brooke Murphy and Richard Hays, School of Medicine, James Cook University, Townsville, Queensland, Australia

Many of the more recently established medical schools, in both the developed and the developing world, have adopted as part of their mission an interest in meeting the health needs of particular populations and regions they serve. This is in contrast to many of the longer-established and better-known medical schools, whose ambitions may be more focused on “producing the best”, regardless of the needs of the surrounding populations and regions. All medical schools could be placed somewhere on the spectrum of social accountability, if their performance were measured against agreed criteria that indicate social accountability.

The strong international demand for admittance to medical schools means that medical education remains a seller’s market and, increasingly, a global market. Universities are not immune to the effects of globalization. Well-established medical schools market themselves internationally, often setting up campuses in other nations. Medical schools in the former Soviet Union and eastern European nations are actively seeking to internationalize. Offshore schools, such as those in the Caribbean, are attempting to expand into the Pacific area. Further, the advent of Internet-based schools is imminent, meaning that students may be able to earn basic medical degrees at a distance in a virtual setting, using local clinicians as “accredited” tutors. (1)

These trends may be unstoppable as long as strong demand continues, but will they produce medical graduates who possess the skills necessary to provide high-quality care either locally (as in Web-based schools) or back in the country of origin of the international students? How can governments determine the suitability for registration of international students from schools about which little is known? Further, how can prospective students obtain information on the newer international and Web-based programmes, for which they are willing to pay high fees?

Determining the suitability of international programmes can be addressed through accreditation. Many nations have accreditation processes for medical schools: Australia has one of the stronger models (2) and the World Federation for Medical Education (WFME) has recently developed draft international guidelines that aim to define high-quality medical education in any national health and education system. (3) But these guidelines are more appropriate to the familiar “bricks and mortar” schools than to the brave new world of distance education through cyber-schools. The current model of assigning accreditation teams to visit and examine in detail the programmes of all medical schools is costly for an individual government or medical society and may not even be possible within a reasonable timeframe.

The aim of any accreditation process should not be to prevent consumers from pursuing a career in medicine but to help them, and the governments of countries from which they come, make better de-
decisions on the viability and quality of the chosen school. Most of the world still needs more doctors, particularly in rural areas and in the developing world, so increased access for groups not now included should be encouraged, but exploitation countered. We suggest that the following principles be adopted in such a “socially accountable” accreditation programme.

International standardization, with local relevance
The current draft World Federation standards form the basis of a set of internationally relevant accreditation standards. These may need some revision, particularly to include consideration of how quality can be achieved in a more community-oriented, distance education-based medical programme. Some current draft standards reflect traditional Flexnerian approaches, rather than the more recent integrated curricula, and are more focused on the educational process than on what skills graduates should possess. The WHO concept of a more broadly skilled community-based physician (e.g. the “Five-star doctor”) as an outcome should perhaps be incorporated. (4) Further, broader input is needed from nations likely to be providing and receiving international students, and some standards may need local adaptation to reflect local health system structures.

Central coordination of the process
An international organization should assume responsibility for implementation of the accreditation process. Adoption of the process should be voluntary and designed to attract and reward medical schools seeking accreditation. The accreditation should be time-limited but require follow-up assessment of issues highlighted in earlier visits, rather than necessarily repeating the entire process. The reward for successful accreditation should be international listing (e.g. in WHO registers and Web sites) that include the date of the accreditation, membership of the visiting team and access to the accreditation report.

Local or regional implementation
Accreditation should be conducted on a regional basis, such that individuals who know and understand the local health care and education systems make the judgment. Because the cost of the accreditation process would be borne by the school seeking accreditation, costs could be reduced by offering in poorer nations the possibility of small teams or perhaps even a single assessor. The visit should follow, and be guided by, a self-evaluation by the medical school seeking accreditation. The duration of visits should be determined by the precise nature of the task but should not exceed more than five working days. Detailed feedback should be provided through a report to the school concerned.

Interface with local licensure requirements
Medical graduates from such a WHO-listed medical school may return home with a recognized or registerable degree, but may still require additional assessments to achieve licensure to practise in their home nations. To facilitate a return to practice at home, accreditation processes may need to consider how well the medical school under review prepares its students to take international licensing examinations. Most developed nations have such barriers (PLAB in the United Kingdom (Professional and Linguistic Assessment Board), USMLE (United States Medical Licensing Examination) in the United States of America and AMC (Australian Medical Council) in Australia), and the trend towards jurisdictions developing their own exams for foreign graduates or using the results in one of the current exams is likely to become more common as governments confront the issue of how to assess the standard of overseas graduates applying for registration.

Summary
Medical schools now serve an international market and their managers should consider how their programmes can produce graduates capable of meeting the health needs of not only their regional population, but also of the people of the students’ own countries. The best way to collect and share information about the suitability of international medical programmes may be through a centrally coordinated but locally implemented accreditation process for medical schools. Ideally, accreditation standards will include consideration of outcome and performance aspects as well as structure and function.

References
3. Standards of the World Federation of Medical Education [http://www.sund.ku.dk/wfine/].

Dr Murphy is a consultant in information technology implementation and Dr Hays is the Foundation Dean, School of Medicine, James Cook University, Townsville, Australia. 4814 AUSTRALIA (Fax: +61 7 4781 6886; E-mail: brooke.murphy@bigpond.com; richard.hays@jcu.edu.au).

Brooke Murphy

ACCREDITATION

TOWARDS UNITY FOR HEALTH, APRIL 2001
Action research to influence primary health care: reflections on TUFH

Jorge Montalvan, Faculty of Medicine, University of Panama

All the available information indicates that the gap in the health status of affluent and poor populations within and between countries is widening and that the goal of Health For All is regrettably distant still. In addition, new demands and new challenges appear constantly:

- structural reforms to our economies to adjust them to a global market are not necessarily oriented by our recognized values of equity, quality, relevance and cost-effectiveness, and frequently result in worsening the already dire health conditions of our most vulnerable populations.
- emergent and re-emergent diseases, which greatly increase the disease burden, principally of those whose health status is already the most precarious;
- the growing deterioration of the world environment, which is seriously threatening the biosphere with consequences not well understood;
- the disturbing diminution of the quantity and quality of water available for human needs;
- a growing population, characterized essentially by their poverty and ignorance and concentrated in our developing countries.

Consequently, if Health For All is still our universal goal, we must realize it is essential to make efficiency the basic necessary requisite for the functioning of every health delivery system, for the optimal use of available resources, already limited in relation to the challenges, is the only possible approach towards equity in the system.

Unity is needed

Nevertheless, of course, the fragmentation of the system reduces any possibility to advance towards our values. Therefore—after decades of awareness of its reality—we cannot and should not hide the cause of this fragmentation: the non-critical and selfish mentalities prevalent in the most powerful agents present in the health delivery systems.

Individual and collective actions all too frequently seem oriented exclusively towards the acquisition and conservation of power, and our experience is that any drive for change almost naturally encounters resistance due to inertia and mental laziness, or to a knee-jerk fear of change, or to a mere interest in keeping or increasing the privileged position of those agents.

Perhaps the most important contribution of the TUFH project is the acknowledgement of the need for all actors to understand their roles and to allow all the changes needed to do away with the fragmentation of the health delivery system. Indeed, we must ensure that the prevalent attitudes and behaviours express solidarity towards our fellow human beings who are most in need.

Even if we must admit that the recommendations for an action agenda are sensible and accurate, it is nonetheless important to point out that some agents have more responsibility than others in the effort towards unity and that the motion to change can be the initial responsibility of some agents only.

It should be clearly stressed that the transformation cannot be initiated in our countries without a clear and evident demonstration of political will from the power elite.

Similarly, at the international level, WHO cannot obtain significant results if its alliances with other United Nations agencies and multinational and national funding institutions are not developed and strengthened.

The research booster

It is necessary to accept and demonstrate forcefully that in many countries—at least in this part of the world—the drive to reform the health services delivery system must come from outside, and that the required additional resources and impetus should be made available only if the political determination is adequately evident. On the other hand, the availability of additional resources will depend on the evidence produced by adequate and relevant preliminary research that justifies the specific actions proposed. Actually, research itself can be in many cases the initial step in the process towards unity.

It is important therefore to appreciate fully the significance of action research in establishing the process towards unity for health. This research will yield knowledge about the exact nature of:

- Strengths and weaknesses that can be identified for each component of a health system or each stakeholder (policy-makers, health managers, health professionals, academic institutions and communities) and threats and opportunities present in the social, political and economic context;
- Designing optimal strategies for institutional changes;
- Optimal contributions required from all stakeholders of the ➤
The Phuket Consensus
Building partnerships among stakeholders for unity in health

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 both reflects and influences the health of the communities and environments in which they live, work and play.
- Each person has the right to healthy environments and equitable, effective, 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 an Action Agenda

This agenda is proposed to address the specific objectives of the project “Towards Unity for Health” (TUFH), which are to improve the relevance and performance of the health service delivery system to better meet people’s needs. The TUFH project aims to do this by facilitating coordination/integration of the wide spectrum of interventions geared towards individual health and community health at the level of a given population and by creating productive and sustainable partnership among key stakeholders working at that level, namely, policy-makers, health managers, the health professions, academic institutions and communities.

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, and 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 and ensure substantive support for TUFH by these and all other 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 and 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 Towards Unity for Health.

Jorge Montalvan, MD, PhD, is Director, Instituto Nacional de Investigaciones en Salud y Desarrollo, Universidad Latina, Panama, and Professor, Faculty of Medicine, University of Panama, P.O. Box 91, Zone 9, Panama, PANAMA (Telephone: +507 261 5157; +507 614 2522; Fax: +507 227 8877; E-mail: montalva@sinfo.net).
World directory of medical schools
Supplemental information

The following information on medical schools has been received by WHO from the governments of its Member States since the publication of the second issue of this newsletter:

**Belize**
A licence was granted to the following school to operate from 23 August 1999 to 23 August 2009:

Grace University School of Medicine

**Chile**
A certificate was granted to the following school on 28 April 2000:

Facultad de Medicina
Universidad de Los Andes
San Carlos de Apoquindo 2200
Casilla 20106
Las Condes-Santiago

**Ecuador**
The following school was approved by the Superior Academic Council in October 1994 and recognized by the National Council of Superior Education (CONESUP) in May 2000:

Facultad de Medicina
Pontificia Universidad Católica del Ecuador
Av. 12 de Octubre 1076 y Patria Torre 1, Piso 7
Quito

**Hungary**
The names of the universities in Hungary have been changed due to reorganization. The revised list of medical schools is as follows:

Semmelweis Egyetem (Semmelweis University)
Ullói út 26
1085 Budapest

Debreceni Egyetem, Orvos-és Égészségtudományi Centrum
(University of Debrecen, Medical and Health Sciences Centre)
Nagyerdéi krt. 98
4012 Debrecen

Pécsi Tudományegyetem,
Orvostudományi és Égészségtudományi Centrum

(University of Pécs, Medical and Health Sciences Centre)
Szegeti ut 12
7624 Pécs

Szegedi Tudományegyetem, Szent-Györgyi Albert Orvos-és Gyógyzseléz-s tudományi Centrum
(University of Szeged, Medical and Medicine Sciences Centre)
P.O. Box 481
Zrínyi utca 9
6701 Szeged

**India**
Award of MBBS degree recognized by Medical Council of India from:

Terna Medical College
University of Mumbai
Terna
Navi Mumbai
Maharashtra

**Mexico**
Instruction has begun at:

Escuela de Medicina “Don Santiago Ramón y Cajal” del Instituto Westhill
Universidad Nacional Autónoma de México
Mexico City

**Pakistan**
The following school has been provisionally recognized by the Pakistan Medical and Dental Council up to the 4th year of MBBS class:

Ziauddin Medical College
4/B, Block ‘6’
Clifton
Shahrah-e-Ghalib
Karachi 754600

**Philippines**
Instruction began in 1996 at:

College of Medicine
University of Perpetual Help[em]Rizal
Las Piñas City

Readers are reminded that WHO has no authority to grant any form of recognition or accreditation to schools of medicine or other training institutions. Such a procedure remains the exclusive prerogative of the national government concerned. WHO limits itself to publishing information on medical schools that has been provided or confirmed by the governments of its Member States.

The seventh edition of WHO’s World directory of medical schools (xiv + 441 pages, ISBN 92 4 150010 7, WHO order number 1157268) contains information on 1641 medical schools in 157 countries. The directory sells for CHF 45.00 or USD 40.50; the price in developing countries is CHF 31.50. Addresses of national WHO distributors can be requested by electronic mail from <publications@who.int> or can be found on the WHO publications Web pages: <http://www.who.int/dsa/>.

For information on specific schools, please see the following URLs:

- <http://whqlibdoc.who.int/publications/WDMS/WDMS_A-C.pdf>

In addition, please see the Towards unity for health newsletter, issue 2, October 2000, pp. 36–37.
Since its inception in 1948, WHO has published world directories of schools of health personnel. The *World directory of medical schools* (WDMS) is the only one published in recent years. The last and seventh edition was issued in 2000. Since then, updates from governments about medical schools have appeared in this newsletter.

WHO is now considering ceasing to publish both the WDMS and the updates. This is because, although WHO has always made it clear that inclusion of medical schools in the WDMS does not constitute formal recognition or accreditation by WHO of their programmes, misinterpretation and misuse—including commercial exploitation—of inclusion in the WDMS persist.

Also, it is increasingly easy for individuals and organizations to obtain information on formal recognition of medical schools directly from national authorities. Finally, the evolving demands on WHO’s staff make it unrealistic to expect to continue even the present level of maintenance of information on medical schools.

An electronic database of medical schools is now under development. This database is intended to cover a wide range of areas such as curriculum content, educational approaches, quality assessment and the relationship of medical schools with other institutions (please see the article of Dr Mark Boyer in this issue). A revision of this database to include significant features and changes in medical schools is foreseen as the result of a cooperative effort among several agencies actively involved in international medical education.

A global consortium on medical schools may be established to improve the quality of medical education as well as the capacity of medical schools to respond to societies’ priority health needs. Further information on a possible global consortium on medical schools will appear in the next issue of this newsletter, in October 2001.
### Addresses

#### WHO headquarters
World Health Organization  
1211 Geneva 27, Switzerland  
(Telegraph: UNISANTE GENEVA;  
Telex: 415 416;  
Telephone: +(022) 791 21 11;  
Fax: +(022) 791 31 11)

#### WHO regional offices

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<th>Office</th>
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<th>Telephone</th>
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| Africa | Regional Office for Africa | Temporary address: Parirenyatwa Hospital; P.O. Box BE 773; Harare, Zimbabwe  
(Telegraph: +(001) 407 733 9244;  
Fax: +(001) 407 726 5062) |
| Americas | Regional Office for the Americas  
Pan American Sanitary Bureau | 525-23rd Street, N.W.; Washington, D.C. 20037; USA  
(Telegraph: OISAPANWASHINGTON;  
Telex: 248338;  
Telephone: +(1 202) 974 3000;  
Fax: +(1 202) 974 3663) |
| Eastern Mediterranean | Regional Office for the Eastern Mediterranean | P.O. Box 1517; Alexandria 21511, Egypt  
(Telegraph: UNISANTE ALEXANDRIA;  
Telex: 54028 or 54684;  
Telephone: +(203) 48 202 23;  
Fax: +(203) 48 38 916) |
| South-East Asia | Regional Office for South-East Asia | World Health House; Indraprastha Estate; Mahatma Gandhi Road; New Delhi 110002, India  
(Telegraph: WHO NEW DELHI;  
Telex: 3165095 or 3165031;  
Telephone: +(91) 11 331 7804;  
Fax: +(91) 11 332 7972) |
| Western Pacific | Regional Office for the Western Pacific | P.O. Box 2922;  
1099 Manila, Philippines  
(Telegraph: UNISANTE MANILA;  
Telex: 27652;  
Telephone: +(632) 528 8001;  
Fax: +(632) 521 1036) |
| European | Regional Office for Europe | 8, Scherlgsvej; DK-2100 Copenhagen  
(Telegraph: UNISANTE COPENHAGEN;  
Telex: 39171717;  
Fax: +(45) 3917 1818) |

#### WHO collaborating centres in human resources development

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<th>Centre</th>
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| Centre collaborateur de l’OMS pour la Recherche en matière de Développement des Ressources humaines pour la Santé | Faculté des Sciences de la Santé; Université nationale de la République du Bénin; B.P. 188; Cotonou, Benin  
(Telephone: +(229) 300 001;  
Fax: +(229) 301 298) |
| WHO Collaborating Centre for Education and Medical Practice | Faculdade de Medicina; Universidade Federal de Minas Gerais; CP 100; Belo Horizonte, Minas Gerais 30.130–100, Brazil  
(Telephone: +(55 31) 239 7167;  
Fax: +(55 31) 273 4985) |
| WHO Collaborating Centre in Medical Education and Practice | Centro de Ciências da Saúde; Universidade Estadual de Londrina; Cx. Postal 6001; CEP 86051; Londrina, Paraná, Brazil  
(Telephone: +(55 432) 268;  
Fax: +(55 432) 21 2000;  
Fax: +(55 432) 27 6922) |
| WHO Collaborating Center for Health Manpower Development | McMaster Health Sciences International; McMaster University;  
1200 Main Street West; Hamilton, Ontario, Canada L8N 3C5  
Please contact: Helen Wagner, Administrative Assistant;  
(Telephone: +(1905) 525 9140, ext. 22318;  
Fax: +(1905) 524 5199;  
E-mail: wmhsi@mcmaster.ca) |
| WHO Collaborating Centre for Medical Education and Practice | Facultad de Medicina; Universidad de la Frontera; Montt 112 - Casilla 54-D; Temuco, Chile  
(Telephone: +(56 45) 212108;  
Fax: +(56 45) 212108) |
| WHO Collaborating Centre for Development of Human Resources for Health | Faculty of Medicine; Suez Canal University; Ismailia, Egypt  
(Telephone: +(26) 3297 scufm un;  
Fax: +(26) 328 935;  
Fax: +(26) 329 982) |
| WHO Collaborating Centre for the Development of Human Resources for Health and for Primary Health Care | Department of General Practice and International Health Management; Istituto Superiore di Sanità;  
Viale Regina Elena 299; I-00161 Rome; Italy  
(Telephone: +(396) 4938 7294;  
Fax: +(396) 4938 7295) |
| WHO Collaborating Centre for Training of Health Professionals | Department of Training in Public Health and Bioethics; Istituto Superiore di Studi Sanitari, Largo del’Artide 11, Rome, Italy-00144 |
| WHO Collaborating Centre for Problem-based Learning in Health Professions Education | International Health Management Centre; Istituto Superiore di Sanità;  
Viale Regina Elena 299; I-00161 Rome; Italy  
(Telephone: +(396) 4938 7294;  
Fax: +(396) 4938 7295) |

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**Centre collaborateur de l’OMS pour le Développement des Ressources humaines pour la Santé**  
Département de Pédagogie des Sciences de la Santé; U.F.R. sur la Santé, Médecine et Biologie humaine de Bobigny; 74, rue Marcel Cachin; 93012 Bobigny CEDEX, France  
(Telephone: +(3311) 48 38 76 40, ext. 224 / (3311) 48 38 76 41;  
Fax: +(3311) 48 38 77 77)

**Centre collaborateur de l’OMS pour le Développement des Ressources humaines**  
Fondation Mériel, Centre des Pensières; 55, avenue d’Annecy; 74290 Veyrier-du-Lac, France  
(Telephone: +(33) 50 64 80 80;  
Fax: +(33) 50 60 19 71)

**WHO Collaborating Centre for Educational Development of Medical and Health Personnel**  
Educational Development Centre; Shaheed Behesti University of Medical Sciences and Health Services; Teheran, Islamic Republic of Iran  
(Telephone: +(98) 21 293 211;  
Fax: +(98) 21 294 228)

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**Centre Collaborador de la Organizacion Mundial de la Salud para la Formación de Recursos Humanos**  
Facultad de Medicina; Universidad Nacional Autónoma de México; Edificio “B” Primer Piso; Apartado Postal 70-443; México, DF 04510, Mexico  
(Telephone: +(52 5) 616 1182;  
623 2401/2402;  
Fax: +(52 5) 616 1616;  
E-mail: acq@servidor.unam.mx)
WHO Collaborating Centre for Health 
Manpower Development
Office for International Relations; 
Faculty of Medicine; Rijksuniversiteit 
Limburg; Postbus 616; 6200 MD 
Maastricht, Netherlands 
(Telex: 56880 fg n n; 
Telephone: +(3143) 881 520; 
Fax: +(3143) 670 708)

WHO Collaborating Centre for Research 
in Health Manpower Development; 
Community-Based Educational Systems 
(COBES) Programme
Faculty of Health Sciences; University of 
Ilorin; PMB 1515; Ilorin, Nigeria 
(Telex: 33144 unilon ng; 
Telephone: +(23431) 221 844)

WHO Collaborating Centre for Research 
and Training in Educational 
Development of Health Personnel
Department of Medical Education 
(DME), College of Physicians and 
Surgeons, 7th Central Street, Defence 
Housing Authority, Karachi 75500, 
Pakistan 
(Telephone: +(92 21) 588 7111/ 
588 3285; Fax: +(92 21) 589 3062)

WHO Collaborating Centre for Quality 
of Care
Medical University of Southern Africa, 
Box 203 Medunsa 0204, 
Republic of South Africa 
(Telex: 32 0580 sa; 
Telephone: +(27 12) 529 4669; 
Fax: +(27 12) 560 0274)

WHO Collaborating Centre for Health 
Care Professionals Development 
Institut d’Estudis de la Salut; Balmes 
132-136; 08010 Barcelona; Spain 
(Telephone: +(3493) 238 6900; 
Fax: +(3493) 238 6910; 
E-mail: aob@ies.scs.es; 
Web: http://www.iesalut.es)

WHO Collaborating Centre for Research 
and Training in Educational 
Development
Educational Development Centre; 
Faculty of Medicine; University of 
Gezira; P.O. Box 20; Wad Medani; 
Sudan

WHO Collaborating Centre for Medical 
Education
Faculty of Medicine; Chulalongkorn 
University; Rama IV Road; Bangkok 
10330; Thailand 
(Telephone: +(662) 252 7859; 
Fax: +(662) 254 1931)

Centre collaborateur de l’OMS pour la 
Recherche et la Formation en matière 
de Développement de la Formation des 
Personnels de Santé
Centre National de Formation 
Pédagogique des Cadres de la Santé; 
67, boulevard Hedi Saidi; Bab Saadoun; 
Tunis 1005, Tunisia

WHO Collaborating Centre for Primary 
Health Care/Public Health Education 
School of Public Health; Loma Linda 
University; Loma Linda 92530; 
California; USA

WHO Collaborating Centre for Leadership 
Ship Development for Health for All 
School of Public Health; University of 
Hawaii; 1960 East-West Road; 
Honolulu; Hawaii 96822; USA 
(Telephone: +(1800) 956 7486; 
Fax: +(1800) 956 5296)

WHO Collaborating Centre for Educational 
Development of Health Professionals 
and Health Care Systems 
Department of Medical Education 
(M/C 591); University of Illinois College 
of Medicine at Chicago; Box 0996; 
Chicago, Illinois 60680, USA 
(Telephone: +(1312) 996 3590; 
Fax: +(1312) 413 2048)

WHO Collaborating Centre for Educational 
Development of Health Professionals 
and Health Care Systems 
University of Illinois College of Medicine 
at Rockford; 1601 Parkview Avenue; 
Rockford, Illinois 61107-1897, USA 
(Telephone: +(1815) 395 5600; 
Fax: +(1815) 395 5887; 
E-mail: Buz2@uiuc.edu or 
cbs4601@uicvmc.ais.uiuc.edu)

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

WHO Collaborating Centre for the 
Dissemination of Community-oriented, 
Problem-based Learning 
Primary Care Curriculum; Social 
Medicine Program; Department of 
Family and Community Medicine; 
School of Medicine; University of New 
Mexico; 2400 Tuckerver Avenue, NE; 
Albuquerque; New Mexico 87131-5241, 
USA 
(Telephone: 660 461; 
Fax: +(1505) 277 2165; 
Fax: +(1505) 277 0657)

WHO Collaborating Centre for International 
Health 
University of Texas Medical Branch at 
Galveston; 1,142 Bethel Hall; 301 
University Boulevard; Galveston, Texas 
77555-0862, USA 
(Telephone: 766603; 
Fax: +(1409) 772 0870; 
Fax: +(1409) 772 0875)

Nongovernmental organizations 
In official relations with WHO in 
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Conférence internationale des Doyens 
des Facultés de Médecine d’Expression 
française
(Monsieur le Professeur Pierre Farah, 
Président); Doyen de la Faculté de 
Médecine; Université St.-Joseph; B.P. 
11-5076, Beirut, Lebanon 
(Telephone: +(961) 1 614 004; 
Fax: +(961) 1 614 054; 
E-mail: pfarah@usj.edu.lb)

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

The Network: Community Partnerships 
for Health through Innovative 
Education, Service and Research 
(Coordinating Secretary; 
Dr P. Vluggen); P.O. Box 616; NL- 
6200 MD Maastricht 
(Telephone: +(3143) 388 1522/1524; 
Fax: +(3143) 367 0708; 
E-mail: secretariat@network.unimaas.nl 
World Wide Web: http://www.thenetwork.org)

World Federation for Medical Education 
(Prof Hans Karle, President); 
Faculty of Health Sciences; 
University of Copenhagen; 
The Panum Institute; Blegdamsvej 3; 
2200 Copenhagen N, Denmark 
(Telephone: +(45) 35 32 70 68; 
Fax: +(45) 32 32 70 70; 
E-mail: wfme@adm.ku.dk)

World Medical Association 
Dr Delon Human, Chief Executive 
Officer, WMA Secretariat; B.P. 63; 
01212 Ferney-Voltaire, France 
(Telephone: +33 450 40 7575; 
Fax: +33 450 40 5937; 
E-mail: inform@wma.net)

World Organization of Family Doctors 
(WONCA) 
(Prof W.E. Fabb, Chief Executive Officer); 
World Organization of Family Doctors; 
Locked Bag 11; Collins Street East Post 
Office; Melbourne Victoria 8003, 
AUSTRALIA 
(Telephone: +(61) 3 9650 0235; 
Fax: +(61) 3 9650 0236; 
E-mail: wonca@onaustralia.com.au)
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:

Dr Charles Boelen,
Department of Health Service Provision;
World Health Organization,
1211 Geneva 27, SWITZERLAND
(telephone: +41 22 791 2510;
fax: +41 22 791 4747;
e-mail: boelenc@who.int).

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