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EQUAL OPPORTUNITIES
FOR HEALTH
ACTION FOR DEVELOPMENT

International
conference

Equal opportunities
for health:
action for
development.
A plan of action
to advocate
and teach
global health

A COMMON COMMITMENT AND PLAN OF ACTION FOR GLOBAL HEALTH

"We are convinced that health is not a consumer good, but a fundamental human right. As such, it cannot be bought or sold. If health is a right, access to health services cannot be a privilege. If health is a right, it is our duty to fight for universal respect of this right."
(Doctors with Africa CUAMM, Policy Document, 2000).

For 60 years, promoting and protecting the right to health for all and particularly the most vulnerable sections of African populations has been and still is the mission of the Italian Ngo Doctors with Africa CUAMM. Guaranteeing health for all means ensure that everybody has access to the highest attainable standards of health regardless of his/her social and economic conditions, political views, ethnicity, age and gender. To fulfil its mission, Doctors with Africa CUAMM currently works in seven African countries (Angola, Ethiopia, Kenya, Mozambique, Sudan, Tanzania, and Uganda) where it operates with a long-term developmental perspective aiming at strengthening local health systems by delivering an adequate mix of effective services at hospital, district, and community/family levels, by training human resources for health, establishing public-private partnerships and by advocating equitable financing.

Despite being Doctors with Africa CUAMM's core business, implementation in the field cannot alone work towards reduction of inequalities in health which, in today's globalized world, are not only economically and socially unjustified but also ethically and morally unacceptable. Awareness of the interdependency of health issues at a global level must be raised also in the so-called North of the world. A common effort is therefore required towards reduction of such inequalities and everybody is called to be accountable and to take action to promote global health.

Based on these premises and together with 29 relevant partners and associates, Doctors with Africa CUAMM has promoted and implemented the project "Equal opportunities for health: action for development", aimed at mobilising public support in Europe for the promotion of global health. Within the project, on 03-04 April 2009 the international conference *"Equal opportunities for health: action for development. A plan of action to teach and advocate global health"* was held at the Department of Sociology of the University of Padova. 150 international participants representative of the health community attended the conference with the aim of elaborating a common plan of action to promote and teach global health, therefore focussing on concrete proposals and actions. Elaborated by four different working groups (namely: teaching global health at schools of health and human sciences; life-long learning of health professionals on global health; the role of international health cooperation in advocating, teaching and implementing global health; strategies for mobilising and sustaining financial and human resources to advocate and teach global health), such proposals have been collected in a final commitment paper which is the base for future action for global health advocacy and teaching.

This publication contains the conference proceedings, including the conference programme and list of participants, plenary session presentations, background papers prepared for the working groups, and the final commitment paper. The study "*Sustaining equity in the private-not-for-profit sector in Uganda: a public responsibility*" conducted by the Faculty of Health Sciences, Uganda Martyrs University and commissioned by the project in order to collect data on access to health in Uganda is also published in this review. As well, the article titled *"Teaching and training health professionals"* was kindly provided by the Institute of Tropical Medicine of Antwerp, Belgium, as an additional input for discussion.

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background papers

HEALTH PROFESSIONALS AS EFFECTIVE GLOBAL HEALTH ADVOCATES

The project "Equal opportunities for health: action for development"

In today's globalised world, health care workers are called to embrace a global approach to health and have a clear understanding of social, cultural and environmental factors affecting health and illness. Given the various social and professional roles they play and the variety of contexts they work in, health care workers can in fact act as pressure group and become activists in promoting the right to health for all and influence the elaboration of more equal policies. To promote an active role by the health community, a cultural change is needed as well as investment in education and training.

By / Giovanni Putoto, Serena Foresi, Elisabetta Bertotti / Doctors with Africa CUAMM / Italy

Health is a fundamental and universal human right incorporated into international legislation. One of the pillars in the fight against poverty, health is essential for the full development of human potential, not only for the physical, but also for the intellectual and emotional growth of every individual, and for the development of the productive and learning capacities required in order to ensure economic well-being and social advancement, both of which, in their turn, are a necessary element to avert potential social imbalances and conflicts.

Guaranteeing health for all, means promoting equal opportunities, justice, development and peace. In today's globalized world, this seems one possible path, given the general agreement within the corpus of preventive and curative medical technologies; the scientific knowledge and financial resources now available; and, for the first time in history, the commitment of all nations to the fight against poverty in their pursuit of the eight ambitious Millennium Goals. The health objectives amongst these Goals concern malnutrition, cutting infant mortality rates, improving maternal health and controlling epidemics.

Notwithstanding this, even though at the global level there has been an overall improvement in people's state of health, this improvement has really only affected one section of the population: indeed, not only are the disparities between nations growing, especially those between the North and South of the World, but also the gap between social groups is widening within nations themselves. This latter is particularly clear and important in developing countries, where access to health services is difficult for people who are already economically and socially vulnerable, and this causes them to retrogress even further, deepening their poverty.

It is clear how in today's globalized world these inequalities are socially determined, avoidable, unnecessary and unjust. Therefore, they can be referred to as inequities, as they are unacceptable, not only economically and politically, but also at the ethical and moral level. A real and shared commitment is required in order to raise awareness to confront these inequities because – quoting Richard Horton, Director of the Lancet – "Children and mothers are dying because those who have the power to prevent their deaths choose not to act. This indifference – by politicians, policy makers, donors, research funders, and civil society – is a betrayal of our collective hope for a stronger and more just society, one that values every life no matter how young or hidden from public view that life might be. It signifies an unbalanced world in which only those with money, military strength, and political leverage determine what counts and who counts. As health professionals, we should not accept this pervasive disrespect for human life"[1].

Only through collective action and mobilization for the creation of a movement to promote the right to health for all will it be possible to confront this indifference and raise awareness, in particular, among the health community. Given the various social and professional roles they play and the variety of contexts they work in, health professionals should be more aware of the importance of a global health approach and have a clear understanding of social, cultural and environmental factors affecting health and illness and of their ability and responsibility to influence them. Both as individuals and as members of professional bodies and public or private organisations, health care workers can in fact perform an important function as information spreaders and opinion makers. In other words, they can act as a pressure group for promoting a global approach to health and, by elaborating more equal health policies, become *de facto* activists in promoting the right to health thus helping to remove the barriers that stop the right to health from becoming a reality for all.

Based on these premises, and seeking to mobilise public opinion so as to create equal opportunities for health, the Italian Ngo Doctors with Africa CUAMM has been promoting the project *Equal opportunities for health: action for development*, which, co-financed by the European Union, has been carried out from May 2007 to July 2009 in partnership with diverse institutions representative of the health community in 6 member states (Italy Germany, Poland, the UK, Belgium and Spain). Participants come from various areas: Universities, students' associations, health and hospital authorities, trade unions, research centres, scientific societies, non-governmental associations[2].

To mobilise an active role by the health community and in turn

to promote more equitable health policies, a cultural change is needed as well as investment in education and training on global health at all levels, both at university and in the field of lifelong learning.

As far as academic teaching is concerned, mapping of undergraduate courses on global and international health at Italian Medicine and Surgery Faculties has revealed that current *curricula* are too heavily focused on national and predominantly clinical aspects and lack any global approach to health. Thus, they are not able to meet the needs and challenges of a globalised world. Global health is mostly taught in elective courses and there is poor coordination regarding contents, as also there is a diversified geographical distribution of courses, with a very few courses available in the South of Italy. With a view to increasing the number of courses and promote coordination, a proposal for a *curriculum* has been drawn up within the project, which includes six teaching modules, namely: Health and its determinants; The origins and development of health systems. Health as a human right; Globalisation and health; Inequalities in health and in health care assistance; Immigration and health; and, International health cooperation. This proposal has been circulated through the network of contacts which was set up during the mapping activity and was welcomed by University staff in almost all Italian Medicine Faculties, who – after participating in a training of trainers – have been promoting electives in global health in their own Faculties. Training and programming of new electives have favoured sharing experiences and good practices and reinforcing a pool of experts on global health who are able to act as promoters and advocates for the inclusion of such issues in the core *curricula* of Medicine Faculties.

Besides academic teaching, global health has been also promoted in the area of lifelong training through seminars and workshops organized in collaboration with local Health and Hospital Authorities. Using similar contents to those in the *curriculum* proposal, the seminars have sought both to raise awareness on global health related issues and to strengthen those social and professional competences and abilities which health workers today need if they are to operate in this complex, changing and global context. The seminars also tried to stimulate health workers to become active promoters of the right to health, both by working in the field of international health cooperation in developing countries and by advocating health policies that guarantee equal access.

In order to elaborate a common plan of action to promote and teach global health and to stimulate the creation and strengthening of strategic partnerships, an international conference *"Equal opportunities for health: action for development! A plan of action to teach and advocate global health"* was held at the Department of Sociology of the University of Padova on 03-04 April 2009. This Conference – which was attended by 150 international participants representative of the health community – offered an opportunity to bring students, faculty and professional staff, researchers, representatives of medical companies, health and education organisations/institutions, and health community members together to discuss health inequalities and other major challenges facing today's health workforce, and to focus on proposals and projects to foster global health teaching and advocacy. Split into four working groups (teaching global health at schools of health and human sciences; lifelong learning of health professionals on global health; the role of international health cooperation in advocating, teaching and implementing global health; and strategies for mobilising and sustaining financial and human resources to advocate and teach global health), such proposals have been collated into a final commitment paper which will be the basis for future action to update *curricula* and education patterns, to link academic teaching and professionalism, to promote interdisciplinary approaches and strengthen strategic partnerships.

As well as intervening at the level of training and advocacy, the project *Equal opportunities for health: action for development* has also been committed to raising awareness by organising workshops for promoters and activists who, in their turn, have been involved in organising workshops and awareness raising events. Furthermore, given the importance of disseminating information in order to mobilise public opinion, some publications have been drafted and published within the project, including the translation of the 3rd Report of the Italian Global Health Watch *"Global health and development assistance. Rights, ideologies and deceit."*, the present issue of Doctors with Africa CUAMM's "Health and Development" review, and the realisation of the study "*Sustaining equity in the private-not-for-profit sector in Uganda: a public responsibility*" conducted by the Faculty of Health Sciences, Uganda Martyrs University.

Education, training, advocacy and public awareness raising play a pivotal role in the promotion of global health. Indeed, informed health workers can act as opinion makers and information multipliers as well as influence the elaboration of more equal health policies. To be more effective and promote a global health movement, coordinated actions and efforts as well as strengthening of networks are needed.

For more information, please visit: **www.mediciconlafrica.org/globalhealth**.

1 Richard Horton, *Countdown to 2015: a report card on maternal, newborn and child survival.* Lancet 2008, 371: 1217-19.
2 Partners: OISG, Italian Global Health Watch (IT); Department of Medicine and Public Health, University of Bologna(IT); Department of Public Health, University of Florence (IT); SISM- Italian Secretariat of Medical Students (IT); Nuffield Centre for International Health and Development, University of Leeds (UK); Redemptoris Missio Medicus Mundi Poland (PL); action medeor e.V. (DE).
   Associates: Department of Environmental Medicine and Public Health, University of Padua (IT); Department of Public Health and Microbiology, University of Turin (IT); Department of Internal and Specialist Medicine, University of Catania (IT); Department of Experimental, Environmental Medicine and Biotechnology, University of Milan (IT); IRCCS Burlo Garofolo (IT); Prince Leopold Institute of Tropical Medicine (BE); Medicus Mundi Spain (ES); ONSP-National Observatory of Residents in Paediatrics (IT); IPASVI, Padua College of Nurses (IT); Medical and Dentists Association of the Province of Padua (IT); Padua Hospital Authority (IT); Doctors with Africa CUAMM support groups (IT).

HEALTH INEQUALITIES AND STATE OF THE WORLD'S HEALTH

Global health challenges for the health community

Inequity is the result of historical differences in people's circumstances which have evolved over thousands of years. Today's world is characterized by significant disparities in health status or in the determinants of health between groups with different levels of underlying social advantages or disadvantages, both between countries and within countries themselves. The challenge for the health community is to work towards a new world order based on equity.

By / Sam Okuonzi / African Centre for Global Health and Social Economic Transformation / Uganda

Equity in health is the absence of systematic disparities in health status or in the determinants of health between groups with different levels of underlying social advantages or disadvantages that are usually mediated through wealth, power or prestige (Braveman, 2004). Conversely, health inequities are the differences in health status that are unnecessary, avoidable, unfair and unjust (Dahlgren and Whitehead, 1992). Inequities in health systematically put groups of people at a disadvantage through such factors as being poor, female, or members of a disenfranchised racial, ethnic or religious group.

Equity is an ethical principle; it is also consonant with and closely related to human rights principles. The right to health is the right to the highest attainable standard of health as indicated by the health status of the most socially advantaged group. Assessing health equity requires comparing health and its determinants between different social groups. These comparisons show whether national and international policies are leading towards or away from social justice in health.

However, equity is not equality. Individuals have different attributes such as age, sex and genetic makeup, which create significant differences in health. Such differences are expected and unavoidable. Because of such differences, to attain equity, services or resources ought to be redistributed unequally. Thus, in vertical equity, equal resources ought to be given for health services and health determinants for equal needs of different groups. Conversely, in horizontal equity, unequal resources are given or allocated for health services and health determinants for unequal needs of different groups (Braveman, 2004).

MAGNITUDE OF HEALTH INEQUITY

Global and national health inequities are currently colossal. Consumption by an average person in a poor country is about USD 500 per year, while in a rich country, it is about USD 50,000 - 100 times more (Lindstrand *et al.*, 2006). In a poor country there are 300 child deaths per 1,000 live births as compared to only 3 per 1,000 live births in a wealthy country, again by a factor of 100 times.

A child born in Sierra Leone lives 45 years less than one born in Japan. And a child born in Afghanistan is 8 times more likely to die before his/her 4th birthday than one born in Singapore. There are also huge health inequities within countries. Infant Mortality Rate (IMR) varies by a factor of up to 4 between the richest and poorest groups in the same country (**table 1**).

HISTORY AND DRIVERS OF HEALTH INEQUITY

The current huge differences in health around the world are linked to historical differences, the global economic structures, and local factors. The history of mankind is now traced to Africa (Diamond, 1997). Mankind started in Africa and migrated as hunters and gatherers, with similar levels of welfare. But subsequently people followed different courses of history due to differences in their environment, not because of biological differences. There is no evidence to suggest that those who prospered and became well off over time, were more intelligent or better endowed physically than those who did not.

Certain situations and events have led to the current unequal and unjust world (**figure 1**). All humans were hunters and gatherers, surviving the hard way. Then humans migrated around the world, and settled in almost all parts of the world about 10,000 years ago. The people who settled in the Middle East first practiced agriculture. Subsequently, agriculture was independently discovered in the Americas, Asia and Polynesia, and to a less extent in Africa. Eventually, after thousands of years, agriculture had spread around the world. In the areas where agriculture first started, certain local animals and plants were suitable for domestication. No new plants and animals have been domesticated for the past 4,000 years. The plants and animals have only been taken around the world and raised in the new places. With the discovery of agriculture, food security through the storage of grains ensured predictable availability food. As a result of food

TABLE 1 / IN-COUNTRY HEALTH INEQUITY BY IMR (PER 1000)

COUNTRY	RICHEST QUINTILE	POOREST QUINTILE	FACTOR %
BRAZIL	30	100	3.3
INDIA	50	158	3
INDONESIA	30	120	4
KENYA	60	138	2.3

Source: Victora, 2003

availability, human population shot up. **Table 2** shows how the population in areas where agriculture started and flourished increased more rapidly.

Larger population brought with it the need to organize and manage society. In particular, the need to know numbers and to keep a record of things like tax payments etc. arose. Hence, arithmetic (later mathematics) and writing were invented. This improved orderly management of societies. Those discoveries laid the foundation for better and deeper knowledge, knowledge creation and propagation. With better knowledge, people invented better and faster means of transport (ships, chariots, etc.) and weapons for hunting and wars. Thus, it became possible for those who had this advantage to have wider and more frequent contact with other humans through trading and conflicts. It was also possible to explore and exploit the world as far as possible.

Colonization plus kingdoms and empires were the result of such exploration and exploitation. By interacting with different peoples through wars, trade, colonization and empires, more and better knowledge was accumulated by this group of humans in Eurasia compared to other humans who did not have the advantage of a head start in agriculture. Superior knowledge led to the creation of civilizations and economic and military superpowers. These in turn led to the domination and control of other humans by the group which had had a head start in agriculture. It became imperative for this group to stop other human groups from competing to control resources. A global economic and social system was thus designed by default, which evolved into the current unequal and unjust world.

Those who had a head start in agriculture and had other favourable factors such as good climate, relative freedom from disease and easy topography (the Euroasia region) ascended, through these events, to dominate the world. But others, particularly Africans, to whom agriculture was introduced thousands of years later, remained greatly deprived of this initial knowledge and the advantages that went with it. Africa was disadvantaged by disease, thick tropical forests and harsh deserts, making human contact and interaction (and hence transmission/assimilation of knowledge) impossible.

Mainly as a result of the economic exploration and exploitation by the Eurasians (later Europeans) the growth of global wealth increased from 2,000 per capita in 1,000 AD to 70,000 USD per capita in 2000 AD an increase of 350 times (**table 3**). But the world population increased only 20 times, from 300 million in 1000 AD to 6 billion today (**table 2**).
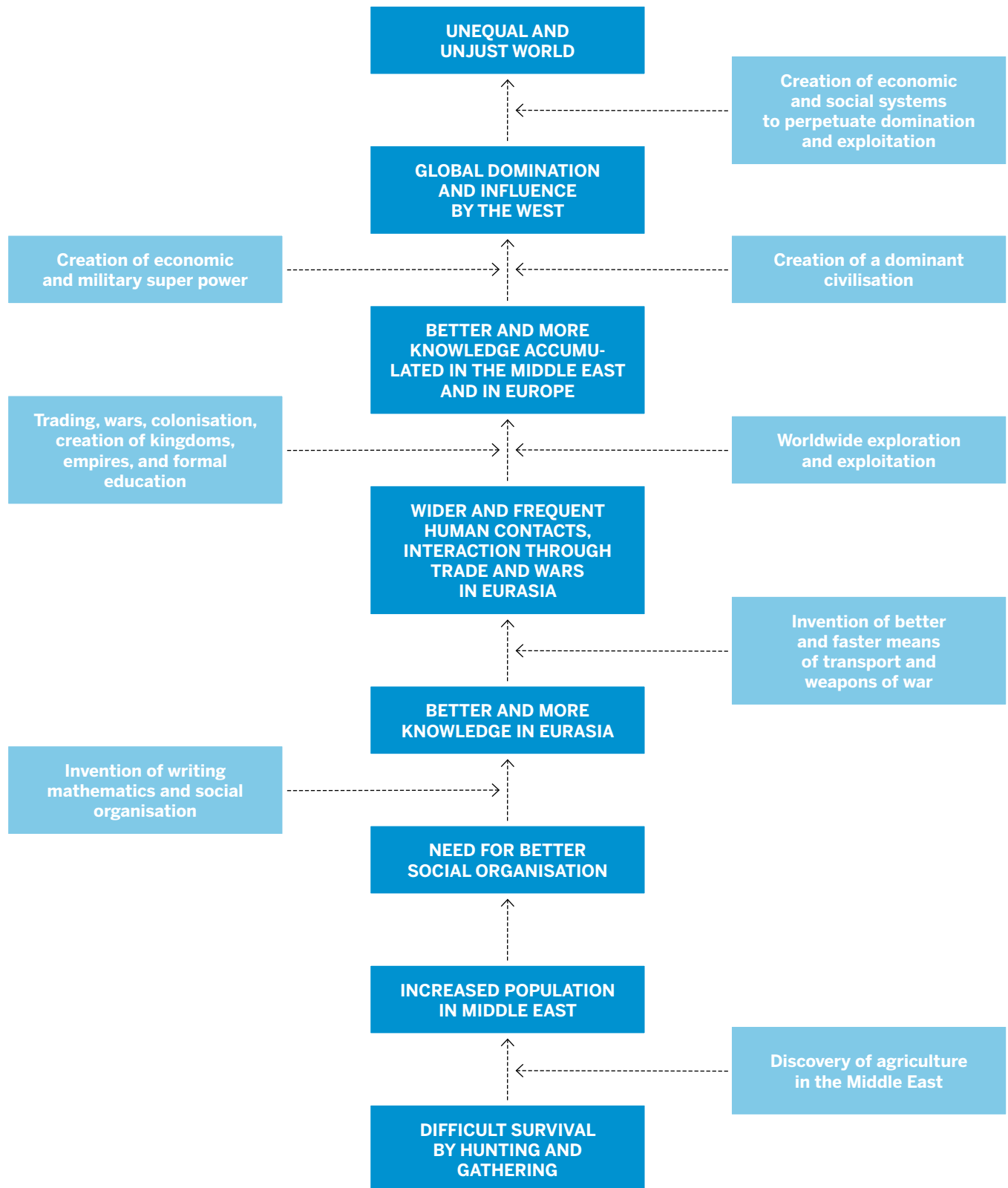
THE FREE-MARKET AND INEQUITY

The global economic system that has been created is free-market globalization. In this system, transnational corporations accumulate and spread capital and trade around the world. These corporations have gained much power globally and have in many cases surpassed the power of national governments. A new cultural global entity of the elite has been created comprising rich, educated and powerful social groups (Raskin *et al.* 2002). Inequity within countries is driven and maintained by various factors including corruption, poor governance, a free-market policy that is based on inequity, lack of capacity for policy analysis and planning, fragmentation of government systems into conflicting interest and value systems and programmes, and, by poor stewardship.

Free-market ideology is based on private entitlement and personal liberty (Raskin *et al.* 2002). The market is seen as a neutral and just distributor of wealth and as being self regulating. It is believed that the market should not be interfered with. Government is viewed as being unnecessary and intrusive in private life. Everybody is considered to have been equally endowed with physical and mental attributes, therefore people who become poor or disenfranchised are seen as having chosen to be so. Therefore, according to this logic, since it is choice people make to be what they are, inequality has to be accepted and expected. Economic policy to support this philosophy has been propagated around the world by the World Bank and International Monetary Fund since the 1990s.

It was called the Washington Consensus and comprised privatization; reduction of government size and of its role in people's

FIGURE 1 / KEY SITUATIONS AND EVENTS LEADING TO THE CURRENT INEQUITABLE WORLD

UNEQUAL AND
UNJUST WORLD

Creation of economic
and social systems
to perpetuate domination
and exploitation

GLOBAL DOMINATION
AND INFLUENCE
BY THE WEST

Creation of economic
and military super power

Creation of a dominant
civilisation

BETTER AND MORE
KNOWLEDGE ACCUMU-
LATED IN THE MIDDLE EAST
AND IN EUROPE

Trading, wars, colonisation,
creation of kingdoms,
empires, and formal
education

Worldwide exploration
and exploitation

WIDER AND FREQUENT
HUMAN CONTACTS,
INTERACTION THROUGH
TRADE AND WARS
IN EURASIA

Invention of better
and faster means
of transport and
weapons of war

BETTER AND MORE
KNOWLEDGE IN EURASIA

Invention of writing
mathematics and social
organisation

NEED FOR BETTER
SOCIAL ORGANISATION

INCREASED POPULATION
IN MIDDLE EAST

Discovery of agriculture
in the Middle East

DIFFICULT SURVIVAL
BY HUNTING AND
GATHERING

Source: Author's compilation

TABLE 2 / GLOBAL POPULATION GROWTH OVER 2,000 YEARS ('000,000)

YEAR	0	1000AD	1500AD	2000AD
ASIA	174	183	283	3516
EUROPE	34	39	88	388
AMERICAS	7	13	21	83
AFRICA	17	33	46	760

Source: Lindstrand *et al.*, 2006

TABLE 3 / GLOBAL GROWTH OF WEALTH IN GDP/CAPITAL USD PURCHASING POWER PARITY

	1000AD	1500AD	2000AD
ASIA	500	600	3,000
JAPAN	400	500	20,000
WEST EUROPE	400	500	17,900
NORTH AMERICA	400	400	26,000
AFRICA	400	400	1,400
TOTAL	2,100	2,400	67,300

Source: Lindstrand *et al.*, 2006

lives; liberalisation (removal of rules and regulation) and macro-economic stability, mainly the control of inflation, and liquidity that could be used for social services (Stiglitz, 2002). The free market system has other consequences, including unsustainable use of natural resources; unsustainable population increase; environmental degradation; increase of inequity, which is causing social unrest; and, conflict and terrorism.

systems. The third is to establish social welfare systems that are sustainable, equitable and affordable. And the fourth is to create and promote national and global leaderships that can work towards a new world order that supports sustainability of resources and equity. Such a world order would work on the basis of values of democracy, equality, solidarity, tolerance, respect for nature and shared responsibility (Lindstrand *et al.* 2006).

CHALLENGES

Thus, four challenges need to be addressed to create a world that is equitable, sustainable and affordable. The first is to make the global economic system equitable and just. The second is to create sustainable and equitable global and national health

WAY FORWARD

A number of strategies have been suggested: firstly, developing countries need to assert their influence in the world through the five factors by which the western world has dominated the world – financial system, technology, culture, media and military

power (Amin, 2000). Developments in China, India and Brazil are in the right direction. But more of the poorer nations need to be involved through such forums as the group of 77.

Secondly, fundamental changes in values have to be made in order to construct a new economic system. The goal of this new system must be to attain sustainable development, peace and social stability. This will entail a shift from free-market values (of profit, competition, materialism, domination of others and individualism) to social values (of equity, sustainability, tolerance and shared responsibility).

Thirdly, a new global governance is necessary. The United Nations (UN) must be reformed so that it has a democratic parliament of representatives from across the world. A real central bank for the world must be created to replace the IMF using a global currency to replace the US dollar. The role of the World Bank also has to be redefined in order to collect surpluses to lend to poorer nations as development aid. A genuine World Trade Organization (WTO) must be set up based on free trade rules that apply equally to all countries. The environment and sustainable use of resources will be key factors in global governance.

Fourthly, the health system must be reformed in such a way as to strengthen the health workforce, by creating capacities in countries to plan, implement and evaluate the health workforce; by changing the micro-economic policies to reduce constraints on expanding the health workforce; and by increasing access to higher medical education through networking. Also the reform of health financing has to be led by the country concerned, with the promotion of public financing which is either tax-based or heavily subsidized. In addition, health information systems have to be promoted to encourage access to public health data, to establish an incentive structure for collecting, sharing, analyzing and integrating data; and through use of independent third parties for evaluation (G8, 2009).

Fifth and last, international aid has to be reformed using the Paris Declaration principles of alignment with recipient governments' policies, fostering harmony among donors, managing for results appreciated by all stakeholders, and mutual accountability between donors and recipient countries (Fritz and Menacol, 2007).

CONCLUSION

Inequity is the result of historical differences in people's circumstances which have evolved over thousands of years. But some groups of humans have exploited their historical advantages to dominate the world economically, socially and militarily. However, the economic and social system which operates in the world today is unsustainable and needs to be reformed. A new world order is required, especially as the current system is beginning to break down through the global economic meltdown (Shutt, 1998). The challenge for the health community is to work towards a new world order based on equity, and not to waste time and effort trying to achieve equity in a world that has been designed to be inequitable.

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TRAINING
NEW DOCTORS

University teaching and global health

In the traditional approach to teaching and learning medicine, local students and local teachers use a local curriculum. This approach seems to be outdated and discussion is about the need to include global health in the teaching *curriculum*, therefore setting the study of medicine within the global context rather than the context of a single country and also promoting the cultural role of the health professional doctors as opinion makers.

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Global health is a challenge to define, and even more a challenge to improve. A broad definition of global health is given by the United States Institute of Medicine as "health problems, issues, and concerns that transcend national boundaries, may be influenced by circumstances or experiences in other countries, and are best addressed by cooperative actions and solutions"[1].

Most medical and post graduate students in rich countries think that there should be more teaching on global health issues, and many have led the way in calling for global health to be included in their curriculum. Little is known, however, about the experiences of teaching and learning about global health in medical schools in developing countries, which are in the frontlines of global health problems.

Globalisation is accelerating and is forcing us all to realise that we cannot isolate ourselves from international issues. The interconnectedness of the world and the implications it has for all has become very real. The health sector, too, is being profoundly affected by changing global processes, from the HIV/AIDS pandemic, to the increasing flows of refugees and migrants, from the controversy over global pharmaceutical patents to the health implications of the World Trade Organisation. The issues of the day all affect the work of a doctor. It is no longer enough for medical curricula to teach about national medicine; our new doctors want, and need, more.

Internationalisation, one of the most important forces in higher education today, presents a powerful challenge and an opportunity for medical schools and post graduate schools of Public Health. Factors encouraging internationalisation include: globalisation of health care delivery, governmental pressures, improved communication channels, development of a common vocabulary, outcome-based education and standards, staff development initiatives, competitiveness and commercialization.

A three-dimensional model based on the student (local or international), the teacher (local or international), and the *curriculum* (local, imported, or international), offers a range of perspectives for international medical education. In the traditional approach to teaching and learning medicine, local students and local teachers use a local *curriculum*. In the international medical graduate or overseas student model, students from one country pursue in another country a *curriculum* taught and developed by teachers in that country. In the branch-campus model, students, usually local, have an imported *curriculum* taught jointly by international and local teachers. The future of medical education, facilitated by the new learning technologies and pedagogies, lies in a move from such international interconnected approaches, which emphasize the mobility of students, teachers, and *curriculum* across the boundaries of two countries, to a more transnational approach in which internationalization is integrated and embedded within a curriculum and involves collaboration between a number of schools in different countries[2]. In this approach, the study of medicine is set within the global context rather than the context of a single country.

The importance of learning about the determinants of health is increasingly recognised. In the 1993 document on medical education, *Tomorrow's doctors*[3], The UK General Medical Council stated that understanding "the wide range of cultural, environmental and ethical issues that will increasingly impinge on the problems of health" is a priority. In the modern world, with accelerating globalisation, these health determinants are both global and local.

A number of issues have important global health implications: they are important in doctors' training both for educational reasons, in that they are among the most influential health determinants worldwide and, for practical reasons, since they affect the health of patients doctors deal with, whether at home or abroad[4]. The social and cultural dimension of globalisation is one of increased interconnection with people, goods, and ideas. Populations are becoming more multicultural, and health professionals are treating patients from many different countries. More people are travelling, making it necessary for doctors to be able to respond to the demand for travel health information. Borders are traversed more easily by wars and diseases, complicating the control of infectious diseases, such as tuberculosis, and doctors are more likely to encounter refugees, with their specific mental and physical health problems. Information now spreads very rapidly, and it is important to understand how research agendas are being shaped by global priorities[5].

A major force behind globalisation is that of global economic liberalisation and the political commitment to introduce markets into all spheres of public life, including health services [6]. Global bodies such as the World Trade Organisation and the World Bank, as well as Western governments, argue that this process will be beneficial to all, but there is much evidence that the opposite is true [7]. The gap between rich and poor both within and between countries has increased, and poverty is the greatest threat to health worldwide, with more than 880 million people lacking access to basic health care [8]. In many less-developed countries, health services are struggling to survive. They have a huge burden of disease and illness to cope with.

Violent conflicts are a growing threat to global health. At the beginning of the 20th century, 14% of the victims of violent conflicts were civilians; now it is 90% [9]. The Global Burden of Disease Study predicts that, by 2020, war will be one of the top ten causes of loss of disability-adjusted life-years.

The issue of access to medicines in the developing world has been brought to wider attention by campaigns to lower the price of antiretroviral therapy for individuals and governments in sub-Saharan Africa and other developing countries.

Technological advances are producing many new players in the field of global health. Information and communication technologies allow real-time video connections between experts, and instantaneous access to the latest information in online databases [10]. Although this development has brought many new benefits, there is also a risk that the knowledge could be used in ways detrimental to health, such as the potential to use genome mapping to produce biological weapons with effects on specific ethnic groups [11].

The cultural role of the health professional doctor as opinion maker should be emphasized in the training curriculum, together with lobbying and advocacy for health policies designed with equity in mind.

Training should be done at various levels:

1 / Degree in Medicine and Surgery.
2 / Postgraduate course in Public Health.
3 / Health Personnel.
4 / Cross-cutting disclosure.

1 / SCHOOLS OF HEALTH AND HUMAN SCIENCES

The courses should aim to:

○ Define the most important variables revealing the health of the population and identify proximal and distal determinants in a national and local context.

○ Outline the historical development of health systems and the evolution of the concept of the right to health, identifying the constituent elements of the main health organisations and their correlation models with models of welfare.

○ Examine the impact of globalisation on health, by identifying the main relationships between health and development.

○ Measure inequalities in health and health care and describe the policies of contrast.

○ Outline the current context of migration by identifying the main implications for health, including socio-demographic aspects, regulatory proposals for action, and transcultural aspects of the health assistance for immigrants.

○ Recognise the potential to struggle against inequalities in health access and identify the main opportunities for committed medical and health professionals to focus on international health cooperation.

2 / POSTGRADUATE PUBLIC HEALTH COURSES

The health professions are directly affected by issues of global health and are often in the front line in international cooperation. Working in an international context means that professionals need extensive and thorough training in the different epidemiological characteristics of diseases on supranational scale, need to acquire the competencies needed to make a contribution in public health interventions.

Current university curricula have yet to respond adequately to today's demand for, to the need for, teaching on global health, it is still not part of basic medical training, and in this changing world, it should be. This is particularly true for those who specialise in public health, where epidemiological tools and possession of planning, organisational, management and evaluation skills within the health sector are part of the specific job profile.

Thus these issues should become part of any core curriculum at the school of specialization in public health, so that the future experts will have the tools to assess health systems, to compare them, to participate in programs and health cooperation abroad, and to do research in the field of inequalities in health.

3 / HEALTH PERSONNEL

Basic courses should be specially designed in order to adapt them to the context and to the specific needs of the personnel. These courses should aimed to create a network in the field of international cooperation and training path for health personnel focusing on topics concerning health cooperation in development and immigrant reception in National Health Services' facilities.

4 / GENERAL POPULATION

Today internet is undoubtedly the most effective way to disseminate information. Blogs, where qualified experts provide adequate responses on medical issues both to the general population and to public health and health professionals, have proved to be a success and are certainly among the initiatives that should be promoted and followed up.

CONCLUSIONS

As well as being important for academic and clinical reasons, the inclusion of global health in the curriculum offers other benefits for the training of health professionals. One practical consideration is that health professionals have increased possibilities and desire to travel and work abroad nowadays, and some level of global health knowledge will be important in this case. Other health professionals may choose international health as a vocational training path- a possibility that will be aided by some level of undergraduate exposure to the subject.

Medical training can often channel a student into specific modes of thinking and responding and exploring global health issues also aids the general development of a health professional. The ability to appreciate diversity, challenge prejudice, analyse change and the forces that shape society, and to be able to function in a range of circumstances, are important skills [12]. A broad understanding of health throughout the world, for diverse populations, is essential if health professionals are to be seen as experts in health. If health professionals are to have a strong voice in discussions on health, they must grasp the international dimensions of their subject.

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TEACHING GLOBAL HEALTH AT SCHOOLS OF HEALTH AND HUMAN SCIENCES

Background paper for working group 1

The impact and pressures of globalisation on health are evident. Health promotion in the age of globalisation necessarily involves a new health paradigm and professionals with appropriate knowledge, skills and attitude in a new field called "global health". Defining "global health" has significant consequences on teaching *curricula* for health sciences and medical schools.

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"The primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social. Medicine and politics cannot and should not be kept apart."
Geoffrey Rose [1]

The medical community must realise that, under the increasing pressure of globalisation processes, the world is rapidly changing. Globalisation in communications, finance and economy, the increased number of migrant workers, tight international interdependence in production and use of energy, global concern with food and clear water supplies, alarm for pollution and global warming, depict a world in which nation-states and national borders are no longer sufficient to define homogeneous communities with unique characteristics. The impact produced by this global interdependence on the determinants of health, and the policy response of countries and international actors call for a novel approach by those concerned with human health who may not be ready to face such a challenge. Health promotion in the age of globalisation necessarily involves a new health paradigm and professionals with appropriate knowledge, skills and attitude in a new field called "global health".
However, while little disagreement exists on the urgency of this challenge, the scope and the exact features with which it is manifesting are less clear. In fact, both the terms tropical medicine and international health have, for many years, been in use within the international health community to address issues related to the health needs of developing countries and the role of the entire world community in addressing them. However, is the term "global health" nothing but more of the same understanding about how health determinants, actors and context interrelate at global level or, indeed, is a totally new approach being developed to face new realities on the ground? And how should the health community respond to these new theoretical and practical developments?
This paper is an attempt to define global health and to look at the consequences this definition may have on teaching curricula for

health science and medical schools. A simple definition of global health could be: health without borders. These three words capture all the different concepts of global health.

1 / NATIONAL BORDERS ARE NO LONGER A BARRIER TO THE SPREAD OF DISEASES

In this sense, global health has always existed ever since the first human beings started to inhabit the planet and even before if one considers animal diseases. Viruses and bacteria have never cared about borders, long before the advent of HIV and SARS. Nor have the contaminants that humans started pouring into air, soil and waters when they first forged a bronze tool. And what about the spread of obesity, cardiovascular disease and cancer that travels alongside the spread of lifestyles and behaviours? Even the causes of death and disease that we classify as injuries and accidents cross borders: a peasant at a wedding party in Baghlan can be killed by a bomb armed in Louisiana, a Polish bricklayer has a broken leg while building a house in Lisbon, Italian tourists are the victims of a bus accident in Mali. The World Health Organization (WHO), and even before the League of Nations Health Bureau, has tried to define a set of rules and regulations to stop or limit the spreading of diseases. But for every arbovirus or heavy metal whose circulation is restricted there are dozens of mycobacteria and dioxins that easily travel across continents. It is clear that only global policies, agreed upon and put into practice by everybody, can control global disease [2].

2 / NATIONAL BORDERS ARE NO LONGER A BARRIER TO THE SPREAD OF DETERMINANTS OF HEALTH

The proximal causes of death and disease (bacteria, chemicals, injuries, and the like) have no borders, as explained above. Are the distal determinants of health influenced by the existence of borders? Health-related behaviours clearly spread across borders: smoking, eating, moving, working, doping, mating, consuming, driving, feeding, breastfeeding. You name them, they are all unaware of borders [3]. And the WHO Commission on Social Determinants of Health is saying that even the social determinants

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FIGURE 1 / GLOBALISATION AND SOCIAL DETERMINANTS OF HEALTH

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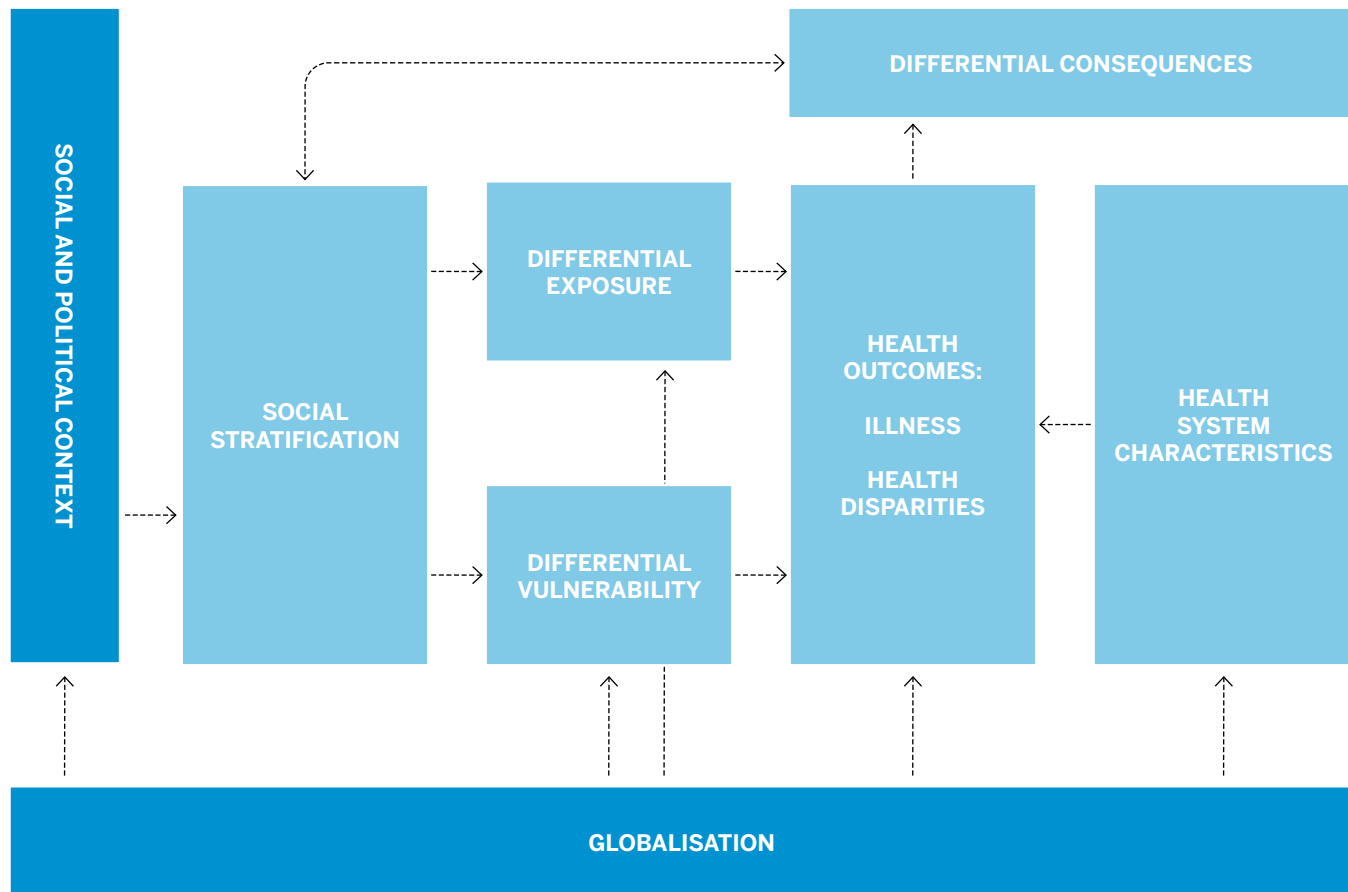
of health are without borders: income, poverty, employment, social policies, citizenship, gender, socio-cultural and economic status, racism, power, discrimination, agriculture, urbanisation, child development, food industry, environmental changes, financial services, education, daily living conditions [4]. As illustrated in **figure 1**, taken from one of the WHO Commission background papers [5], globalisation operates simultaneously on different groups of health determinants to influence illness, health outcomes and health disparities.

3 / NATIONAL BORDERS ARE NO LONGER A BARRIER TO THE SPREAD OF HEALTH CARE AND HEALTH POLICIES
The far right box in the figure shows that globalisation has a bearing also on the characteristics of health systems. That is no surprise: ever since the International Monetary Fund (IMF) started imposing its structural adjustment policies and the World Bank published its "Investing in Health" report [6], health systems and services worldwide have been shaped on global models especial-

ly in countries burdened by external debts [7]. User fees are now universally applied. Government health services are being privatised in many countries and private health services flourish everywhere. Standard essential health care packages are planned by global health care initiatives and delivered, in a standard way, from Angola to Tajikistan. Health professionals worldwide are being trained, especially as far as in-service training for global health initiatives implementation is concerned, by the same trainers who adopt the same training tools. Flocks of global consultants travel worldwide to analyse situations and make plans, often copying from one another, from one place to another. Finally, a well protected monopoly on research allows a few transnational companies to control the global market of drugs, vaccines and other diagnostic and therapeutic tools. Globalisation, however, may also favour the dissemination of good policies. For example, the Baby Friendly Hospital Initiative has been implemented in hundreds of countries and contributed to increasing breastfeeding rates, or at least to stopping and reversing the decrease [8].

The Lancet has promoted several initiatives to improve the delivery of effective interventions for maternal, neonatal and child health [9]. There are policies for environmental protection that are spreading, though far slower than they should, to many regions of the world [10]. Yet somehow the sharing of good policies is being hindered by fragmentation. Tens of so-called Global Health Initiatives have developed and are still developing good or improved policies for the prevention and control of specific diseases and conditions, or for health promotion, but they tend to concentrate on their own field [11]. They do not realize that only through strong and sustainable health and social systems, let alone participation and empowerment of target communities, will their good policies have a chance of being applied and of succeeding. A global movement is needed to advocate for global health policies that, revitalising the principles in the Alma Ata declaration, focus on primary health care, intersectoral initiatives, appropriate technologies, self-reliance and self-determination [12].

4 / NATIONAL BORDERS ARE NO LONGER A BARRIER TO THE SPREAD OF HEALTH CARE WORKERS

Thousands of health professionals from high income countries, often but not always moved by humanitarian ideals, migrate to low-income countries to help run health systems and services that are short of staff. At the same time, hundreds of thousand of health professionals move in the opposite direction, looking for better working and life conditions for themselves and for their families. Low income countries invest important proportions of their scarce budgets in the training of human resources for health only to see part of this investment vanish and contribute to the welfare and gross domestic product of high income countries. Everybody is concerned about this brain drain, WHO dedicated the 2006 World Health Report to this issue [13], and a new Global Health Workforce Alliance has been established [14]. But nobody has so far been able to devise and implement a policy capable at least of compensating low income countries for their losses and, hopefully, of starting to re-balance health workforce distribution.

5 / NATIONAL BORDERS ARE NO LONGER A BARRIER TO HUMAN RIGHTS VIOLATIONS

The war on terrorism, the re-emergence of torture as a tool for ensuring security, the creation of detention centres in places where rights are less demandable (Guantanamo, secret jails in third countries, extra-territorial prisons for immigrants, etc.) are issues, with a strong and growing impact on the health professions, an impact which cannot be dealt within national boundaries. The ubiquitous "security" argument, together with health workforce's greater mobility, exposes professionals to a new context that requires both careful, in-depth analysis, and the definition of new common operational strategies. Health professionals' loyalty towards patients is seriously threatened by the creation of settings and systems that restrict or deny human rights and make it hard to allocate responsibility for the protection of these rights and demands. New tools are therefore needed, on the one hand aimed at directly involving health professionals in accepting this responsibility, by elaborating and delivering specific knowledge on medical ethics and human rights defence and giving them the tools for detecting and adequately facing cases of discrimination, rights violation and torture; and, on the

other, at fostering a global transformation of the institutions that are meant to watch over the medical code of conduct and its violations, in order to guarantee to health professionals support and assistance (or, on the other side, sanctions) in every place in which they could be called to work.

6 / NATIONAL BORDERS SHOULD NO LONGER BE A BARRIER TO THE SPREAD OF HEALTH

Health is far from global. Inequalities are wide and widening [15]. Inequities are cruel. We all travel on the same ship (the Titanic?), but the gap between the few first class and the many third class passengers is so huge that very few of the latter will escape a life burdened by misery, hunger and disease. Health will not improve globally unless a new paradigm for development is applied: banking and financing must be regulated, climate and the environment must be protected, energy must be produced and used wisely, different rules for international trade and intellectual property must be agreed upon, as well as different agricultural and industrial policies, and so on, tackling all the social determinants of health. At the same time, health and social systems must be reinforced, starting from the principle that health care is a right, not a commodity [16]. We need a completely new paradigm to break down the current barriers to global health.

If all the above is true, how does it apply to teaching global health in health science and medical schools? Should all health students (medical, nursing, midwifery, etc.) be exposed not only to a module on global health, but be taught all other disciplines in a global health perspective? For a long time, scholars have been advocating a new medical model, and therefore a new way of teaching medicine. The current model is centred on biological determinants of disease, within a reductionist framework and with strong dominance of the body-mind dualism [17]. A social and environmental approach to medicine, such as those put forward by Virchow [18], Rose [1], Marmot [19] and Friel [20], one that would be global by definition, does not find its way easily in an academic and research world that is dominated by champions of the biomedical approach.

Yet things are changing, albeit slowly. Several authors, including medical students, have started to plead for bringing global health issues into medical teaching [21-23]. Centres for research and teaching on global health have started to blossom in the United States and Canada [24-31], as well as in Europe. In Canada, a survey of 17 medical schools showed that despite both the strong and growing demand from medical students and changing societal forces that are calling for better global health training, the approach to global health education still ranges from, "none is required", to well-developed courses, two-year electives that include didactic and overseas training [32]. In the UK, global health teaching is mainly proposed to medical students through Bachelor of Science degrees in international health, though these are available only in some universities [33]. In Italy, a recent mapping on 40 medical schools revealed the presence of global health and health equity courses, almost all optional, and ranging from 6 to 20 teaching hours, in only 11 universities [34]. Most of these have been set up and continue thanks to the goodwill of few teachers. No subjects related to global health are included in the students' standard curriculum. There are probably many other examples from different parts of the world, including other EU countries, that are not reported in medical journals yet may

have an important bearing on how medical teaching is changing to accommodate global health. It is unlikely, however, that these efforts represent a majority movement; improving global health teaching in health science and medical school curricula requires national leadership from governing academic bodies that is, currently, far from being actuated. International consensus could certainly help in this process.

Offering optional training in global health must therefore be seen as an initial step towards the achievement of something more: a change of paradigm. The final goal of current efforts is not to create a sort of protected environment in which enlightened teachers and motivated students discuss poverty, inequities, immigration and aid. The final goal is to promote a change from a biomedical model (focused on individuals, illness, treatment, specialist medicine and proximal causes of health and disease) to a new one that, by promoting intersectoral collaboration and community participation, will give priority to populations, prevention and health promotion, primary health care and social determinants of health, the ultimate causes of disease (as depicted in **figure 2**) [4].

A proposed action plan aimed at achieving this goal could develop through the following steps:

1 / Creation of a network of motivated stakeholders committed to global health teaching (including research centres, universities, students and residents associations, and NGOs), at a European level, in order to exchange experiences, compare evidence, develop best practices and advocacy strategies towards relevant institutions (e.g. national and international regulatory bodies, professional bodies, policy-setting institutions).

2 / Elaboration of documents, programmes, and under and post-graduate curricula, in order to disseminate information and create consensus on the incorporation of global health issues into health science and medical schools.

3 / Creation of global health opportunities within curricula, exploring the potential of three key components such as: core curricula, elective programmes, and opportunities for in depth study, starting by providing optional modules and so attracting student and faculty interest.

4 / Research on ways and strategies for how to best deliver this teaching to under and post-graduate students (including teaching methodologies, e.g. PBL, on-line education, etc.).

FIGURE 2 / THE INDIVIDUAL AND SOCIAL DETERMINANTS OF HEALTH AND OF INEQUITIES IN HEALTH

Source: Amended from Solar & Irwin, 2007
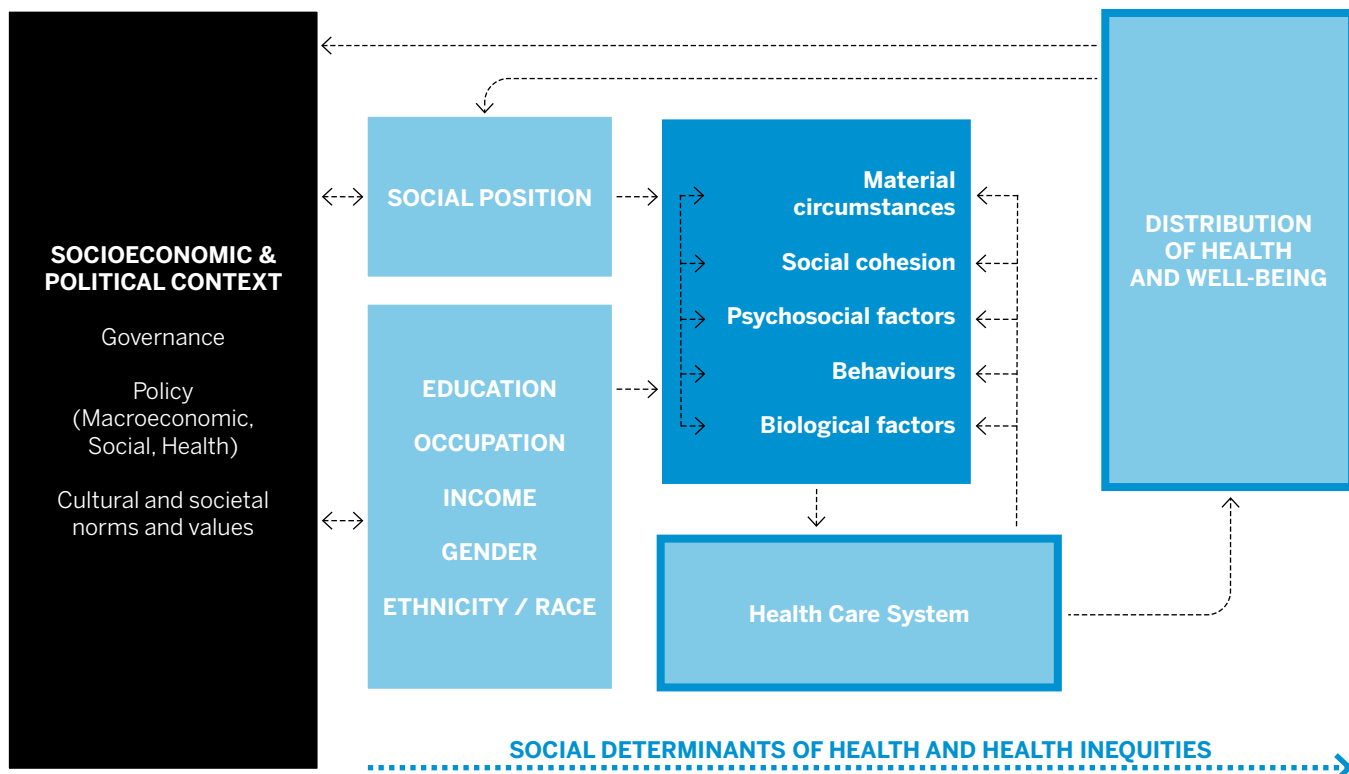
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LIFELONG LEARNING ON GLOBAL HEALTH

Background paper for working group 2

The growing awareness that health is a public good and that a new global cooperation is needed, a human right approach to health and the social responsibility health professionals have in promoting global health, are among the reasons why global health issues should be included in lifelong learning. Indeed, training health professionals requires new knowledge and skills that go beyond the traditional approach to diseases and their biological aspects.

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"Distinctions between domestic and international health problems are losing their usefulness and are often misleading."
Institute of Medicine, 1997

"The separation between domestic and international health problems is no longer useful."
Brundtland GH., WHO, 2001

A new paradigm known as lifelong learning has emerged for post graduate training of health professionals. This is a concept that can be defined as a process allowing health professionals to acquire, maintain and improve their knowledge, competencies and attitude to optimise their individual and organisational performance during their working life. This paradigm has determined a shift from the traditional post graduate training model, which focused on the medical discipline and on the needs of individual professionals, to the Continuing Professional Development (CPD) model, where the focus is on across-the-board quality of service and on the value of the team. There is a large consensus regarding the core competencies which each trained health care worker could or should do: e.g. to provide patient-centred care, to apply quality improvement, to utilise health informatics, to employ evidence-based practice, and to work in a multidisciplinary team.
In terms of CPD, another important factor is the accreditation system. It is well known that, at the international level, there are several CPD accreditation systems (Peck *et al.*, 2000), which are different from each other in terms of the approaches they use, for example the accreditation system could either be compulsory or voluntary, however, they all have some common denominators, e.g. the use of credits to revalidate qualifications and/or specialisations or to satisfy legislative requirements.

MEANING OF LIFELONG LEARNING (LLL) AND CONTINUING PROFESSIONAL DEVELOPMENT (CDP)

Lifelong learning (LLL) is a term that is widely used in a variety of contexts; however its meaning is often unclear (Aspin, 2007).

The term recognises that learning is not confined to childhood or the classroom, but takes place throughout life and in a range of situations. During the last fifty years, constant scientific and technological innovation and change has had a profound effect on learning needs and styles. Learning can no longer be divided into a place and time to acquire knowledge (school) and a place and time to apply the knowledge acquired (the workplace) (Fischer, 2000).
Continuing Professional Development (CPD) on the other hand, is defined as systematic, ongoing, self-directed learning; it is an approach or process of how you plan or manage your whole working life (GMC, 2008). Continuing medical education (CME), i.e. organized learning activities, is considered to be part of CPD (Allison, 2006). However, the two terms LLL and CPD will be used interchangeably in this paper.

CPD CYCLE

The cycle, as illustrated in **figure 1** consists of four steps, which are centred on documentation and portfolio development.
The portfolio is central to the CPD cycle representing a comprehensive record for the whole process of learning and personal growth.

REFLECTIVE LEARNING: AS CDP APPROACH

One approach for continuity of learning is reflective practice, which enables individuals to learn from their experiences. People naturally reflect on their experiences, particularly when they are new to the profession. However, we need to articulate our reflections in some systematic way so that we remember what we thought and build on that experience for next time. Possible ways that we can do this are by keeping a diary or learning journal, or critical incident analysis (Plummer, 2001). However, reflection in itself is not sufficient to promote lifelong learning and professional development. Unless we act on our reflections

FIGURE 1 / STEPS OF CPD CYCLE

EVALUATING

REFLECTION

ACTING

PLANNING
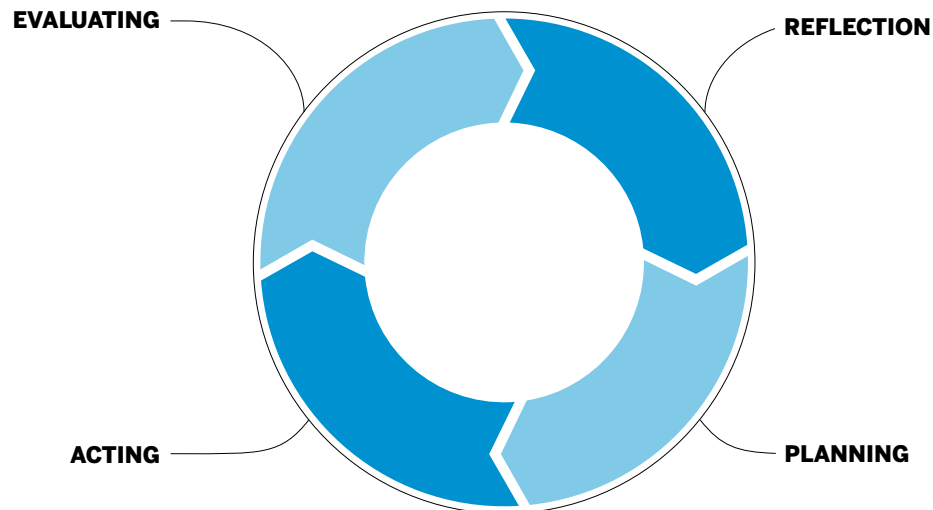
Step 1: Reflect, meaning self-assessment to identify personal training needs

Step 2: Plan, designing of a personal development plan including both formal and informal learning activities

Step 3: Act, putting plan into action to meet identified needs and goals

Step 4: Evaluate, assess plan implementation and whether objectives have been achieved

Source: Peck *et al.* 2000

of ourselves and on the opinions of others then no development will take place.

The Kolb Cycle, developed by Kolb (1984) provides a useful model to develop our practice. The Experiential Learning Cycle comprises four different stages of learning from experience that must be followed in sequence (**figure 2**).

○ It is important to reflect on the experience to make generalisations and formulate concepts.

○ Learning must be tested out in new situations.

○ The learner must make link between the theory and action by planning, acting out, reflecting and relating it back to the theory.

On the other hand Donald Schön (1991) proposed a theory of reflective practice and part of professional development that comprises two different types of reflection, i.e. "reflection-on-action" and "reflection-in-action".
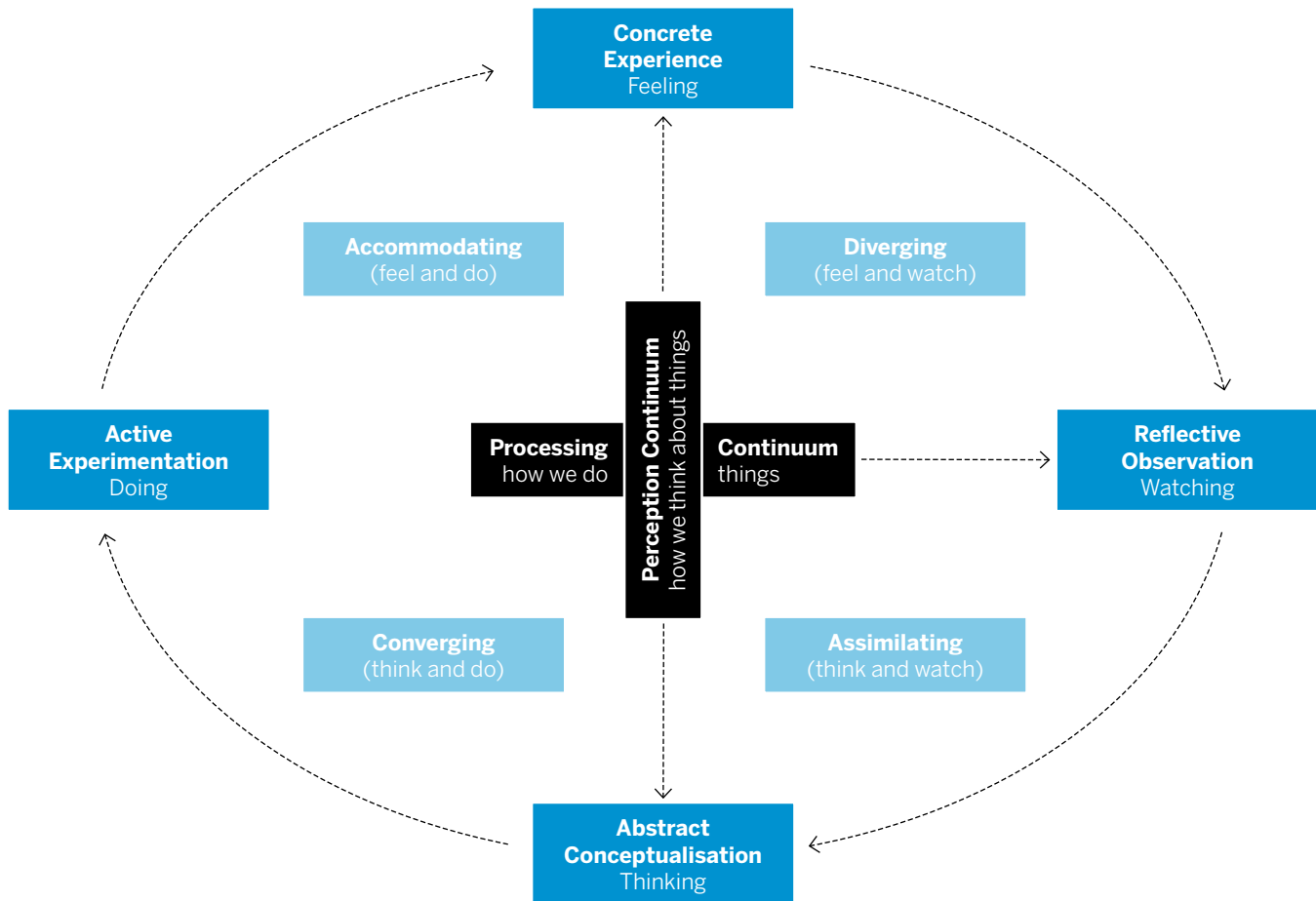
"Reflection-on-action" is a review after practice which allows practitioners and managers to take this reflection on their previous experience with them when they go into action the next time. This previously acquired knowledge and practice would then allow individuals to be able "reflect-in-action" – simultaneously reflecting and doing i.e. "thinking on their feet". This implies that professionals can reach a stage where they are competent enough to be able to think or reflect about their practice and modify their actions almost immediately.

John Cowan (1999) builds on Kolb's and Schön's theories of experiential learning and reflection and represents reflective practice in the form of series of loops (**figure 3**). The loops represent three types of reflection based on three types of activity. He suggests that anticipatory "reflection-for-action" takes place initially and is a way for practitioners and managers to work out what experiences they can bring to a situation prior to action (Loop a). The initial exploratory activity brings together existing "intellectual baggage" and preliminary information that may prove useful. Intermediate "reflection-in-action" (Loop c) serves to review progress made so far and then to identify gaps that may inhibit development. This is then followed by concentrated activity that builds on the reflective analysis and consolidates the learning. A final "reflection-on-action" is a review activity which defines the useful learning and development that has taken which is followed by further activity that would then start the cycle again by being reflection for the next action.
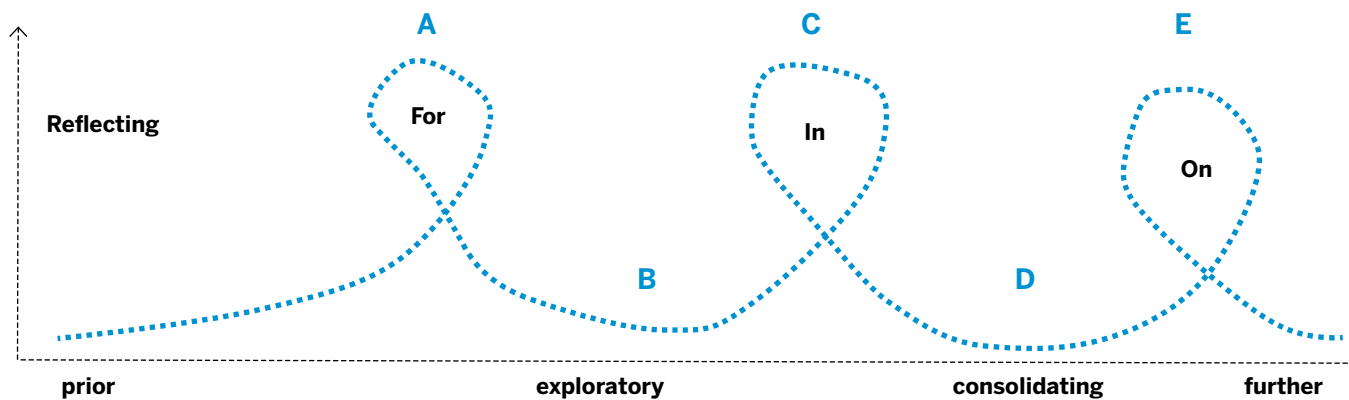
But, is this model still suitable to deal with the global issues of health?

FIGURE 2 / KOLB'S EXPERIENTIAL LEARNING CYCLE

Concrete Experience
Feeling

Accommodating
(feel and do)

Diverging
(feel and watch)

Perception Continuum
how we think about things

Processing
how we do

Continuum
things

Active Experimentation
Doing

Reflective Observation
Watching

Converging
(think and do)

Assimilating
(think and watch)

Abstract Conceptualisation
Thinking

Source: Atherton JS, 2005

FIGURE 3 / COWAN'S REFLECTIVE LOOPS

Reflecting

A
For

C
In

E
On

B

D

prior   exploratory   consolidating   further

GLOBALISATION AND ITS EFFECTS ON HEALTH

Powerful forces are shaping the world. With massive movements of people and goods new and old infectious diseases like the AIDS pandemic and avian influenza, haemorrhagic fever, tuberculosis and other infectious diseases are spreading through the continents posing serious health threats and causing economic loss (Morens, 2004). To make matters more complex, not only does what has been called "microbial traffic" travel from one country to another; but also ideas and lifestyles travel too. Smoking is one case in point. Already about four million people die from smoking-related causes every year. By 2020 that number will grow to ten million, making tobacco the leading killer worldwide (WHO, 2000). Chronic diseases in general, are becoming increasingly important. Four out of five deaths from chronic disease now occur in low- and middle-income countries. Their prevention and management require a comprehensive primary health care approach (Beaglehole, 2008).

The globalisation of health goes beyond diseases and risk factors to include health care and its inputs. For instance, Africa faces a shortage of 800,000 doctors and nurses, and currently trains only between 10 and 30% of the skilled health workers required to meet ongoing needs. Every year, the continent that already manages 25% of the global burden of disease with only 3% of the global health workforce loses 20,000 trained health professionals to migration. This is due in part to poor working conditions and, in some cases, to political instability, conflicts and civil wars (WHO, 2006).

The research gap is another example. The huge discrepancy in health research funding has been captured in the expression "the 10/90 gap" – drawing attention to the fact that of the USD 73 billion invested annually in global health research by the public and private sectors, less than 10% is devoted to research into the health problems that account for 90% of the global burden of diseases (measured in Disability - Adjusted Life Years or DALYs) (Global Forum for Health Research, 2004).

Globalisation has helped people and countries to overcome long-standing problems, but it is not without its imbalances and losers. New forms of social exclusion feed on the old scourges of poverty and social injustice. Inequalities in health exist between and within countries (WHO, 2008). The range of life expectancy is staggeringly large: from 32,5 years (both sexes) in Swaziland to 82 years in Japan. Evidence suggests that in each country, the higher the socioeconomic quintile of the household, the lower the rate of child and maternal mortality. In South Africa research has shown that among people with high blood pressure, the wealthiest 30% of the population were more than twice as likely to have received treatment than were the poorest 40%. Most of these inequalities are not inevitable if economic growth is embedded in social empowerment and autonomy (Marmot, 2006).

Finally, the effects of climate change, environmental pollution, and degradation of natural resources on a global scale might represent some of the challenging hazards to health in the near future (McMichael, 2006). Natural disasters and scarce resources can lead to mass population movements and conflicts, which are associated with increased mortality and with reduced physical and mental health (Coupland, 2007). In this regard, fragile and poorer countries are more at risk than others (Rosser, 2006).

Overall it can be said that while many of these health issues are recognised as important internationally, they seem to be ignored at national and sub-national levels. As a result many health professionals are not trained in these important aspects of their work. A gap exists between CPD and global health issues. This gap needs to be filled.

WHY IS IT IMPORTANT TO INCLUDE GLOBAL HEALTH IN THE CPD?

There are several reasons for including global health issues in the CPD. Among the most important is the growing awareness that health is a public good and that some risks to health are global in scope and can only be countered by new global cooperation (Chen, 1999). Nobody can expect to tackle and solve the problems mentioned above on their own.

In addition, the human rights approach and, more generally, the articulation of a coherent global ethical perspective that acknowledges the importance of all persons, regardless of where they live, can provide a normative basis for taking global health seriously as a moral issue (Alkire, 2004).

But health professionals have a specific social responsibility when taking action on global health issues. A longstanding contract exists between society and health workers whereby people's illnesses are treated within a locally defined health system.

The failure of these health systems, in many contexts, to serve the interests of the poor should be a matter of concern, analysis and action for the health workers (WHO, 2008). For this to happen, international cooperation for health should be based on the exchange of experiences in common problems, evidence of alternatives, and empathy (Frenk and Gomez, 2002).

Training health professionals in the 21st century therefore requires new knowledge and skills that go beyond the traditional approach to diseases and their underlying biological factors. It should also go beyond the traditional debates on the quality and sustainability of the western health system.

International health, policy analysis, investigation of the social determinants and health system strengthening are some of the basic competencies for the health workforce of the 21st century. These, together with other skills, form the basis of what health professionals can do to improve health for the world's poor (BMA, 2007).

When health workers are exposed to such issues and discussions, they develop the capacity to appreciate diversity, overcome prejudices and analyze the real forces at work in society (Neufeld, 2001).

Moreover, investing in studies, research and training on such issues would also help protect our population from international risks and promote national interests in the world (Shaywitz, 2002).

Helping resource limited countries to improve the functioning of their health systems can contribute to improving national security, limiting internal conflict and mitigating migration (Horton, 2001).

As has been noted, one priority that the training of health professionals should take into account is the current failure to serve the public good and the lack of a global perspective (BMJ, 2004). The global health agenda cannot be left to individuals, however well intentioned, nor to non governmental organisations, howev-

er respectable, if the results are not to be restricted to emotional and *ad hoc* humanitarian actions.

Smith and Richards (2001) noted that, as trainers, we should be convinced that "Medicine knows something about the tension of having commitments at home and abroad. It is akin to the tension of doing your utmost for the patient in front of you but at the same time recognising commitments to other patients and the broader world. The group that devised the Tavistock principles for everybody in health care, recognised the tension in its second principle: care of individual patients is central, but the health of populations is also our concern".

MAJOR OBSTACLES TO BE CONSIDERED IN PREPARING A CPD COURSE ON GLOBAL HEALTH

There are several obstacles that CPD organisers need to consider when planning and designing courses on global health. These obstacles, which could be institutional, cultural, organisational or financial, are highlighted below.

INSTITUTIONAL OBSTACLES

Local health authorities and directors of health care organisations and institutions may not consider global health either a priority or an opportunity for change within the organisation. In this respect training on global health may compete with other more pressing health priorities such as: clinical governance, clinical risk assessment, continuous quality improvement, institutional accreditation, health prevention and safety, waiting lists, emergencies etc.

CULTURAL OBSTACLES

Cultural barriers are usually related to the so-called "biomedical model". According to this model health is freedom from disease, pain, or defect, thus making the normal human condition healthy. The model focuses on physical processes such as the pathology, biochemistry, and physiology of a disease, but does not take into account the role of social factors or individual subjectivity. Health professionals, clinicians in particular, may not be interested in attending courses on global health which are not based on evidence or to discuss problems whose solutions are considered outside the medical domain.

METHODOLOGICAL AND ORGANISATIONAL OBSTACLES

Traditionally, CPD is confronted by many methodological and organisational issues that may negatively influence the effectiveness of training health professionals. One problem is the split between theory and practice. This risk is particularly clear if training in global health is based on a purely paperwork approach (i.e. literature reviews, analysis, conceptual framework, complicated statistics etc.) without any connections and correlations being made with the daily life and experiences of the health workers both as professionals and as citizens.

Another barrier is lack of interaction between trainers and trainees. Adult people cannot and should not be considered passive learners without experience and active thinking. Moreover, trainers may not be up to the challenge, especially as global health is

a relatively new subject with few knowledgeable people on the matter. Careful attention and efforts need to be made to ensure that trainers have the knowledge and the skills to train health professionals in global health.

Finally, like many other well documented CPD activities, training in global health may become a boring rehash. In this case, health professionals may only be interested in doing some training for opportunistic reasons (i.e. get the credits and forget the training). Fresh, real and compelling contents should be continuously evaluated and included in any course.

FINANCIAL OBSTACLES

Training costs money, and public funding is scarce and, as things are at present, private funding often represents more of a risk than an opportunity. It is important to identify allied decision-makers in the potential donor organisations and universities, using strategic planning, and direct these arguments to them; for example, attract the interest of students who will demand a new course and provide evidence on the effectiveness of tackling the social determinants of health to improve health status. Convincing regional health authorities that teaching about global health questions will contribute to health development by importing useful models/organisational patterns from other countries which could serve as a useful strategy when lobbying for additional funds and for overcoming financial obstacles.

HOW TO MOVE FORWARD? A TEN POINT AGENDA

1 / Start off by selling the idea to and buying the support from your CEO (general director) and CPD director (or Continuous Medical Education or Training director) to include a course on global health in a multi-year training program in your context (district health authorities, hospitals etc.).

2 / Set up a small group of like minded and cohesive people with different professional backgrounds who are interested in global health (i.e. public health and clinicians doctors, midwifes, nurses, health allies, and others). Make sure that professionals with experience in international health work for developing countries, migration, development, etc. are involved and where possible included in this group.

3 / Collect and read the most relevant papers on global health issues published in the literature most of which have been and are being made available by the project "Equal opportunities for health action for development".

4 / Identify and analyse policy, plans and program documents of your own country where international health cooperation is part and parcel of national and regional policy and plans.

5 / Gather field based experiences of international health made by local colleagues in developing countries. Analyse them critically and use them as case studies to compare and contrast the health status and the health system of your country with those countries (i.e. analyse strategies used by different countries to address challenges for improved organisation and management, working with multiple actors, financing and resourcing of health care, and inequalities in health).

6 / Prepare a training plan on global health with a good balance struck between theory and practice. Leave enough room

for questions, discussions and interaction between trainers and trainees. Focus on connections, and implications, between international and national, foreign and local health issues (i.e. health related to poverty, migration, security, foreign policy, economic crisis, etc.). Evaluate the course continuously and harness updating and innovativeness.

7 / Make sure that the trainers are people with adequate knowledgeable of the various topics. If necessary think about the possibility of arranging a ToT (training of trainers) on global health by linking with other local, regional and national institutions which share the same interest.

8 / Do not forget the importance of networking. Where appropriate, take on board NGOs, professional health associations (i.e. medical associations, nursing and midwifery associations, etc.),

regional and local authorities, universities, corporate socially responsible, social groups etc. in order to widen the audience and strengthen the message.

9 / Advocate changes to improve the health situation and living conditions of poor people in your country and also, in developing countries by supporting international health cooperation projects abroad.

10 / Promote networks with universities and health professional associations to get them involved in practical initiatives, e.g. to raise funds for projects through self taxation or other fund raising activities, to offer post-graduate students opportunities for experience in projects in developing countries, etc. Consider tapping other sources of funds, e.g. foundations, lotteries and EU funding programmes (aid, regional development).

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THE ROLE OF INTERNATIONAL HEALTH COOPERATION IN PROMOTING GLOBAL HEALTH

Background paper for working group 3

Health professionals should play a leading role in creating and expanding the awareness that health is a universal human right for which resources should be allocated as a priority, even during economic crisis. The concepts, values and practices that would be coherent with the right to health should be more adequately taught to students and health care professionals and cooperation promoted between the people engaged in international cooperation and medical schools, students, medical organisations and practitioners to advocate for global health.

By / Fabio Manenti, Agostino Paganini / Doctors with Africa CUAMM / Italy

The Italian Constitution [1], in perfect harmony with international declarations and conventions [2] defines health and access to health services as a universal human right. By definition a right can only exist if the bearers of the duty to satisfy it are clearly identified, fully aware, informed, accountable and empowered to do so.

Households, communities, national and local authorities in western European countries generally have the knowledge and the resources for health care and even if pockets of inequalities do still exist in Western Europe, by and large Governments do allocate the financial, organisational and human resources needed as is clearly demonstrated by impressive progress made in life quality and expectancy [3]. With the cost of health increasing yearly 2% above the GDP growth rate, the question of sustainability will become soon very acute.

The recent debate in Italy on whether to exclude groups of people from access to health services on the basis of immigration status is not only epidemiologically reckless, but also, most importantly, violates a recognized duty to contribute to the fulfilment of the inherent right to health for all and therefore also to services [4].

For the same reason, countries, with a GDP too low to provide the population with the services needed for a healthy life cannot be left to face the responsibility for ensuring equitable and adequate access to health services, food security, safe environment, basic education and economic opportunities on their own. Responsibility is not confined within geopolitical borders. International health cooperation is an obligation for the global community. It is the only way of eliminating the health inequalities, that mark our global human community today.

The provision of relatively expensive ARV drugs to all HIV patients in the least developed countries is not only epidemiologically sound (low virus load under treatment combined with universal screening will play a major role in stopping the epidemic) but also clearly illustrates the principle that sustainability and responsibility for essential and effective health interventions are a shared obligation and not a narrowly defined national one. Although the above principle seems to be generally accepted within these types of interventions, other programs for safe motherhood and newborn care (maternal and newborn mortality is higher than that for AIDS, TB and malaria put together) that should be benefitting from the idea of "shared obligation", do not get anything like the same financial support as the others which raises a big question mark about what is really being understood at the international level by "shared responsibility" in eliminating health inequalities.

ADVOCATING FOR GLOBAL HEALTH

The concept of global responsibility briefly described above still does not have the support of a strong civil society movement, particularly in Italy where Government funds for development assistance, support to global health included, are the first to be severely cut in national budget laws, every time the economy slows down or other priorities requires extra resources [5].

In the presence of the unprecedented financial and economic crisis threatening world markets, there are strong indications that allocations for international cooperation, including health cooperation, will be severely curtailed, unless strong signals are sent by society that politicians will be penalised for doing so and that they will be held accountable for broken promises [6]. Unfortunately this kind of response from the public is extremely unlikely, as there is generally little awareness and understanding of the right to health, of health inequalities and related issues, not only among the general public but also within the medical establishment, which should take the lead in influencing the public opinion. Many factors can be held responsible for having created this situation, one where we continue to act as if the poor need only be helped in good times and are not entitled to a fair share of available resources in leaner times. And we, the organisations engaged in international health cooperation, have not been investing enough of our attention, time and resources in creating a solid understanding within our society and culture that not fulfilling our promise to invest 0.7% of our GDP in aid is a national dereliction of duty which is having severe, and often dramatic, consequences for millions of poor people.

Universities, and in particular medical schools, institutions of

learning, still regard teaching and studying global health as a soft-option, a second class subject, and do not seem to be aware of the moral, cultural and scientific consequences of this attitude. Medical practitioners have not yet perceived the connection between their profession and role in society and the moral duty to inform and mobilise public opinion on the issues of global health. Active, systematic interaction and communication is urgently needed between the people engaged in international cooperation and medical schools, students, medical organizations and practitioners to advocate for global health [7].

International health cooperation agencies should create networks with universities, medical schools, health professional councils etc. and involve them in cooperation programs and projects: direct, practical engagement, such as, direct fundraising and the direct involvement of professionals from councils and associations; or by offering training opportunities and experiences in developing countries for medical students.

Health professionals should play a leading role in creating and expanding the awareness that health is a universal human right for which resources should be allocated as a priority, even during economic recession.

They should show their commitment as advocates for global health in their day to day practice, starting with a different attitude towards their use of resources. Allocation of resources should be based on evidence-based medicine that each health professional has to contribute to. They should influence allocation of resources through their routine choices of diagnostic tests, treatment and drugs, basing them on the real benefits and improvements in the population's health and not on private and commercial interests.

Health professionals can and should help to produce data on how resources are allocated at their local council level, and so identify what is of real benefit for the population and what needs are still unmet, thus highlighting local inequalities. These data should be used to lobby politicians, who need consensus from their constituencies, and as a means of making communities better able to understand global health and the shared responsibility to eliminate health inequalities.

The international health cooperation agencies should produce data on how international aid resources are being allocated; and what results and impact they are having at the local level where they operate and what needs are still unmet, highlighting, in particular, health inequalities and the value of the aid really needed. These data should be used to lobby politicians and stakeholders and demand a different (better) and higher allocation of resources to the health sector.

Academics should be involved in producing data, "evidence" of what does and doesn't work when trying to improve population health in countries with limited resources; medical faculties should liaise with other faculties (anthropology, socio-economic, agriculture, earth sciences etc.) to understand other determinants, factors influencing, health and development. This data could again be used to lobby for different allocation of resources. Thus international health cooperation agencies, academic staff and health professionals and the medical community in general should work together to advocate global health and lobby politicians and organisations so that they really implement policy and politics for the public benefit of the public and in its interest, and fulfil, meet their moral and ethical obligations.

TEACHING GLOBAL HEALTH

The role of international health cooperation agencies in teaching global health should start with recognition of the fact that the concepts, values and practices, that would be coherent with the right to health, are often either inadequately, or even not, taught to students and health care professionals in the North.

This means that any curricula and methodologies of the industrialised countries that are transferred to training institutions in the South and are used just as they are, without adaptations, could have a highly deleterious effect on the values, professional choices and work ethics of health professionals active in poor countries.

While in the North, because of huge amount of financial and human resources invested in health, this "gap" in teaching has a less dramatic impact on access to health services, it becomes crucial where both financial and, especially, human resources are limited: if most of these latter lack motivation, awareness and genuine interest in the health of the population and, in particular, in the less advantaged among the society the consequences are even more serious.

Thus teaching on global health and, in particular, on the moral obligations of health professionals, should be introduced in training institutions in the South too. Opening their programs to students and health care professionals from the North, would also give the latter the opportunity to get first hand experience of global health realities and offers one example of how to involve the medical community in global health and make them recognise the need to teach it.

A recent agreement between the University of Padua and Doctors with Africa CUAMM for example has provided an expanded framework of cooperation for the training of future health professionals in the field of global health, including research, didactics and exchange activities between the University of Padua and African health authorities and universities, as well as for information and experience exchange between Doctors with Africa CUAMM and the University of Padua, including short term missions of academic staff in Africa.

Furthermore, postgraduate students will have an opportunity to spend up to one year of their specialised training in Africa, with Doctors with Africa CUAMM providing support and ensuring tutorial assistance. Yet another good example of the role of international health cooperation in teaching global health is contained in the agreement between the Italian Secretariat of Medicine Students (SISM) and Doctors with Africa CUAMM, which provides Medical students with the opportunity to spend one month at a Doctors with Africa CUAMM health programs in Africa.

IMPLEMENTING GLOBAL HEALTH

At the end of the day, the most important issue is to support all those who have the duty when fulfilling their obligations to those who have the right in such a way that health inequities disappear and the capacities of families, communities and authorities in poor countries are strengthened and expanded. The challenge for international agents of health cooperation is to move away from a concept were action has become synonymous with projects, towards building the capacities and empowering internal agents of change. Today with few notable exceptions of very fragile or even failed

countries, the majority of poor countries have national health policies and systems. National resources are generally not sufficient, capacities and competencies are scarce and systems still weak. Our role should be to increase the capacity to deliver evidence-based effective services in order to achieve the milestones of the Millennium Development Goals and to strengthen the foundations on which we will achieve equity and health for all.

One of the major obstacles facing international cooperation initiatives is the fragmentation of issues: the multiplication of global initiatives, the absence of a strong global coordination role and the inability of local authorities of poor countries to fully benefit and integrate all external inputs at the delivery point: the health district. A well performing health system is one that is able to pursue intermediate objectives such as access, quality, equity, efficiency and sustainability. The ultimate impact is the improvement of health (reduction of mortality and morbidity). Whether or not these goals will be achieved is strongly influenced by the management capacities of district health teams and their success in focusing limited resources on priority problems. It requires both technical and political knowledge, skills and focused action.

On the positive side, the fact that health systems need to be strengthened if we are to achieve better health for all is increasingly being accepted, in theory at least, but not yet in practice: as is clear from demonstrated by the stable and unacceptably high, maternal mortality – one the best proxy indicators of effective health services and systems in resource constrained countries [8].

While child mortality has declined, in part as a result of vertical interventions such as immunization, distribution of vitamin A and adoption of ORS etc., other health inequalities still require immediate, rapid and focussed action on the financing, quality and accessibility of health systems, if we are to provide other lifesaving knowledge and medical technologies equally, to all.

As well as an increase in international resources, which is urgently needed but unlikely to materialise for the next couple of years, there must also be profound changes in the way available resources, either internally or externally generated, are allocated, changes made must happen without further delay so as to ensure that poor households are not excluded from health services.

To do this, international health cooperation has to begin to develop strategic plans for strengthening health systems in selected areas of intervention and to gather data to see whether with correct evaluation of gaps and by allocating resources on the basis of priority of needs it will be possible to repeat the achievements of MDGs concerning maternal and child health, in controlling the 3 big epidemics of today: HIV/AIDS, TB and malaria.

One example: in Ethiopia, in the South West Shoa Zone, an area of more than a million habitants, Doctors with Africa CUAMM, began by building a functioning hospital (St. Luke Wolisso Hospital and College of Nursing) and is now moving outwards to strengthen the capacity to provide curative and preventive services at the district level, working in line with the National Health Policy of deploying and empowering health extension workers to deliver a package of health services direct to the communities.

Another: in Tanzania, in the Iringa rural district, an area with more than 250,000 inhabitants, Doctors with Africa CUAMM is supporting the Tosamaganga district designated hospital by providing curative services, in particular for mothers and children, as well as carrying out a public health intervention, in cooperation with the district authorities, to promote preventive essential health services within the national framework of intervention. Focus is on empowering the local community and local health workers to build a functional information health system and to improve general assessment of priorities and needs for better planning and allocation of resources. The availability of reliable data is essential for evaluating international health cooperation performance and the impact of local health system strengthening and is crucial if we are to claim that foreign assistance is effective and efficient.

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FINANCIAL AND HUMAN RESOURCES TO TEACH AND ADVOCATE GLOBAL HEALTH

Background paper for working group 4

Promoting equal opportunities for health involves guaranteeing access to quality health care services, which is indeed a vital determinant of health. To ensure universal health coverage, not only are financial resources needed but also properly skilled human resources capable of making those systems function adequately and effectively, thus advocating and catalysing the change towards better equity in health.

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1 / CURRENT STATE OF AFFAIRS AND CURRENT ENVIRONMENT

The goal of promoting equal opportunities for health is to mitigate the impact of risk factors associated with broad determinants of health leading to premature death and illness, and ultimately, to improve the quality of life for individuals and communities.

Access to quality health care systems is, in itself, a vital determinant of health. Thus they need to be designed and financed to enhance equitable, universal health coverage around the world. However, without a foundation of properly skilled human resources, health care systems cannot function adequately or effectively.

But how well-equipped are health and medical graduates to understand, advocate and catalyse the change towards better equity in health worldwide? Can they design better and more equitable health systems? Schools of public health need to respond to the needs of 21st-century students and to think ambitiously about scaling-up access to appropriate education and training.

Shaping public and global health education around the world to better promote equal opportunities for health, seems therefore a good public investment. It certainly is one of the international learning community's main challenges in the coming decades.

In Europe, more and more organisations are recognising the increasing importance of health in an ever more interdependent world. Initiatives are being undertaken to start cooperating and networking between, e.g. international development cooperation, politicians and the academic community. The project "Equal opportunities for health: action for development"[1] is carrying out a strategy on teaching and advocacy for global health. The "Europe in the World" initiative by the European Foundation Centre [2], for instance, urges spending 5% of resources on global and development issues outside Europe.

Academia has indeed begun to elaborate global health training programmes to inform health professionals through cross-disciplinary didactic and experiential learning. Global health programmes have proliferated across both North and South, with *curriculum* content spanning research skills, cultural studies, social sciences and basic sciences. To do this, many public health schools in developed countries are collaborating with others in developing nations, offering exchange programmes and the opportunity to do joint projects or fieldwork in the affiliated school. But a lot of work still has to be done.

1.1 / MAIN ACTORS AND STAKEHOLDERS

Getting the "global" into public health resulted historically in a strong rise in importance of actors outside governmental or intergovernmental organizations and agencies. Today, the changing landscape of international cooperation and health involves so many new actors, approaches and funding opportunities that there is an inevitable sense of chaos accompanied, however, by excitement about the opportunities ahead.

Training centres, including both ad hoc training centres (e.g. tropical and international medicine schools) and more mainstreamed centres (e.g. hospital training centres beginning to teach global health issues) increasingly have to find their way through this pandemonium to be heard and get their activities financed.

The following cannot be more then a non-exhaustive list of examples of how existing training facilities are coping with global health issues in their academic coverage or are looking for networks.

MULTILATERAL

Gro Harlem Brundtland, a previous Director General of WHO, some years ago, during a meeting with the Washington-based international business community [3], reflected on how "…the separation between domestic and international health problems is no longer useful…". An unwelcome statement, given that the entire process to globalise health had, since soon after the creation of WHO, been dominated by Washington itself and by its allies and closely linked to advancing their interests.

A / EUROPE
Switzerland

The Swiss government and seven major universities [4] reached an agreement in July 2005 to create the Swiss School of Pub-

lic Health Plus (SSPH+). SSPH+ is a national coordinating body whose purpose is to improve the existing postgraduate training programmes in public health and health economics. Since early 2008, the SSPH+ has been managed as a foundation. Every founding university contributed a starting capital of CHF 60,000 and new members have to bring in an equal part. These funding assets are being increased by state, regional and/or local federal subventions, donations and earnings on capital.

United Kingdom and Scotland

Medact – an organisation of health professionals that researches and lobbies on global health issues – has produced a global health studies *curriculum* pack. This has been used in several medical schools to incorporate global health modules into the undergraduate medical *curriculum*. At University College London, the International Health and Medical Education Centre has been introducing global health to undergraduates. Since 2001, an intercalated BSc in International Health has been running. An elective programme is also being developed, which students do in Tanzania.

The Centre for International Public Health Policy (CIPHP) was created in the School of Health in Social Sciences at the University of Edinburgh. CIPHP offers programmes at PhD and Master levels [5], with a strong focus on public health policy in the context of widening global and domestic health inequalities. CIPHP also offers an undergraduate year in International Public Health Policy, leading to the award of the degree Bachelor of Medical Sciences with Honours in International Public Health Policy. The honours year is available to undergraduate medical students from both Edinburgh University and other medical schools.

Sweden

Some medical schools have already introduced global health into teaching. At the Karolinska Institute, Stockholm, global health has been a part of the medical *curriculum* since 1996. A five week full time optional course is available to students twice a year and has become the most popular elective course in the *curriculum*, taken by over half of the students. The aim is to teach how socioeconomic, cultural, and environmental factors determine the health of nations and how the global burden of disease and demographic patterns vary between and within countries.

The Netherlands

Global health teaching is not standard in the basic *curriculum*. The medical faculties of the two universities in Amsterdam (The Vrije Universiteit and the University of Amsterdam) run an elective course entitled "Health and issues of war and peace." A working group has been set up by four Dutch organisations (WEMOS; The International Federation of Medical Students Associations' in the Netherlands; The Johannes Wier Foundation on Health and Human Rights; and the NVMP, Dutch Affiliate of the International Physicians for the Prevention of Nuclear War) to develop a model *curriculum* on global health issues, including facilitating material such as case studies, CD-ROMs, and video. Consequently, the Global health Education Project (GHEP)[6] is now lobbying eight Dutch universities to implement and integrate this *curriculum*, either as an elective module or in the core *curriculum*.

Belgium

The Plate-forme d'action santé-solidarité is a Brussels-based network between labour organisations, public health insurance institutions, foundations, ONG and universities for coordination of strategies to enhance progressive and universal health policies in Belgium, Europe and around the world. Interdis [7] is a partnership within the University of Ghent Association and aims at connecting expertise between disciplines and also between education and practice for an efficient health care management. Because health [8] is an informal and pluralistic platform, which is open to Belgian academic institutions and schools for public health, Belgian medical (and related) development NGO, government services involved in medical development cooperation and international healthcare actors in general.

B / THE AMERICAS
United States and Canada

Among other topics, schools in the USA offer courses in international health. The Johns Hopkins School of Public Health defined the model adopted in other public health schools in the US, even though there are some organisational differences in the programmes. The Johns Hopkins School, however, has remained mainly research-oriented.

According to the umbrella organisation Association of Schools for Public Health (ASPH) [9], accredited public health schools in the USA generally offer five core disciplines: biostatistics, epidemiology, health services administration, health education/behavioural science and environmental health.

On behalf of the schools of public health, ASPH receives grants and works with federal and private agencies on projects aimed at strengthening public health education and the public health profession. The ASPH/CDC Allan Rosenfield Global health Fellowship Program offers global health training opportunities for recent graduates of ASPH-member accredited schools of public health (MPH and doctoral level).

Founded in 1991, the International Health and Medical Education Consortium (IHMEC) changed its name in 2005 to the Global Health Education Consortium [10] (GHEC). GHEC now links over 1000 doctors, faculty and health care educators, representing 65 medical schools in the US and Canada, who are dedicated to global health education in health profession schools and residency programs. GHEC facilitates *curriculum* and training materials development, clinical training, career development and education policy. GHEC members are active in more than 70 health profession schools and training programs in the United States, Canada, Central America and the Caribbean.

In Canada, the Centre for International Health (CIH) [11] at the Dalla Lana School of Public Health of the University of Toronto is making constant efforts to develop global health *curriculum* and teaching programs at the graduate and undergraduate levels, e.g.: mainstreaming of global health in the undergraduate medical *curriculum*; new Masters and PhD programs in global health in the Dept of Public Health Sciences (PHS); a new undergraduate course in the Health Studies Program; global drug policy teaching in the Faculty of Pharmacy, etc. Overseas electives for medical and other students and residents are being facilitated, mostly by the University of Toronto, but also from other Canadian and US universities.

C / ASIA

A review of public health education in the WHO South-East Asia Region in 2005 showed the existence of several postgraduate courses in India, Indonesia and Thailand, and undergraduate courses in other countries. However, there is a great variation in

institutes and courses offered in the region with regards to quality assurance, teaching standards and faculty members' competency in practical field experience. There is no information about whether there is teaching on global health included in these courses. In Australia, public health competencies are fostered by on-the-job, in-service training, context-specific continuing education programmes and short courses, distance and self-directed learning packages, and postgraduate university-level courses.

Bangladesh

The James P. Grant School is one of a new breed of public health institutions based in a developing country. It offers courses relevant to Bangladesh and there has been a shift over the last decade to cover international public health issues as well as local concerns. This school attracts students from both developing and developed countries. Courses are given in partnership with international schools, including Johns Hopkins, Harvard etc.

D / AFRICA

The University of Pretoria's School of Health Systems and Public Health offers a self-directed learning programme including epidemiology; health policy and management; environmental and occupational health; disease control; health research ethics and health promotion.

Africa urgently needs a plan for developing its public health education capacity. Lack of critical mass seems a key gap to be addressed by strengthening sub regional centres, each of which should provide programmes to surrounding countries. Here must be more research linked to public health education and to educational institutions. Changes in the past decade have meant that today there are schools in countries such as Benin, the DR Congo, Ghana and Uganda, to name but a few, dealing with international public health issues and local concerns.

E / THE REST OF THE WORLD

The last few decades have witnessed new schools, in developing countries such as China, Brazil, India, Kazakhstan and Thailand, revealing the growing interest in international public health issues and local concerns. Courses range from one to seven years, require varying amounts of fieldwork and cater to professionals, who are already working in public health, as well as to recent graduates. Depending on the school, a student can opt to study full-time, part-time or by correspondence, online; earn anything from a master's degree in public health (MPH) to a doctorate; or take a short course and receive a qualification in a particular subject.

There is a lot more going on about the issue of global health teaching in the world. It is not within the scope of the current discussion background paper to be comprehensive. A list of useful internet links to international institutions is provided in the annex to this document.

1.2 / CURRENT CONSTRAINTS

Governmental and non-governmental organisations alike are currently dealing with important resources capacity constraints which prevent services from being delivered in sustainable ways. Challenges include highly visible constraints on number, distribution, and training of service delivery staff, especially in countries hardest hit by economic crises, long term consequences

of structural adjustment policies and impact of communicable disease epidemics.

There is a new sense of urgency developing about scaling up training in global health. Increasingly, governments, researchers, and international health practitioners are involved in containing health emergencies; managing shifting health risks due to globalisation; responding to food insecurity; and responding to continued human and natural disasters due to climate change, ignored political atrocities, and failed nation-building.

At the same time, changing global processes themselves creates profound new challenges for the health sector: from the HIV/AIDS pandemic, to the increasing rates of refugees and migrants; from the controversy over global pharmaceutical patents to the health implications of worldwide trade agreements. It is argued that more global economic liberalisation and a political commitment to introducing markets into all spheres of public life, including health services, would be beneficial to all, but there is now growing evidence that the opposite has happened.

The global health industry has become ever more a mixed bag of unclear accountability and exciting opportunity. The infusion of large, new funding sources from philanthropy and the unprecedented attention provided by celebrities, former presidents, development economists, multinational banks and others has stimulated the field of global health. It is in need of careful study and consideration of new forms of governance and improved knowledge of health in a globalised world.

Despite some benefits, the proliferation of Global Health Partnerships (GHPs) has raised several problems at country levels, resulting in too many cases of parallel processes and wasted resources[12]. For instance, in many GHPs, disease specific priorities dominate and focus on narrow issue specific goals. These goals are not always aligned with existing country priorities and programmes, diverting funds and resources away from these priorities. Lastly, the extremely high transaction costs to government and donors are in part the result of having to deal with multiple initiatives.

In the Bamako 2008 Call to Action on Research for Health[13], the issue of uneven financing of research for health and development particularly in developing nations was tackled. Governments of the 56 participating countries were reminded that, so far, too little health research has been focused on the health of the poor in low- and middle-income countries. They were called upon to allocate at least 2% of their health budgets to research. Other authors confirmed the low priority donors give to of donor's priority on funding for research and teaching[14].

Moreover, a 2007 discussion paper from the Regional Network for Equity in Health (EQUINET) in Southern Africa[15] attributes the health system's shortfall to the brain drain of health care workers who follow a hierarchy of "wealth". The exodus of personnel migrating from rural to urban areas, from public to private sectors, from lower to higher income countries within the region, and from the region to industrialised countries, further increases and exacerbates health inequities that already exist.

1.3 / CHALLENGES AND NEEDS

To effectively convince potential donors to invest in global health teaching, the strongest argument should now be that on a global scale acting on social, non-monetary determinants of health as a way to advocate health equity is formally recognised as a core

function of development [16], though this statement is still challenged from the usual corner [17].

Medical curricula in our universities cannot rely anymore solely on teaching national medicine; our new doctors want, and need, more. They need to know more about the world in general (and not just the patterns of disease elsewhere) to understand the physical and mental conditions they are being presented with. It is not sufficient to simply know their technical fields in international health contexts, which is a good clinical reason why global health issues should be on the medical *curriculum*, but there are others too. They need to become familiar with important skills that any professional ought to learn: to appreciate diversity, challenge prejudice, analyse change and the forces that shape society, and to be able to function in a range of circumstances. Hence the need for critical interdisciplinary training of next generation health professionals in and conducting research on global health teaching as an effective tool.

Furthermore, there is need to build an in-depth knowledge base about the architecture of health development aid, through bi-, multilateral or corporate donors active worldwide and in or with Europe. Such knowledge needs to be disseminated through a range of channels, including the Internet, hard copy publications and information releases. This knowledge base can be used to give customised answers to information and research requests from members and partners in the academic community.

Global health training that is irrelevant to national health priorities and divorced from public health practice is useless and constitutes a lost opportunity. More resources need to be mobilised internationally for this and the modality of training needs to be re-evaluated, i.e. to mirror the quality criteria and methodologies of industrialised countries but still meeting local needs in a global context.

In addition to the need to train large numbers of new public health professionals in the South, a further challenge for the academic community is the need to improve the retention and performance of the existing public health workforce. As suggested by another working group [18], those who advocate and promote teaching about global health in the North should not overlook this systemic failure in the South, which is a consequence of a variety of push and pull factors but is equally vulnerable to activities supporting training in the South.

As a starting point for criteria for sustainable global health teaching activities and financing, we should advance the recommendations of the WHO Task Force on Scaling Up Research and Learning on Health Systems [19]:

1 / Mobilise around a high-profile agenda of research and learning to improve the performance of health systems.

2 / Engage policy makers and practitioners in shaping the research agenda, and using evidence to inform decision-making.

3 / Strengthen country capacity for health systems research backed up by effective regional and global support.

4 / Increase financing for health systems research and learning. In accordance with these criteria and specific global health challenges, innovative approaches will be required to mobilize alternative sources of financing for advocating equal opportunities, including those such as:

a / To involve resources from the whole of the government (not only the Ministry of Health) to address the social determinants of health.

b / To actively engage civil society and nongovernmental organisations in global health advocating and teaching activities.

c / To strengthen capacity for global health teaching across sectors and at multiple levels.

d / To gather evidence regarding the efficacy of promoting equal opportunities in health and the utilisation of such evidence in policy decisions and programming.

Possible financing for global health teaching within resource streams for global health should be critically assessed and could be looked for across several new mechanisms:

○ So-called Tobin-taxes or currency transaction taxes: a universal 0.1% yearly tax could raise as much as USD 132 billion, a purely European one could raise USD 16 billion.

○ Innovative taxes on airline tickets that could yield between € 568 and 2763 million yearly.

○ International finance facility schemes, like the one introduced recently in support of the GAVI, that should be able to raise up to USD 50 billion per year.

○ Public-private partnerships, that already contribute close to 2.2% of global official development aid.

1.4 / GOOD PRACTICES

When and where development efforts for global health have succeeded, such success depended on effective relations between stakeholders, whether donor or recipient nations, health systems, village recipients, or NGOs. Nevertheless, little attention has been paid to what sorts of training might be required to ensure successful outcomes in health development.

The strategy carried out and the network established with the project "Equal opportunities for health: action for development" on teaching and advocacy for global health have embedded the following teaching activities:

○ Open university programs for students and health care professionals from the North providing them with the opportunity to test first hands global health realities.

○ An agreement between Padua University and Doctors with Africa CUAMM to provide an expanded framework of cooperation for global health training.

○ Giving postgraduate students the opportunity to spend up to one year of their specialised training in Africa.

○ Giving undergraduate medical students the opportunity to spend one month with Doctors with Africa CUAMM health programs.

○ Training qualified local health professionals (doctors, nurses, midwives, technicians and managers) in global health issues.

At national government level there are examples of how with some political will this changing field of health can be seen in a global context and as background to a sustained academic response, e.g.:

• The United Kingdom is attempting to establish policy coherence with the development of a central governmental global health strategy based on health as a human right and global public good. Rooted in the recognition of globalisation and its effects on health, this new effort will bring together the United Kingdom's foreign relations, international development, trade and investment policies that can affect global health.

• Switzerland has prioritized health in its foreign policy by emphasizing policy coherence through mapping global health across all

government sectors. Through the Departments of Interior (Public Health) and Foreign Affairs, an agreement on the objectives of international health policy was submitted to the Swiss Federal Council to guarantee coordinated development assistance, trade policies and national health policies that serve global health.
• Brazil has demonstrated policy coherence through its assertion of health as key to its own development and as a basis for South-to-South cooperation. In particular, Brazil's role in asserting flexibility in the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement to support the health concerns of sovereign nations set the stage for an integrated, rights-based approach to trade policy.
• The Global Health Security Initiative (GHSI) is an international partnership to strengthen health preparedness and response globally to biological, chemical, radio-nuclear and pandemic influenza threats. Launched in November 2001 by Canada, the European Commission, France, Germany, Italy, Japan, Mexico, the United Kingdom and the United States of America, WHO provides technical support for the initiative [20].
• The ministers of foreign affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand established an initiative on Global health and Foreign Policy in 2006 and with an Oslo Ministerial Declaration in 2007, that recognized the need for new forms of governance to support development, equity, peace and security.

1.5 / OPENINGS FOR COOPERATION AND ACTION

Medical graduate students and leading academics should be, and are, leading the transformation for research into current global processes, their impact on health, and what the response from the medical profession should be. The International Federation of Medical Students Associations (IFMSA) [21] has longstanding experience in participating in the international debate around the issue of improving global health. IFMSA takes care of its own fundraising and is managed by students only. The Centre on Global Change and Health (CGCH) [22], created around the turn of the century at the London School for Tropical Medicine and Hygiene, is an example of a cross-departmental initiative that has brought together staff and students from a wide range of disciplines to contribute to research on globalisation, environmental change. CGCH has been collaborating with the WHO since 2006.
Many science researchers and entrepreneurs, originally from the developing world, are currently working in high-income countries. Although many of these researchers express a desire to give back skills to their countries of origin, there is little evidence of any systematic interaction related to science and technology with their countries of origin [23]. That may be because few of them are aware of any the mechanisms that could facilitate this interaction. Some initial efforts are being made to call on G8 countries to create initiatives to help brain drain scientists contribute to science and technology development in their home countries. The publication of global directories of teaching institutes or the creation of international networks across all health system disciplines have both had a positive influence:
O In 2008 the WHO, in collaboration with Denmark's University of Copenhagen, published global directories of teaching institutes across all health system disciplines including medicine, pharmacy, dentistry and public health.

O Medicus Mundi Switzerland has an internet inventory of postgraduate training opportunities at "healthtraining.org". This website provides comprehensive information on postgraduate training and further education in the field of international health.
O Building Leadership for Health (BLFH) is a set of free training resources designed to support health system development in both resource-poor and resource-rich countries. Currently BLFH has over 70 courses and hundreds of lectures on aspects of health leadership, community leadership, public participation, health economics, planning health futures and knowledge management for health. Over 1000 copies of BLFH material have been distributed on CD-ROMs and an online version is also available on the Global health Campus.
O The International Association of Health Policy (IAHP), founded in 1977 as a scientific, political and cultural organisation, acts as an international, interdisciplinary network of scholars, health workers and activists with the aim of promoting the scientific analysis of public health issues and providing a forum for international comparisons and debate on health policy issues. Considerable attention is also being paid to the dialogue between North and South and East and West. IAHP members in South America are active under the ALAMES and in Europe under the IAHP in Europe Association which both have their own bodies and activities.
O Global Health Action (GHA) [24] is a non-profit international health and development organisation with headquarters in Metro, Atlanta (USA). Their mission is to improve the health of people and communities around the globe through education and training in leadership, management, and health promotion. Since 1972, GHA has trained thousands of health professionals and community leaders from 94 countries with scheduled trainings, on-going technical support, and customised courses. It should not be confused with Global Health Action, the international peer-reviewed Open Access journal affiliated with the Centre for Global Health Research (CGH) at Umeå University, Sweden.
Technological advances are producing many new players in the field of global health. Information and communication technologies allow real-time video connections between experts, and instantaneous access to the latest information available on online databases. In the climate of globalisation, debates concerning the technologies we should be allowing, and those we should control, will find keeping up with the spread of information difficult.
The "call for action" made at the 2008 Bamako meeting [25] pleads for assisting low-income countries through international collaboration and regional alliances. It offers a real point of reference to argue for building and strengthening research for health capacity, for establishing networks of researchers and regional centres of excellence, for ensuring coherent and sustainable funding, for improving education and career opportunities in research and research management and, for strengthening harmonisation of regulation and ethical conduct.
Among the key actors within the spectrum of global health are, of course, the nation-states themselves; organisations for cooperation between industrialised countries (e.g. OECD); recently formed organisations of middle-income countries (like the Group of 20); other regional organisations (EU, ASEAN, OAS, etc.); the United Nations (UNDP, WHO, UNICEF, UNAIDS, etc.)

and a growing number of highly diverse new alliances and networks and non-state players (MSF, BMGF, etc.).

1.6 / POSSIBLE PARTNERS FOR JOINT VENTURES

At the European level, according to the EC treaty, the principal responsibility for organising health services lies with the Member States. But the EU has an important complementary role to play in encouraging cooperation, promoting coordination of policies and programmes and providing support and added value, for example through networking and the sharing of good practices [26].

A key message for the European Union (EU) is to play a more proactive role in teaching global health working together with the private sector, for example foundations, corporations, health professional groups. The mechanism for this collaboration should be a European strategy to protect, promote and improve global health, and should offer opportunities for exchanging ideas and learning from each other and for developing joint action. To fulfil this new role the EU needs to extend its social and economic policies to embrace global health as a keystone for prosperity, security and solidarity within its values and commitments. The creation in 2004 of the European Partnership on Global health [27] was a good step in that direction.

The following policy issues [28] seem imperative for the EU if it is to formulate a European strategy on global health:

1 / Europe must make global health a priority.

2 / Europe must include global health in all fields of policy.

3 / Europe must assert its approach to global health governance.

4 / Europe must establish a societal dialogue and partnership for global health.

5 / Europe must act now for global health.

Alternative multinational models, including private-public partnerships, have developed as a result of efforts by various groups to augment or, in some cases, bypass the authority of multinational organisations. Focused programs have seldom taken a broad view of how these programs integrate through donors and within recipient health agencies. Economic self-interest groups (International Federation Pharmaceutical Manufacturer's Association, International Chamber of Commerce, etc.), and philanthropic organisations, such as the Rockefeller Foundation, the Rotary Club, the Bill and Melinda Gates Foundation and others, have added to a growing crew of international actors with varying agendas.

Many GHPs are made up of both public and private sector organisations that collaborate in decision-making processes and in implementing projects. Increasingly, resources channelled towards specific diseases have been mobilised through these initiatives, rather than going directly to countries.

2 / QUESTIONS AND EXPECTED OUTCOMES FOR THE WORKING GROUP

Can the working group come up with an outline of an action plan to create strategies and main activities to reach the objective of mobilising and sustaining financial and human resources for advocating and teaching global health, including actual steps and possible partners?

The aim that should be achieved by such an plan of action should include setting some key priorities for the transformation and scaling up in the field of the educational process for global health training itself, taking into account the following principles:

O The need to develop and sustain innovative multidisciplinary academic courses, research and programs which advocate and advance global health.

O The call for enhancing education opportunities for work/study at universities in the North and in developing countries.

O The will to enable excellence in global health education and to facilitate opportunities to retain capable and motivated students.

O To identify and attract international scholars and students to the academic community.

Some of the following suggested benchmarks, goals and priorities about how to implement such transformations and scaling up could be discussed, completed or endorsed by such a plan of action:

1 / A consistent, growing demand for training centres to enable, facilitate, global health education and collaboration, together with strategic international universities and organisations.

2 / Interest in learning about and contributing to global health issues as evidenced by steadily increasing numbers of students reporting that they are choosing global health training offers.

3 / Students are motivated to organise conferences, meetings, lectures and events with themes related to global health.

4 / Study programmes that provide students with overseas opportunities in global health research and education, including multidisciplinary collaboration continue to be set up.

5 / Creation of more Masters and PhD programs in international/global health and more courses at both graduate and undergraduate levels.

6 / Increased number of undergraduate courses in international health which attract more international students.

7 / Further develop short course programmes, that can be offered as part of continuing education and for advanced students.

8 / Extra monitoring and comparison of the outcomes of international volunteer programs, and identification of appropriate strategies for expansion.

ANNEX I / SUGGESTED READING

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ANNEX II / SUGGESTED LINKS

FOUNDATIONS / ORGANISATIONS / INSTITUTIONS

• http://www.concern.ie; Concern.
• http://www.coregroup.org; Child Health & Development Database.
• http://www.dci.gov.ie; Development Cooperation Ireland.
• http://www.dfid.gov.uk; Dept for International Development UK.
• http://www.dochas.ie; Dochas / Irish Network of NGOs Development and relief overseas and/or in the provision of development education.
• http://enrecahealth.ku.dk; The Danish Research Network for International Health.
• http://europa.eu.int/comm/health/ ph_determinants/healthdeterminants_en.htm; EU Link to Health Determinants.
• http://www.afmeurope.org/en/index.php; Friends of Global Fund Europe.
• http://www.edctp.org; European & Developing Countries Clinical Trial Partnership.
• http://www.eldis.org; The Gateway to Development Information.
• http://www.engenderhealth.org; Women's Health Worldwide.
• http://www.ennonline.net; The Emergency Nutrition Network Online.
• http://www.gapminder.org/index.html; Human Development Trends 2005.
• http://www.gega.org.za/index.php; The Global Equity Gauge Alliance.
• http://www.ghwatch.org; Global health Watch.
• http://www.globalforumhealth.org; The Global Forum for Health Research.
• http://www.globalhealth.org; The Global health Council.
• http://www.goal.ie; Goal.
• http://www.health-inequalities.org; European Partners for Equity in Health.
• http://www.hrb.ie; The Health Research Board.
• http://www.hrw.org; Human Rights Watch.
• http://www.hse.ie/en; Health Service Executive.
• http://www.ibfan.org; The International Baby Food Network.
• http://www.iphcglobal.org; The International People's Health Council.
• http://www.lshtm.ac.uk; London School of Hygiene and Tropical Medicine.
• http://www.medact.org; MedAct.
• http://www.msf.org; Medecins Sans Frontieres.
• http://www.oneworld.net; One World.
• http://www.paho.org; The Pan American Health Organisation.
• http://www.phmovement.org; The People's Health Movement.
• http://www.pohg.org.uk/support/about.html; The Politics of Health Group.
• http://www.realizingrights.org; The Ethical Globalization Initiative.
• http://www.skillshare.ie; Skilshare International.
• http://www.sphereproject.org; Humanitarian Charter and Minimum Standards in Disaster Response.
• http://www.theglobalfund.org/en/in_action/stories/archives; The Global health Fund.
• http://www.trocaire.org; Trocaire.
• http://www.ukglobalhealth.org; UK Partnership for Global health.
• http://www.ukhen.org; The Health Equity Network.
• http://www.unaids.org/en; UN-Uniting the World Against Aids.
• http://www.unfpa.org; The United Nations Population Fund.
• http://www.unhcr.ch/cgi-bin/texis/vtx/home; The UN Refugee Agency.

• http://www.unicef.org; The United Nations Children's Fund.
• http://www.wellcome.ac.ukThe Wellcome Trust-Research Funder.
• http://www.who.int; The World Health Organisation.
• http://www.who.int/social_determinants/en; WHO Social Determinant.
• http://www.worldbank.org; The World Bank.
• http://www.gatesfoundation.org; The Bill & Melinda Gates Foundation.
• http://www.globalpolicy.org; The Global Policy Forum.
• http://www.ihe.org.uk; The International Health Exchange.
• http://www.measuredhs.com; Demographic Health Surveys.
• http://www.reliefweb.int/rw/dbc.nsf/doc100?OpenForm; Information for the Humanitarian Relief Community.
• http://www.stoptb.org; Stop Tuberculosis Partnership.
• http://www.un.org; The United Nations.
• http://www.undp.org; The United Nations Development Programme.
• http://www.globalhealth.org; The global health council.
• http://www.geocities.com/alamesgeneral; Asociacion Latinoamericana de Medicina Social (Alames).
• http://www.vdaeae.de; Association of German Democratic Doctors.
• http://www.health.ed.ac.uk/CIPHP; Centre for International Public Health Policy.
• http://www.epsu.org; European Federation of Public Service Unions, EPSU.
• http://freeweb.supereva.com/antoniomuscolino/index.htm; European Network for the Right to Health.
• http://www.socialforum.gr/english_index.htm; European Social Forum in Greece.
• http://www.fadsp.org; Federacion de Asociaciones para la Defensa de la Sanidad Publica - FADSP.
• http://www.hst.org.za; Health Systems Trust - South Africa.
• http://www.healthemergency.org.uk; London Health Emergency.
• http://www.nelmovimento.org; Nursing in movimento.
• AMSA International Health Action Group: Division of American Medical Student Association that focuses on international health issues. The International Health Opportunities Directory is an extensive searchable online resource for volunteer and internship opportunities.
• Boston University School of Public Health: Includes Department of International Health section with information about courses, seminars, programs, and news.
• Centre for Disease Control and Prevention (CDC): Office of Global health at the Centre for Disease control; includes information on current projects and links with other organizations.
• Global health Medical Consortium: Annotated list of websites, related information for those interested in international health.
• Global health Reporting: Global health reports and facts by country or by topic including HIV/AIDS, TB, malaria, and other diseases.
• World Associations of Non-Governmental Organizations: Searchable database of non-governmental organizations by region or country and by type of interest, including health.

FELLOWSHIPS FOR TRAINING IN GLOBAL HEALTH

• Office of Career Services: Advising, workshops, and resources for international internship and work experiences. Contact the OCS Reception (617-495-2595) to schedule an appointment to discuss your internship, career, or professional development interests.
• Funding Sources for International Experience: Database of all Harvard funding sources that support undergraduates pursuing activities abroad including study, work, research, internships, and public service.
• Certificate in Health Policy: FAS program in conjunction with Harvard Business, Law and Public Health Schools, and the Kennedy School.
• Office of International Programs: Links to Harvard-approved study abroad options in the "Study Abroad Programs" menu.
• Fellowships Office, Office of Career Services (3rd floor)
Administers variety of grants supporting international study, internships, or work. The website includes information about fellowships, specific opportunities, resources, information meetings, and workshops.
Office of Career Services Library (Shelf information): Many library resources including: International Research Centre Directory and other international reference books (L1-L4), Fellowship and Grant information (B), Directories of Internships (Reception 1-3).
• Crimson Compass: An on-line database of Harvard alumni/ae throughout the world, who have agreed to talk to students about their respective careers.
• Going Global: Database for Harvard students to access information about internships and jobs worldwide, country guides (includes résumé guidelines, interviewing and cultural advice, and other resources).

• Harvard Initiative for Global health Initiative (HIGH): Interdisciplinary initiative focused on global health issues. Includes information on Harvard courses dealing with global health as well as detailing the multiple avenues through with the University researches and supports global health programs.
• Centre for International Development: Harvard's primary centre for research on sustainable international development offers CID-funded World Teach, Summer Internships, Undergraduate Associates Program, and CID Summer Research Grants. Lists external organizations sponsoring internships/volunteer opportunities.
• Harvard School of Public Health: Information about HSPH's research centres and institutes, faculty, and programs which focus on international public health. Includes information on the Francois-Xavier Bagnoud Centre for Health and Human Rights.
• Francois-Xavier Bagnoud Centre for Health and Human Rights.
• Harvard Kennedy School: Information about their research centres and institutes, faculty, and programs which focus on international work.
• Weatherhead Centre for International Affairs: Largest international research centre within Harvard University's Faculty of Arts and Sciences and offers programs and funding for undergraduate students.
• http://www.feinberg.northwestern.edu/education/global-health/funding/index.html.
• http://www.fic.nih.gov/funding/prodir06.htm.
• http://globalhealth.duke.edu/.

JOURNALS

• http://www.dfidhealthrc.org/
DFID Health Resource Centre.
• http://listserv.paho.org/Archives/equidad.html
Equity, Health & Human Development List Serve.
• http://www.gega.org.za/download/ResearchtoAction04.pdf
Global Equity Gage - Course Reader.
• http://www.globalhealthreporting.org/
Global health Reporting Organisation.

• http://www.thelancet.com/collections/global
Lancet Collection Global health.
• http://www.healthdev.org/eforums/partnersireland
Irish eForum focused on health and development issues.
• http://www.who.int/bulletin/archives/80(12)975.pdf
WHO Bulletin On Globalisation And Health.
• http://www.globalhealthaction.net/index.php/gha
Global health Action.

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1 http://www.mediciconlafrica.org/globalhealth/home.asp.
2 EFC, an independent international not-for-profit association under Belgian law, is dedicated to creating an enabling legal and fiscal environment for foundations, documenting the foundation landscape, strengthening the infrastructure of the sector and promoting collaboration, both among foundations and between foundations and other actors (http://www.efc.be/).
3 Gro Harlem Brundtland spoke at a luncheon with the Washington International Business Council and Executive Council on Diplomacy on April 17th 2001.
http://www.who.int/director-general/speeches/2001/english/20010417_IBCluncheonwashington.en.html.
4 They are the Universities of Basel, Bern, Geneva, Lausanne, Lugano and Zurich. In 2008 the University of Neuchâtel joined. Current President of the Foundation is Prof. Felix Gutzwiller, Director of the SSPH+ is Prof. Dr. Fred Paccaud. http://www.ssphplus.ch/.
5 Such as: global health and public policy, health inequalities and public policy, health systems and public policy, global health and anthropology and by research, public health policy. Director of CIPHP is Prof. Allyson Pollock. http://www.health.ed.ac.uk/CIPHP/postgraduate/.
6 http://www.antenna.nl/nvmp/GHE.htm.
7 http://www.interdis.be/.
8 http://www.be-causehealth.be/becausehealth/Site/Default.asp?WPID=105&MIID=100&L=E.
9 The ASPH represents 40 accredited schools of public health, located in the US, Puerto Rico and Mexico. The schools have a combined 9,600 faculty, 22,000 students and 7,300 graduates per year. Harrison C. Spencer is the current CEO and Linda Rosenstock chair of the board of directors. http://www.asph.org/.
10 http://globalhealthedu.org/Pages/default.aspx.
11 http://intlhealth.med.utoronto.ca/.

12 High-level forum on the health MDGs. Best Practice Principles for Global health Partnership Activities at Country Level. Paris, 14-15 November 2005.
13 Issued by the 3rd Global Ministerial Forum on Research For Health that took place in Bamako, Mali (November 16 -20). More information at http://www.bamako2008.org/index.php?lang=en.
14 Mackellar (2008) and Greco et al (2008) papers in the Lancet.
15 Equinet 2008. Health Personnel in Southern Africa: Confronting maldistribution and brain drain. Equinet Discussion Paper N° 3.
16 Commission on Social Determinants of Health (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report. Geneva, WHO.
17 See The Economist World International editorial comment in the August 28th edition "The price of being well".
18 Background paper for WG 3: The role of International Health Cooperation in advocating, teaching and implementing Global health.
19 Timothy, E., et al 2008. Scaling up research and learning for health systems: time to act. The Lancet. Vol. 372, pp. 1529-31.
20 Information on GHSI available at: http://www.ghsi.ca/english/index.asp.
21 http://www.ifmsa.org/.
22 http://www.lshtm.ac.uk/cgch/.
23 Seguin, B., Singer, P.A., and Daar, A.,S 2006. Scientific Diasporas: untapped resource. Science. Vol 312, pp. 1602-03.
24 http://www.globalhealthaction.org/.
25 Available at http://www.bamako2008.org/index.php?option=com_content&task=view&id=93&Itemid=52.
26 Commission of the European Communities 2008. Green paper on the European workforce for health. COM(2008) 725 final. Brussels, CEC.
27 http://www.efc.be/projects/health/default.htm.
28 From: European Foundation Centre, 2006. European perspectives on global health. A policy glossary. Eds. Ilona Kickbusch and Graham Lister. EFC, Brussels, 2006.

OUR COMMON COMMITMENT

A plan of action to teach and advocate global health

A group of people representative of the health community met in Padua on 3-4 April 2009 on the occasion of the international conference "Equal opportunities for health: action for development. A plan of action to teach and advocate global health" with the aim to share best practices and elaborate concrete proposals and actions to promote global health.

INTRODUCTION

The Conference aimed to bring students, faculty, professional staff, researchers, representatives of medical companies, health and education organisations/institutions, and health community members together, to create new synergies, strengthen partnerships and networks, and outline a plan of action to advocate and teach global health.

To discuss ways of achieving these objectives, participants split into four working groups, each assigned a background paper, in order to address the following issues:

○ Teaching global health at schools of health and human sciences.

○ Lifelong learning of health professionals in global health.

○ The role of international health cooperation in advocating, teaching and implementing global health.

○ Strategies for mobilising and sustaining financial and human resources to advocate and teach global health.

The reports of the four working groups were collected and presented in the final plenary session with the aim of promoting a set of actions that project partners/associates, conference participants, as well as newcomers, may wish to implement to extend and improve teaching and advocacy of global health in their own institutions, constituencies and communities.

The proposed actions are grouped into categories according to a series of principles that participants felt should guide implementation. The proposed actions are generic and need to be tailored to specific situations.

PRINCIPLES

1 / Global health (GH) is a set of subjects that should be introduced into health professional education, but also a biopsy-

chosocial conceptual framework for health and medicine that should replace the current dominant narrow biomedical paradigm.

2 / The importance of learning about the determinants of health is increasingly recognised and many students are calling for GH to be included in their study curriculum and academic staff are seeking a new model of teaching medicine (ref. background paper "Teaching global health at schools of health and human sciences").

3 / Health professionals have a specific professional and social responsibility and can perform an important function as information disseminators, opinion makers and "GH advocates" in their work (ref. article "Healh professionals as effective global health advocates": the project "Equal opportunities for health: action for development").

4 / Health professionals need to be better trained in GH related aspects to face current professional challenges of a globalised world (ref. background paper "Lifelong learning on global health").

5 / Training present and future health professionals in the 21st century requires new knowledge and skills and innovation within the current training path, both under- and post-graduate. Teaching GH needs a multidisciplinary and multi-sector approach, as a way of understanding reality better, informing action, promoting participation and getting support. It implies opening avenues for changes in medical practices (ref. background papers "Teaching GH at schools of health and human science" and "Lifelong learning on global health").

6 / International health cooperation is an obligation for the global community: it originates from and aims at eliminating health inequities that, today, mark our global human community (ref.

background paper "The role of international health cooperation in promoting global health").

7 / Active and systematic interaction is recommended between the organisations engaged in international cooperation and those involved in training and health activities (ref. background paper "The role of international health cooperation in promoting global health").

8 / The concept of global responsibility needs the support of a strong movement based in civil society. To reach a critical mass in teaching and advocating GH, developing a dynamic and robust network of actors is the most promising way forward and needs to be continued and accelerated (ref. background paper "The role of international health cooperation in promoting global health").

9 / There is a large array of sources of funds for GH, we need to identify those best suited for a given teaching project and its related activities (service delivery, development, research, etc), whereas innovative approaches are required to mobilise alternative sources of financing for teaching and advocating GH (ref. background paper "Financial and human recources to teach and advocate global health").

10 / As well as obtaining additional resources, we need to improve efficiency in the ways they are used. Networks can contribute to exchanges of teaching programs, students, teachers and so, of experiences (Ref. background paper "Financial and human recources to teach and advocate global health").

ADVOCACY

11 / Strong advocacy is needed to integrate GH teaching into current activities. Advocacy should be directed towards policy- and decision-makers including national and international regulatory and professional bodies, as well as to teaching and training institutions and their staff.

12 / Set up a group of interested advocates:
12.1 / Invite teachers from different disciplines within health science and medical schools.
12.2 / Use already established multidisciplinary research groups that are working on GH issues.
12.3 / Use events around which individuals and groups from different disciplines aggregate.
12.4 / Liaise with interested teachers in other schools (e.g. economics, political sciences).
12.5 / Involve students and their associations.
12.6 / Involve health professionals and their associations.
12.7 / Try to involve deans and their associations.
12.8 / Combine top down strategies (involvement of deans and

professors) with bottom up approaches (involvement of students, residents and health professionals).

13 / Involve local political institutions (e.g. Regions in Italy):
13.1 / Use media headlines and events on GH issues (e.g. migrants and health) to bring together different institutions with similar interests to raise the issue and possibly take it as a case for research.
13.2 / Involve "champions" (young motivated professionals, well-known people) who can support the cause.
13.3 / Try to influence budgeting processes and the allocation of resources.

14 / Produce data and evidence:
14.1 / On global inequities and social determinants of health and their impact on GH.
14.2 / On what does and does not work in reducing inequities and improving health.
14.3 / On what resources can be allocated from each country/region/local council.
14.4 / Collaborate with non health and medical faculties for other determinants of health and development.
14.5 / Use data on local inequities that should be addressed to benefit local communities.
14.6 / Start from real problems, including marginal ones, and move to generate research and development questions (e.g. health impact assessment of policies), and to involve and promote networking among different disciplines and institutions.

15 / Advocate in practice:
15.1 / Translate the evidence produced into simple messages everyone can understand, to raise awareness among both communities and policy makers.
15.2 / As health professionals who say they believe that health is a human right, try to organise other professionals at a local level, through their associations and activities and raise their awareness on GH with lectures, shared experiences, etc.
15.3 / Show your commitment to GH as a health professional in your day to day practice, so as to increase awareness among the general public.

UNIVERSITY TRAINING

16 / Change curricula:
16.1 / Use the opportunity offered by ongoing revisions to introduce GH into the standard curriculum.
16.2 / Interact with international standardisation or regulatory processes, such as the Bologna Process.
16.3 / Use the importance of health workforce migration within the EU to propose a more harmonised and "modern" curriculum for health professionals who need to be culturally competent.

16.4 / Target health and medical schools as priority institutions to influence teaching, both within the university and possibly acting as advocates with other schools (other targets: professional bodies, scientific associations, local authorities).

17 / Ensure that course contents fulfil defined standards and are regularly updated:
17.1 / Focus on practical aspects/skills (including courses on leadership).
17.2 / Organise training of trainers (contents and methods) to prepare GH teachers.
17.3 / Offer teaching experience and a basic teaching package to universities willing to introduce GH courses.
17.4 / Promote the active participation of students (cooperative learning), including tests for knowledge and monitoring of satisfaction.
17.5 / Set up a committee on teaching methods within the Alliance for Global Health and link with hands on practical and field experiences (learning by doing).
17.6 / Develop a syllabus for teaching GH (core topics, basic package, teaching methods, resources, training opportunities, etc.), created jointly by students and teachers.
17.7 / Promote exchange visits between faculties, universities and NGOs, both within Europe and in developing countries, and seek to establish agreements and formal collaborations and to exchange experiences.
17.8 / Promote students getting experience of working on development projects, in developing countries too.

18 / Ensure that teaching methods are coherent with the messages conveyed (health promotion, multi-sector collaboration, community participation, equity, etc.):
18.1 / Introduce participatory evaluation which involves students and teachers, and includes partners in developing countries.
18.2 / Set up a forum within the Alliance for Global Health where participants can gauge their activities against the commitments stated in an initial declaration.
18.3 / Promote health impact assessment of policies and politics (e.g. on migration).
18.4 / Monitor progress on the teaching of GH; this could be done by the Italian Global Health Watch.

- -
LIFELONG LEARNING AND CONTINUING PROFESSIONAL DEVELOPMENT (CPD)
- -

19 / Advocate including GH as part of CPD at different levels and involve various stakeholders:
19.1 / Join a network of GH institutions at local, national and international levels.
19.2 / Raise awareness about the GH training needs of various categories of health professionals.

19.3 / Raise it as an ethical issue with professional associations.
19.4 / Use national and international events (e.g. World Health day, HIV/AIDS day, TB day).
19.5 / Use every opportunity to make GH issues visible (e.g. press, media, meetings, newsletters, etc.).
19.6 / Try to get CPD credits for courses on GH as an incentive to participate.
19.7 / Organise meetings with the General Director of the hospital/institution and the CPD director, to get their endorsement and commitment, as well as to create a good collaborative environment and to obtain their support.
19.8 / Organise workshops and informative seminars with all relevant stakeholders using case studies and plenary discussions to create awareness and to start networking.

20 / Introduce GH in CPD training:
20.1 / Identify an entry point (e.g. migrants' health) to establish a training programme, so that health professionals will perceive it immediately as relevant.
20.2 / Start small, and involve influential leaders (e.g. known clinicians), providing them with facts and figures and the possible contribution from their field of specialisation.
20.3 / Develop background materials and make them available to health professionals, e.g. using the blog set up by the Italian Global Health Watch in January 2009 (www.saluteinternazionale.info) to stimulate training needs.
20.4 / Organise seminars and educational activities on partnership and collaboration within regions and different local health units for both health and non health experts.
20.5 / Replicate, at local level, positive initiatives implemented elsewhere (e.g. in several Italian locations), linking public institutions (e.g. universities, hospitals, local health authorities) and NGOs in developing and carrying out training activities.
20.6 / Replicate training in new contexts; get financial support from other local stakeholders (e.g. banks sponsoring non profit initiatives, regional and local funds).
20.7 / Deal with financial constraints through a network of committed trainers who will teach for free, as in a hospital in Rome and in other sites, where the total direct cost of a 44-hour course for 20 trainees was € 227: i.e. € 0.25 /trainee/hour.

21 / Involve international health practitioners with experience in GH:
21.1 / Put health professionals in contact with each other to foster passion and interest for GH issues (e.g. set up databases on expertise and work experience in developing countries).
21.2 / Create a platform of experts/testimonials to give guidance and coaching on a regular basis to those who are motivated and interested in gaining international experience.
21.3 / Develop regional consortia of NGOs lobbying to obtain spaces for short missions for public health workers.
21.4 / Establish links and collaborate with international institutions experienced in GH teaching and training.

21.5 / Identify a core group of experienced international health practitioners and train them as trainers so that they can develop courses for health workers in their areas.
21.6 / Explore the possibility of organising workshop on GH in developing countries.

22 / Explore the possibility of introducing GH as a topic in master or other postgraduate courses (international development, health management, etc.).

TOOLS AND METHODS

23 / Develop, improve and update a basic teaching package:
23.1 / Adapt it to suit different circumstances; be flexible with contents, as opposed to a fixed universal approach, so as to better respond to local needs and contexts.
23.2 / Experiment with new teaching methodologies (e.g. role plays, case studies).

24 / Promote the adoption of problem-based learning as a best practice and tool to integrate visions and skills from different disciplines:
24.1 / Look beyond the label of GH and use these activities to learn lessons of best practices (e.g. teaching methods used in Trento for general practitioners' training).
24.2 / Teach how language can be useful to disguise/reveal social phenomena and issues, practicing the use of different languages (e.g. art language) to reveal hidden aspects.

NETWORKING

25 / Promote networks with all types of stakeholders:
25.1 / Universities and research centres, including the Italian Conference of Deans of Medical Faculties.
25.2 / Students and residents associations.
25.3 / Hospitals and local health authorities.
25.4 / Health associations and scientific societies.
25.5s / International health NGOs.

26 / Find a place, or a way, of sharing and exchanging information:
26.1 / Set up an Alliance for Global Health, led by a well known organisation (e.g. Italian Global Health Watch or Doctors with Africa CUAMM in Italy), and make it visible through a website.
26.2 / Designate a second line organisation to provide theoretical and technical support to academic units, hospitals, health authorities and NGOs involved in teaching GH; e.g. organise a library and disseminate relevant literature and other materials.
26.3 / Organise an annual meeting/event to build a continuous and structured process.

26.4 / Twinning of academic units can be useful for teacher and educational programme exchange, and favour cooperation, etc.

27 / Promote and build partnerships among NGOs to coordinate activities towards common goals:
27.1 / Make clear agreements with local authorities and work more closely with communities, responding to their real needs and priorities.

RESOURCES

28 / Make the best possible use of available teachers:
28.1 / Reallocate their workload so as to free work time for GH teaching and related action research/service delivery.
28.2 / Similarly, given that time table and credits are usually fully used in curricula, try to make some room for teaching GH within existing disciplines.
28.3 / If possible, contract teaching out to external organisations (hospitals, NGOs, research institutions) thus involving them in courses.
28.4 / Give health professionals returning from years in developing countries the opportunity to apply for university posts (this requires professional years abroad being recognised as a valid academic criterion).
28.5 / Attract academics from other disciplines (social sciences, economics, etc.).

29 / Involve teachers in service delivery, action research and policy design/influence; involve action oriented teachers and gear their practice in health services towards introduction of change:
29.1 / International organisations request consultants for project identification and evaluation but rarely do so for in-service coaching and technical supervision. Use this argument to convince bilateral cooperation agencies that this consultant involvement is needed and that experienced NGOs and academic units will do it.
29.2 / If we want doctors to improve health systems, we should teach them how to perform bottom-up strategies such as pilot experiments (teaching + research + policy influence + service delivery) and create alliances with social organisations.
29.3 / Promote academic international cooperation, development of public health academic units in low- and middle-income countries, and twinning between institutions.
29.4 / Promote a special curriculum for candidates for health development activities and even for rotations in low- and middle-income countries.

30 / As medical students, create associations and partnership with NGOs and offer students the opportunity to gain experience in projects in developing countries or in marginal groups in their

own countries; those who had this experience will usually promote GH at the local level and continue to do so after graduation.

31 / Use web and information technology to share information with a wider community, practitioners, academics, others.

32 / Prepare modules for teaching GH at primary and secondary schools with the collaboration of the teachers.

- -
FUNDS
- -

33 / Try to convince a wide variety of donors to:
33.1 / Take advantage of specific events (e.g. international meetings) and situations (e.g. economic crisis) to promote the need for GH teaching.
33.2 / Use the international concern for controlling global epidemics (e.g. SARS) as an argument for regional/national authorities.
33.3 / In the same way, use the increased mobility of tourists, workers, people and health professionals, as well as the increasing multilateralism in health policy.
33.4 / Try to convince regional health authorities that teaching GH will contribute to health development by importing useful models/organizational patterns from other countries.
33.5 / Identify allied decision-makers in the potential donor organizations and universities, using strategic planning, and direct these arguments to them; for example, attract the interest of students who will demand a new course.
33.6 / Use evidence on effectiveness of tackling the social determinants of health to improve health status.

34 / Refrain from using public funds for development assistance for teaching GH in high-income countries; additional funds are needed:
34.1 / Try to use funds available at regional, local and institutional levels for CPD; use migration patterns to justify the fact that health professionals must be prepared to tackle their specific health problems.
34.2 / Promote networks with universities and health professional associations to get them involved in practical initiatives, e.g. to raise funds for projects through self taxation or other fund raising activities, to offer postgraduate students opportunities to be exposed to projects in developing countries, etc.
34.3 / Consider as sources of funds, in addition to those listed in the background paper, foundations, lotteries and EU funding programmes (aid, regional development).
34.4 / Because teaching of GH does not come alone, but should be related to action research, service delivery, etc, additional funds can be obtained through research projects.

35 / Public Private Partnership (PPP) is a misleading term: there are private institutions with a social mission (e.g. those in

the partnership for neglected diseases) and public institutions that use a commercial rationale. So far PPPs have not funded teaching of GH, although they could perhaps in the future, which is worth being explored.

36 / There are certain drawbacks to be aware of when applying for funds from different sources:
36.1 / Teaching funding agencies:
O Bureaucratisation of teaching (hyper-standardisation of objectives and tools).
O Educational networks are time-consuming, not always efficient.
O Academism (together with de-professionalisation).
36.2 / Services funding agencies:
O A lot of administrative work.
O Bureaucratisation (see EC aid projects).
O Too much project identification, formulation and evaluation and no in-service follow-up prevent academic units to learn from action.
36.3 / Research funding agencies:
O Too descriptive.
O Too bureaucratic (FP7).
O No possibility of financing action research.

- -
IMPLEMENTATION
- -

37 / International health cooperation has to move to strategic planning of health system strengthening in selected areas of intervention to test that, with correct evaluation of gaps and addressing allocation of resources in priorities needs, it is possible to move to the achievement of the MDG's concerning maternal and child health, as well the control of the 3 big epidemics, HIV/AIDS, TB and malaria:
37.1 / International health NGOs need to have a clear agreement with the local authorities and to work more closely with the communities, responding to the communities' specific needs and priorities.
37.2 / International health NGOs need to work towards a "measurable impact" on the communities of the strategies and activities implemented.
37.3 / Collaboration between international health NGOs and universities should be promoted. Medical faculties could collaborate in producing "evidence" of what works and what does not in achieving impact in a multidisciplinary approach involving also other faculties (socio-economic and others) for the other determinants of health.
37.4 / International health cooperation should become a career opportunity and recognised by universities whereas whoever works in this field should not be denied future career opportunities at universities, hospitals etc when he/she "comes back".

IMMEDIATE ACTION

38 / Come to a common understanding, agreement, of exactly what we mean by GH, and disseminate it to all partners and collaborators.

39 / Obtain consensus on a basic declaration containing fundamental values and a plan of action, signed by individual Conference participants, who will commit themselves to involving their respective institutions in the stated principles and commitments.

40 / Set up an Italian Alliance for Global Health, led by an influential organisation, to coordinate the implementation of the above mentioned plan of action.

41 / Make a list of organisations and their representatives which could act as a focal point of reference for activating important "partners" for the coordination and implementation of sections of the plan of action.
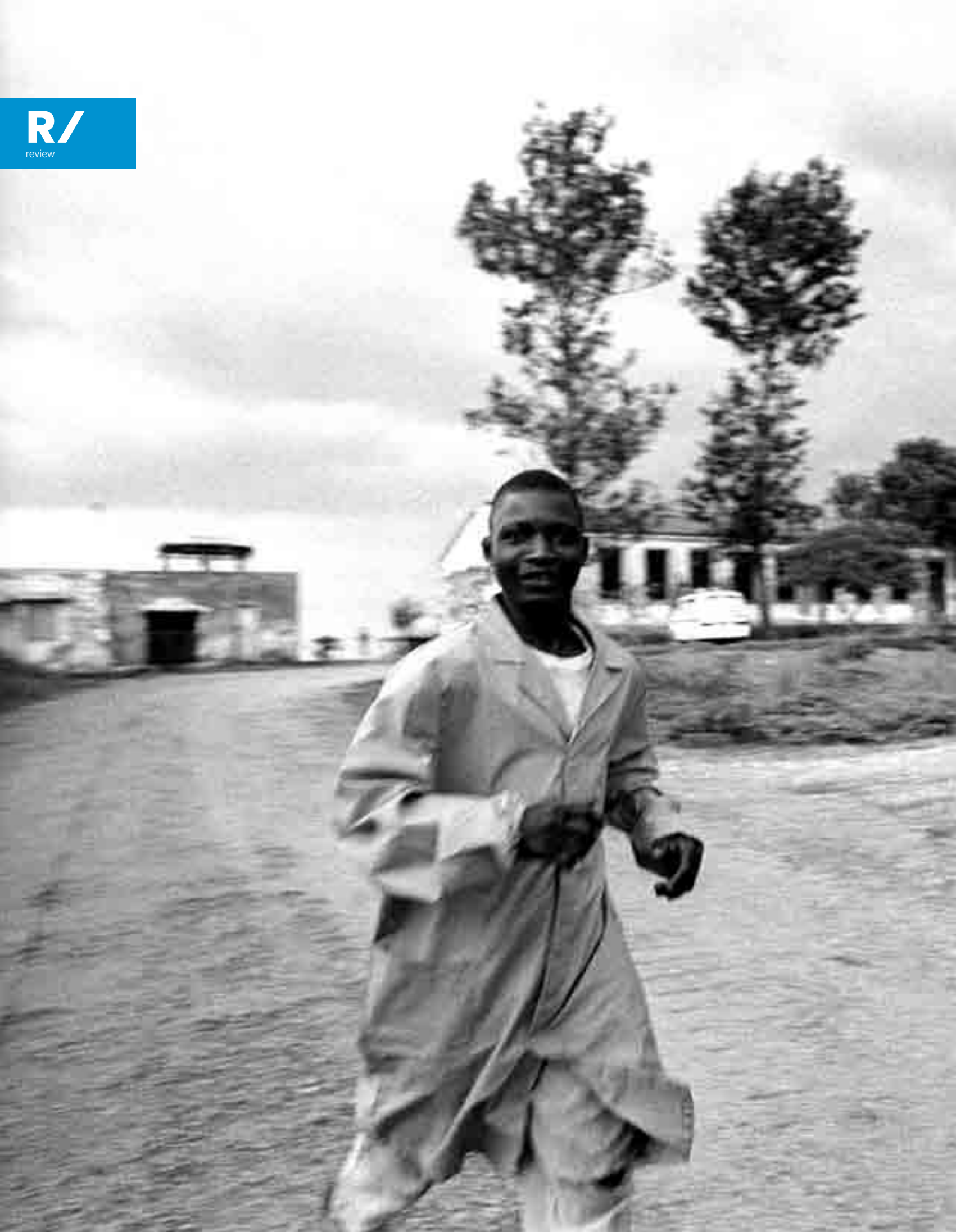
TEACHING AND TRAINING
OF HEALTH PROFESSIONALS

International health and/or international *public* health management

Health professionals can use their skills, practise and contacts to improve equity, influence international policies and develop accessible health care services. Courses on international health can contribute to such vocation by opening avenues for action to students, including a mix of para-professional and para-academic knowledge as well as a mix of teaching and training.

By / Jean-Pierre Unger, Patrick Van Dessel / Prince Leopold Institute of Tropical Medicine of Antwerp/Belgium

Enlightening medical students and doctors on international health issues is laudable: the world village means epidemics and health issues are worth being considered in clinical practice.
However, some health professionals treat international health as a much wider challenge: they use their professional skills, practice and contacts to improve equity, to contribute to change international policies and to develop health care services with a social (not commercial) mission. Courses on international health can contribute to such a vocation by opening avenues for action to their students.

Do to so, such courses need to propose:
1 / Arguments regarding the outputs/outcomes of neoliberal, international health policies.
2 / Hypotheses and methodologies for operational field research aimed at showing authorities the impact of their decisions.
3 / More importantly, they need to open up action perspectives and reflexive methods to develop publicly oriented health services in virtually any environment.
Publicly oriented services are those services with a social, not-for-profit mission. Specific standards for health care delivery and management with a social mission have been formulated [1-3]. To the contrary, health care delivery and management with a commercial mission, aim to maximise the financial return on an investment.

Transmitting arguments and hypotheses related to the effects of dominant policies can be the object of traditional, academic teaching. In contrast, opening action perspectives requires:
O Another type of knowledge: a mix of para-professional (derived from experience) and para-academic (derived from the literature) knowledge
O Other methods to transmit them – a mix of teaching and training.
The present paper aims to describe the specificities of this alternative type of knowledge, to elaborate on appropriate pedagogic methods and to identify the obstacles to such process in a contemporary academic environment.

TEACHING/TRAINING OBJECTIVES IN (INTERNATIONAL) *PUBLIC* HEALT MANAGEMENT

We name *public* health management (*P*HM) the know-how needed to manage and develop publicly-oriented comprehensive health care delivery, disease control programmes, health care services and systems - "with a social mission" or "not-for-profit" (of "public orientation"). In this sense, it is the opposite of the services and systems for delivery and management of care endowed with a commercial mission.
While public health is generally understood as merely addressing "disease control", *P*HM can be defined as a discipline conceived to improve comprehensive health care delivery [a] as well as disease control. It encompasses both health management and health policy skills: but the demarcation between these two domains is fuzzy:
O Field decision makers and health professionals should amend (inter)national policies because too often, policy makers to not see their job as part of a cycle that should have a bottom-up phase.
O The attempt to influence policy is an question of management - as is the optimization of resources use.
O Good policies are designed with an eye to current managerial preoccupations (e.g. their impact upon motivation of health professionals).
Therefore, *public* health management courses should aim at preparing professionals, agents of changes, capable of organising health care, services and systems with a social mission and of contributing to the design of related policies while considering the challenges of international health. At the end of such a course, participants should be able to:
1 / Explaining, discussing and promoting the principles of *public* health management. These principles are related to:
O The delivery of care: characteristics and qualities of family medicine (possibly delivered by non-doctors) and hospital health care.
O The management of a health centre, a general hospital and a disease-specific (or health problem-specific) control programmes.

O The management of an integrated local health system (which meets particular standards [4]), which are made up of a network of first line services, a referral hospital, (generally integrated) disease specific programmes (or health problem specific programmes, like family planning) and their resources. The management of local health systems encompasses responsibilities of organisation and coordination; leadership and decision making; regulation and control; institutions and resources management; and the search for a way of influencing (institutional, regional and national) health policies.

O The control and regulation of public and private health services, with a commercial as well as a social mission.

Public health management is performed within social, cultural, political and economic development perspectives and takes contemporary globalisation into account.

Participants are also expected to explain the specificities of the approach proposed – what distinguishes *public* health management from classical management science for health and traditional public health.

2 / Analysing a real life health situation while applying these principles. One key component of a situation analysis is the study of the health services. The course should contribute to this specific objective e.g. with case studies presented by fellow participants, visits to health services and systems.

3 / Proposing, designing and implementing strategies to develop and integrate an LHS (as defined above) in different environments and to influence health policies so as to promote public oriented care delivery and management.

The primary audience for such courses are managers of health centres, hospitals and local health systems, but PHM courses are designed for conceived for any health professional who wishes to improve health services and systems from *wherever* he/she is working (health services, research / academic units, policy making, disease-specific programmes, etc).

COMPETENCIES IN *PUBLIC* HEALTH MANAGEMENT

Students are expected to master 4 levels of competency [5].

O **Level A** (Malglaive "theoretical" knowledge):
• Understand and construct an analytical framework, made of quality standards and principles, to reflect on LHS development.
• This includes the analysis of influential factors such as health system structure, international policies, relevant social and political factors, stakeholders, etc.

O **Level B** (Malglaive "practical" knowledge):
• Apply the reference framework to one's own and other's experience and to real life situations in order to assess care, services and local systems - and to identify areas for improvement.
• Design health development strategies in different environments – which can be classified according to their main relevant features. The student should know what needs to be done in a given context (in a high, medium or low income level country, through an NGO, in a hospital or a disease programme) e.g. adopting an ad hoc typology. This implies the availability of a meta-theory of strategic knowledge.

O **Level C** (Malglaive "empirical" knowledge):
• Design a detailed strategy and lead a research under operational conditions in a given environment, e.g. action-research, operational research, etc.

O **Level D** (Malglaive know-how and do-how):
• Be able to use the related professional tools correctly to enhance delivery of care from a health development perspective. Examples are supervision, audit, SOAP consultation, demonstration of an antenatal consultation, writing of instructions, use and design of tools for continuity of care for chronic patients, etc.

Figure 1: note that, paradoxically, practical knowledge is rarely developed in traditional schools of public health (unlike in MBAs).

FIGURE 1 / THESE FOUR LEVELS OF COMPETENCIES ARE NOT SEQUENTIAL, RATHER THEY ARE INTER-LINKED
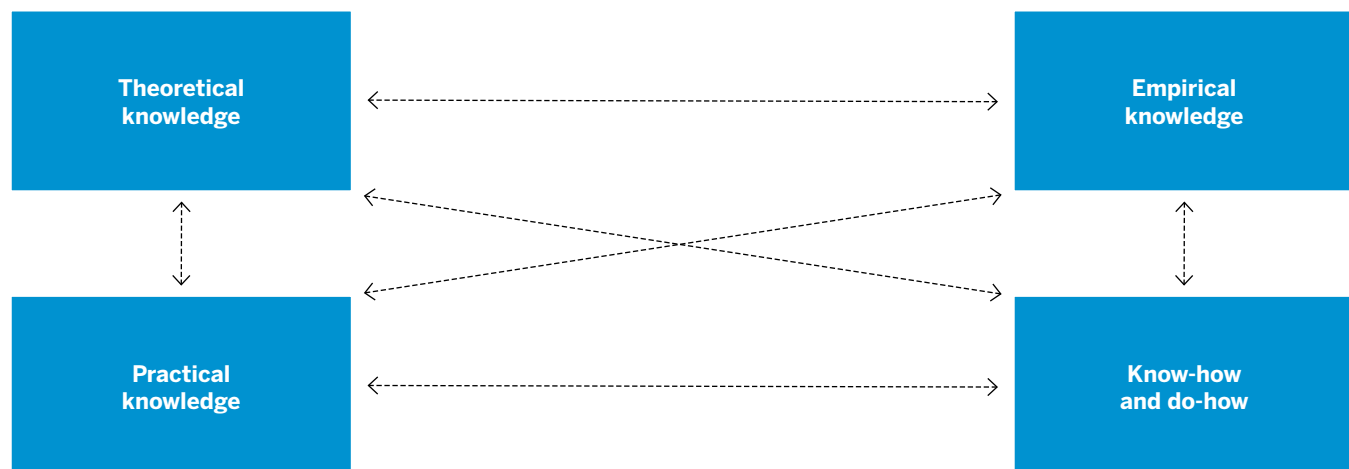
CHARACTERISTICS OF THE COMPETENCIES IN *PUBLIC* HEALTH MANAGEMENT

1 / *P*HM theoretical knowledge is a distinct set of quality criteria attached to delivering comprehensive health care, and to organising services and systems. It reflects publicly oriented values and system thinking.

Because these criteria are inter-related, their sum can be viewed as a reference *framework* for health development. Together with the study of the social, cultural, economic, historical and political context, this framework has been conceived so as to ground health system analysis in any context, in particular a globalised one.

This theoretical knowledge also includes the determinants of health care, services and systems, which have inspired an extensive economic, sociological and political literature. Notice that these determinants are rarely treated as an environment for decision making. Such knowledge also includes the system characteristics of health care (e.g. disease control, medicine and nursing), services and systems and rehabilitation, and lastly, the methods used to produce knowledge.

2 / *P*HM practical knowledge aims at orienting action (reducing uncertainty and enhancing creativity together with efficiency) while developing publicly-oriented systems, services, care and disease control programmes. It is a meta-theory of strategies adapted to a local situation, meant to complement the experience, the common sense and the sense of responsibility of any decision maker. These meta-strategies [6] should be explicitly described and evaluated. Hypotheses on conditions for such strategies can be formulated as follows:

O They need to tune/adjust objectives to means through a sequence of analysis, decision, action and evaluation.

O They need to take into account environmental factors, of which configuration of the health system is the most important. These factors define the validity of such strategies.

O They need to allow for axioms such as those of *P*MH and in particular of PO health care delivery (see above). Such axioms are tied to specific ethical principles: for example, the need to promote specific quality standards with a maximum impact on existing health systems.

O They need to address managerial issues for several resources together: for example, the Bamako Initiative, which associates action on pharmacological and financing resources and their management, with action on community participation.

O They need to aim for several goals simultaneously: for example, access and quality of care together with disease control. This allows for decision making to be as close to real life as possible, while academic teaching tends to analyze health resources on an individual, specific basis.

Examples of meta-strategies that contribute both to systems analysis and managerial/medical decision making are:

O To improve quality of and access to comprehensive care.

O To design and manage disease control programmes and their possible integration.

O To seek influence upon health policies: for example, to strengthen doctor patient communication and promote community participation in public services.

3 / *P*HM empirical knowledge helps in implementing health interventions and specific managerial procedures. It is needed to perform action-research: for example to design a strategy for antenatal care or to introduce family files and to write the related instructions.

4 / Know-how/do-how gathers those techniques which cannot be described by a written instruction: for example, the skills needed to perform a C-section. They are both attitudinal and manual skills relevant to PO services. As an example of its relative specificity, consider the training oriented supervision of family medicine. Not all know-how/do-how is relevant in any environment or compatible with any policy. Supervision is generally not relevant in a country with a neoliberal health policy because family medicine is allocated to the private sector (and self-employed doctors do not accept such practices) while in government services, health care is limited to disease control interventions.

*P*HM courses should offer a mix of these 4 knowledge types, selected because of their importance for publicly oriented health development.

BALANCE IN COMPETENCIES AND KNOWLEDGE TYPES

One issue in academic debate: why should public health teachers be continuously involved in the delivery of health care - and try to improve it? We feel it is necessary because a balance of competencies, drawn from different knowledge types, is needed to teach the organisation of health care delivery.

As *P*HM courses aim to prepare agents for changes, students require a mix of para-professional training and para-academic teaching.

Without professional-like training (or without the conditions to produce such knowledge) linked to academic-like teaching, the transmission of know-how in both health management and policy is at risk of sometimes losing its relevance: "Were management a science or a profession, we should teach it to people without experience. It is neither" [7].

*P*HM teachers need continuous exposure to professional practice not only to know how to do things but also to identify which knowledge types are most useful for students.

There is a price to pay for academic staff to be involved in health services and to attempt to improve health services and policies in real world situations – and to balance maximisation and optimisation while doing that – that is measurable in efforts and opportunity costs.

HOW CAN ACADEMIC UNITS ACQUIRE RELEVANT KNOWLEDGE?

To study and rationalise managerial and clinical decisions and actions, action-research can be used to establish the best course, or courses, of action – and to generalise local strategies. Although the quest for generalisation may harm action research, like much qualitative research, only this type of process of modelisation and comparison will yield truly practical knowledge [8].

At the heart of action research lies a systemic rationale [9] which builds upon important environmental features schematised by the "factual hypotheses" represented in a conceptual model and by the elaboration of a strategy - an "empirical decision".

PROFESSIONAL KNOWLEDGE:

In *P*HM, professional knowledge is in fact "professional-like" because it is characterised by the following features:

1 / Taught concepts need to be relevant for action. Professional knowledge in public health management helps health managers to practise what they preach: to implement their own managerial and policy decisions, as well as those of the community and/or of the "decision makers".

2 / From the teacher's viewpoint, explaining know-how merely gathered from books and papers is not enough. He/she should possess his/her own real life experience and mobilise it to identify relevant problems, to be credible in the eyes of the students and to illustrate some concepts realistically.

The teacher's continuous exposure to situations in health services and policy circles allows him/her to keep up with new solutions, to enrich tool boxes and to generate up-to-date field problems and examples suitable for problem-based teaching. The best examples are derived from personal attempts to change an organisation, a care delivery process or a policy (with a mix of managerial decisions and interventions at policy level). The results of such attempts - whether successes or failures - need to be objectified, e.g. with reflexive methods.

3 / Illustrations from a wide variety of situations, given by the teacher and through the experience and emotions of par-

ticipants drawn from many countries, make it possible to define the domain of validity of a particular strategy. Reflexive methods are needed to assess strategy inputs, processes and outputs, although not necessarily scientific demonstrations (which would otherwise immensely limit the field of suitable illustrations).

This is also a reason why *P*HM teachers should be involved in the development of PO services in heterogeneous environments, because health systems and their environment change constantly. If possible such involvement should be assured under adverse conditions, that is, where government health policies have no social commitment.

In conclusion, 3 of the 4 knowledge types (discussed under "competencies") are professional in essence: empirical and practical knowledge and know-how. The fourth type, "theoretical knowledge", is the only academic one in its biological and/or social science dimensions. This is why *P*HM education requires:

O Professionally oriented and academic teaching.

O Teachers that are permanently exposed to improving delivery of health care, i.e. through systems that are in line with PO standards.

ACADEMIC KNOWLEDGE:

In *P*HM, academic knowledge is in reality "academic-like" because it is characterised by the following features:

1 / It builds on inter-disciplinarity, rather than multi- (or worst, mono-) disciplinarity [10], with concepts and methods belonging to life sciences, health policy and management, social and political sciences.

2 / It uses tendentially qualitative methods from managerial and human sciences - although part of the job is quantitative. The management of health centres, hospitals and LHS is little suited to bio-medical research methods, as the most important part of it is clinical epidemiology - to improve effectiveness of comprehensive health care delivery.

3 / It mobilises political and social sciences, and entails conceiving and interpreting health policies and their determinants.

4 / It uses descriptive studies embedded in concrete attempts to change health policy and/or management.

Notice that *P*HM is a highly specific study domain, which lies at the intersection of numerous fields: for example, health care delivery, health policy, organisation of PO services and participatory management which aims to achieve a balance between specific quality standards. This, together with the fact that evidence-based medicine (EBM) sites merely explore disease-specific concepts and methods, explains why much of the available scientific literature is comparatively less helpful for public health management students than for others.

The model must balance simplicity and faithfulness to reality. *A priori*, the validity of a hypothesis for action is limited to the environment where the research took place. Together with the technical background and the description of the environment, these hypotheses will lead to a formalised strategy (the "action hypothesis") and to technical procedures [11]. Models should potentially offer a large domain of validity. The feedback loop includes technical evaluation of the strategy and its assumptions

and operational evaluation of the implementation. In general, action research requires a reflective attitude from both actors and researchers [12].

Action research assumes that the researcher is involved in the decisions: the aim is to bring about change, unlike with fundamental or with «descriptive/analytical» research, where the objective is merely to explain a phenomenon and to identify correlations between variables. What interests the action researcher

is to succeed, together with the actors, in bringing about a change deemed desirable and to know the conditions of failure or success. In other words, he/she does not remain as an external observer of the process. But success *per se* is not sufficient: the research must also identify determinants of the results. To increase the likelihood of success, researchers must acquire personal managerial skills and conceptualise these to transmit this knowledge. In practice, the scientific guidance of health development projects has given many staff the opportunity to participate in action research.

How can action-research «models» of local action research be generalised? By definition, these models are hypothetical and the conclusions have a local and temporary validity. Therefore, to contribute to decision making elsewhere, they must undergo some generalisation, which requires the models to be refined [13]. The strategies' domain of validity can be enlarged only after repeated and empirical observations of correlation between the interventions and their observed effects. This has three consequences:

O There is a need for effectiveness in action research.

O The quest for field success does not exempt the researcher from properly analysing and documenting his/her failures and successes.

O To compare action models, the strategies' objectives and axioms must be similar.

This gives an overriding importance to teamwork, lengthy follow-up of field projects, intellectual exchanges, teaching programmes and co-ordination with ex-alumni networks.

How to define research priorities in *P*HM? The most important criterion has been that the research projects should contribute to the development of the health services, in which they are carried out. Research projects should also be complementary to each other (e.g. geographically) and progressively cover all clinical, managerial and social action dimensions of health service organisation.

SPECIFICITIES OF PEDAGOGIC METHODS

The transmission of para-academic (or academic-like) knowledge (as defined above) is not merely ex-cathedra. There is a need for interaction between teachers and students in order to use the professional and life experience of course participants as course raw material as much as possible. Several techniques building upon group work, participatory teaching, exercises (e.g. problem based learning) are suited to this type of pedagogical approach. Mobilising the experience of the participants also increases the likelihood that concepts taught will be used in practice.

The transmission of para-professional knowledge requires field demonstrations and visits to pilot health care services (with *ad hoc* analytical frames), role plays (e.g. to train in medical audit practice or in patient-centred care delivery) or direct supervision.

OBSTACLES IN THE ACADEMIC ENVIRONMENT

Only two such obstacles are mentioned here, as they appear to be of paramount importance for understanding the difficulties of implementing the above agenda.

The European Commission has relentlessly aimed at privatising health education and research and at increasing joined ventures in health education programmes. This has had two consequences:

O Research funds were assumed to be allocated to the best academic units. Therefore, some "objective" criteria were looked for. The impact factor of publications became the universally accepted yardstick – while reading a scientific paper was not considered a relevant exercise for research evaluation, as it could result in merely subjective appraisal. Maximisation of impact factors is clearly at odds with maintaining field practice relevant to professional goals.

O Careful project description was demanded to finance research proposals – at the expense of flexibility in research objectives and methods. In this context, it becomes difficult to explore unexpected results as the research plan is laid down for a period of 3 – 4 years. This over-planning represents a drawback for action research, which requires dynamic hypotheses.

Another problem with research on international public health management lies in the fact it must of necessity be inter-disciplinary: academic staff tend to build their careers on specialisation, on the mastery of one discipline (which is more easily publishable).

CONCLUSION

In the absence of a political will and appropriate, international academic policies, the development and transmission of knowledge in international public health management requires a strong commitment rooted in some kind of existential motivation – which links public health to philosophy.

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a Comprehensive health care includes care initiated by a patient demand (discretionary) as well as by health professionals and disease specific programmes. It is delivered by multi-functional services and includes hospital medicine able to handle at least medical, obstetric and surgical emergencies. In low- and middle-income countries, first-line health services would include family and community medicine, which encompasses individually tailored prevention and promotion activities in health institutions as well as mass prevention and clinical interventions that are part of disease-specific programmes. Such care may be delivered by an array of professionals, from physicians and assistant medical officers, to clinical officers or nurses, but not community health workers.

SUSTAINING EQUITY IN THE PRIVATE NOT FOR PROFIT SECTOR IN UGANDA

A public responsibility

Based on cases of hospitals affiliated to the Uganda Catholic Medical Bureaus, this study has examined the size of revenue from key financing options over an 8-year period, specifically trying to show how public subsidies have impacted on the burden of fees on the users and service uptake.

By / John Odaga, Everd Maniple, Vincent Bwete / Uganda Martyrs University / Uganda

ABSTRACT

Equitable access to health care is a key objective of the entire Ugandan health system, and a mission for the private-not-for-profit sector. The financing mechanism of a given health system is crucial in defining its fairness to the population. Given the reliance of the private not-for-profit sector (PNFP) on out-of-pocket payment for their income, the challenge becomes how to provide equitable services, of good quality, in a sustainable way. Based on cases of hospitals affiliated to the Uganda Catholic Medical Bureaus (UCMB), this study examined the size of revenue from key financing options over an 8-year period. In particular, it sought to illustrate how public subsidies have impacted on the burden of fees on the users, and service uptake, over the years. Furthermore, it sought to answer the question whether community-based health insurance schemes (CBHIS) are a viable alternative to out-of-pocket payments. We relied on routine data submitted to the UCMB head office to answer the first set of questions (on revenue structure and impact on utilisation), complemented with interview surveys, key informant interviews, and additional records from sampled hospitals to determine the burden of fees on users. The potentials of CBHIS were evaluated based on records sent from the facilities (hospitals and health centres) that are running those schemes, complemented with results from a parallel survey, conducted by the same team, in the same settings. The main results are that out-of-pocket payment is still the major financing mechanism, although its contribution fell from 63% to 39% over the 8 years reviewed, thanks to subsidies from the government and external NGOs. Government grants which had given some relief had declined to 24% by 2005/06, forcing the sector to rely, once again, on external assistance which stood at 37% by 2005/06. Because of the high level of subsidies (from government and NGOs) the level of fees in 2007 was comparable with those in 2000. High service uptake (bed occupancy rate of 80+) was observed in hospitals with subsidy levels of 70%+. Despite the relatively low levels of fees, many patients were still forced to sell their property and/or borrow money to finance health care. Nevertheless, the number of patients denied, or given only partial treatment, because of non- or partial payment of medical bills, was marginal. Some hospitals lost a large amount of income because of exemption or waiver policies that are in place to protect sub-groups of users. Transport costs were found to be a significant, but hidden, additional direct cost. Community-based health insurance cover is still low, and there was not enough evidence from this study to show whether service uptake among scheme members is higher than among non-members. The key message is that user fees (out-of-pocket) payments remain an inevitable financing mechanism in UCMB-affiliated facilities, and in the PNFP sector as a whole. To achieve equity goals, they need to be kept low. This is possible either through government grants or through external direct assistance.

1 / INTRODUCTION

1.1 / BACKGROUND

Inequity in health is so pervasive that, today, most health goals, both locally and internationally, are framed in the context of equity, if only for sanitary purposes. However, there has been weakness in translating these objectives into explicit strategies and guidelines necessary for achieving them (Gwatkin, 2000). In the health domain, an equitable health programme/system is commonly viewed as one which is financed according to the ability to pay - such that the poor pay less, and are protected from catastrophic expenditures; and one where services are provided or utilised according to need such that financial, geographical and cultural barriers are *deliberately* minimized to provide *equal opportunity* for health care.

The financing mechanism in any given system is especially crucial, as it has wide ramifications for equity, impacting on the availability of care (location of facilities, the kinds of services provided), and on health-seeking decisions at both individual and household levels, as well as at the level of catastrophic expenditure incurred by individuals and households. The main objective of any (fair) financing scheme is that it should protect individuals

from catastrophic expenditure, and should facilitate the availability of necessary services and should minimise financial barriers (WHO, 2000; Pearson M, undated).

In developing countries, user fees are still a common means of financing health care. User fees refer to the payment of out-of-pocket (OOP) charges *at the time of use* of health care. By prescribing the timing of the contribution relative to the time of needing and receiving health care, even someone who could afford the cost of care can fail to get care because the money may not be available at the time of need (Arhin-Tenkorang, 2000). The negative effects of user fees as a barrier to utilisation by the poor are well documented (Arhin-Tenkorang, 2000; WHO, 2000). Furthermore, user fees cannot protect people from catastrophic financial expenditures: the poor especially, could be driven into abject poverty as a result. But, despite the debates about the merits and demerits of user fees as a financing mechanism, its regressive nature is not in contention (Jacobs & Price, 2004; Arhin-Tenkorang, 2000; WHO, 2000; Mwabu, Mwanza & Liambila, 1995).

In order to promote access, there is need to keep out-of-pocket (OOP) payments low. One way of doing this would be through tax-based grants, normally available only to publicly funded health care, or through health insurance.

This study reports on the implications of the prevailing financing mechanisms in Uganda for the equity objectives of the private not-for-profit sector, focusing on the case of the Uganda Catholic Medical Bureaus (UCMB).

1.2 / CONTEXTUAL ISSUES

a / Equity-orientation of policies
Equity is a key guiding principle of Ugandan health policy and health sector strategic plan. The government funds the provision of a basic package of care (the Uganda Minimum Healthcare package) that is said to be pro-poor because it covers the commonest causes of illness and death. To ensure the availability of these services to (and thus their consumption by) all segments of the population, the government abolished user fees in all public facilities in 2001; this was followed by a two to three-fold rise in utilisation of public and PNFP services, especially by the poorer segments of the population (Xu *et al*., 2005; Messen *et al*., 2006). Other relevant policies include increased allocation of funds to primary health care facilities (health centres), and the adoption of a sector-wide approach whereby most of the bilateral aid now goes to fund government priorities through a central budget. SWAp is accredited for redistributing donor aid according to national priorities (need), and thereby minimising the regional imbalances that had been fostered by vertical donor projects. Furthermore, the provision and management of health services are highly decentralised, so local authorities can respond to local needs. There is strong partnership with the private not-for-profit (PNFP) sector in a number of areas, including service provision-a good strategy for equity given their substantial size and rural location. Collaboration with the private sector includes the private for-profit sector as well as traditional and complementary practitioners; however, only the public and PNFP sectors provide preventive services and curative services. Preparations are underway to introduce a social health insurance scheme.

b / Health expenditure
Inadequate funding remains a primary constraint stunting health sector development in Uganda, and especially, making it hard to achieve equity goals. Total (both public and private) health expenditure has of late been around USD 18 – 20 per capita per annum, which is about 8.1% of the country's GDP. Of this, only USD 8 is provided by the government, with a substantial component – more than USD 4 per capita – derived from donors and international lending institutions (Xu *et al*, 2005; MoH, 2004a; MoH, 2004b).

There is no national health insurance system nor is the private insurance market well developed. Only a few small community-based insurance schemes exist. Out-of-pocket expenditures by households constitute 40-45% of the total health expenditure (MoH, 2004a), as is typical of many countries in sub-Saharan Africa (WHO, 2004).

The current public funding (USD 8), even when efficiently used, falls far short of the estimated USD 28 per capita required to provide the Uganda National Minimum Health Care Package (UN-MHCP), even excluding anti-retro viral drugs and the pentavalent vaccine. It is even far less than the requirement of USD 30-40 per capita (WHO CMH 2001; MoH 2004b) when ARVs and pentavalent vaccine are included.

Consequently, only 30% of the Health Sector Strategic Plan, phase 1 (HSSP1) was funded (MoH 2005). HSSP2 is more ambitious (with the inclusion of ARVs and pentavalent vaccine); however, government health expenditure has remained unchanged in real terms. Hence, the population will, perforce, continue to rely on privately financed health care.

c / Accessibility
Although accessibility to health services has been improving over the years, large disparities still remain. The national average for the percentage of people living within 5 km radius of a health facility was 57% by 2000, ranging from as low as 7% in the north-eastern part of the country to 100% in some central and south-eastern districts (SIDA, 2006). The national average is currently said to stand at 72% (Kiwanuka *et al*., 2008), although large inter regional disparities remain.

d / The role of the PNFP sector
The PNFP sector are a significant partner in the health sector in Uganda, accounting for about one fourth of the health care facilities in Uganda, and between 25% and 35% of the total outputs of the national health system. In terms of funding, the PNFP facilities receive less than 10% of the overall health budget (MoH, 2004a; SIDA, 2006).

Their primary mission is the provision of quality services, with a preference for the poor. To this end, most of the PNFP facilities are located in the poor, under-served rural areas, where it is often difficult to attract and retain personnel; areas where culture and low levels of education collude to erect high barriers to health care use. In a number of rural areas in Uganda, the PNFP facilities are the sole providers of the basic health care package. They play a leading role in community-based initiatives that take basic services closer to the people.

The key challenge for the sector now, is how to sustain equitable access to quality health care. Over the last five years or so, more attractive salaries have been offered in the public sector and caused an exodus of workers from the PNFP side to the public sector. Additionally, the cost of services has been rising, and

external aid diminishing. Out-of-pocket payment remains the mainstay of financing health services in this sector. In order to promote more equitable access, out-of-pocket payments must be kept low. Amone *et al.* (2005) found out that to remain equitable, user-fees should constitute less than 30% of the total running cost, with the difference financed through public subsidies or other means.

This study examined the implications of the various financing mechanisms in Uganda for equity (utilisation of services) in the private-not-for-profit sector in Uganda, using the hospitals affiliated to the Uganda Catholic Medical Bureau as a case study. This was because, firstly, the UCMB facilities make the largest share (37%) of all the UCMB facilities. Secondly, it was possible to make comparisons with a previous survey conducted 7 years previously (Amone *et al.*, 2005) regarding some of the objectives. Policy and economic climates had changed over the period, and the study sought to examine how those changes could have affected the financing of health care in the PNFP sector. Most importantly, the study sought to examine the burden of out-of-pocket payments on users and the effects of the prevailing financing schemes on patients' uptake of health care. Last but not least, the study sought to evaluate the potential of community-based health financing as a viable alternative to out-of-pocket payment.

The following sections summarise the methodology used in the study, the main findings and the implications of the findings for policy.

2 / MATERIALS & METHODS

2.1 / STUDY AREAS, POPULATION AND SAMPLING

All the hospitals affiliated to the Uganda Catholic Medical Bureau (UCMB) were considered in the analysis of income structure over an 8-year period (from 1997/98). Comparison with Amone *et al.* (2005) was made with respect to the size of out-of-pocket payment as a financing mechanism, the burden of out-of-pocket expenditure on users, and the effect of out-of-pocket payment on service uptake. Ten hospitals were studied in 2000 by Amone *et al.* (2005). Only 7 of them are included in this study because 3 did not respond to our questionnaires in time.

Interviews with patients/care takers were conducted at the hospitals in our sample to estimate the burden of user-fees on them. Forty patients (20 from OPD and 20 from IPD) were sampled from each of the hospitals to determine the burden of out-of-pocket payments (the basis of sample size calculation can be found in the appendix).

Self-administered interviews of Key Informants (KIs)—chief executives or administrators of the selected hospitals—were undertaken to investigate the existence and application of exemption and/or waiver policies, and to establish the fee structures being implemented at the respective hospitals. Additional data on user fee structures were obtained by reviewing the documents the KIs submitted to the investigators.

UCMB affiliated hospitals and health centres known to be implementing community-based health insurance schemes were also selected to determine whether community-based-health insurance schemes were a realistic alternative to out-of-pocket

payments. To answer our question we obtained and analysed financial and utilisation records from the existing schemes, which were provided by the scheme managers. A desk review of findings from parallel household and facility surveys, conducted in by the same team in the same settings, was undertaken to extract data that were necessary to contextualise the findings of this study. The specific data extracted from this survey were on schemes' membership size, geographic coverage and effect on out-of-pocket payments.

2.2 / SUMMARY OF VARIABLES, INDICATORS DATA COLLECTION METHODS AND SOURCES OF DATA

Table 1 gives a summary of the types of data collected, the sources of the data sets, and the methods of data collection.

3 / RESULTS

3.1 / GENERAL INFORMATION

Although all the 10 hospitals that participated in the 2000 study (Amone *et al.*, 2000) were sampled in this study, only 7 of them completed and returned the questionnaires sent to them. They are presented in the **table 2**. Five additional facilities affiliated to the UCMB were selected to study the performance of CBHIS at these facilities

3.2 / ROLE OF DIFFERENT FINANCING MECHANISMS IN ALL UCMB-AFFILIATED HOSPITALS

a / Major sources of finance
Examination of the revenue structure of all the UCMB-affiliated hospitals revealed essentially three major sources of finance, especially in the context of operating costs.

The first one is private contributions, that come mainly in the form of out-of-pocket payments (also referred to as user fees), paid at the time of seeking care. In a few hospitals this was supplemented with income from community-based insurance schemes (CBHIS), based at the respective hospitals. The data analysed lumped all private contribution together under "user fees", presumably because the size of income from community-based insurance schemes was marginal. Therefore, although, in this report, we present out-of-pocket (user fee) payments as if they are the sole mode of private contribution, it should be noted that in some hospitals, revenues from "out-of-pocket" payments were also inclusive of those realised through community-health insurance schemes, albeit in small amounts. The role of CBHIS is discussed separately in section 3.9.

The second source of income consisted of grants from the central government, both in the form of cash (mainly) and donated items (such as drugs). Only grants intended for the routine running of the hospitals were included in this analysis. Grants extended to training schools, for capital investments, and for coordination of primary health care activities were all excluded.

The third major source was assistance, mainly from external non-governmental bodies, in the form of projects to specific hospitals. External aid intended for capital development were excluded from the analysis.
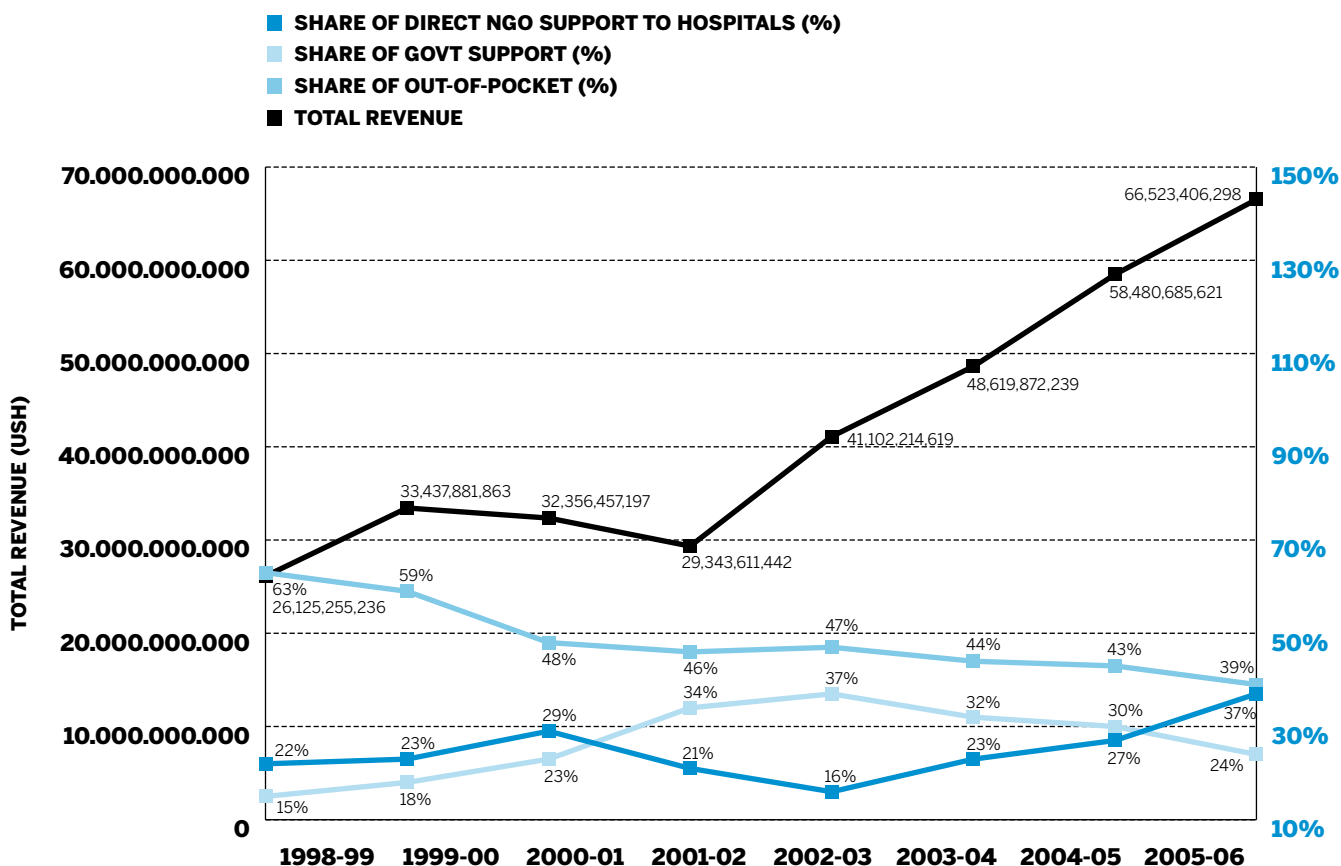
TABLE 1 / VARIABLES, MEASUREMENT, SOURCES OF DATA AND DATA COLLECTION METHODS

VARIABLE	INDICATORS	SOURCE OF DATA & METHOD OF DATA COLLECTION
FINANCING MECHANISM	Sources, amount from each source (absolute & %); looking at trend over 8 financial years for all the hospitals; for the 7 sampled hospitals, 2007 compared with 2000	Review of records (hospital Health Information & Management System reports) at the UCMB office
BURDEN OF FEES AND ABILITY TO PAY	*Total Medical Cost* The average OOP paid for ambulatory and inpatient services *Total economic cost* Total of OOP expenditures, including UF, expenditures on transport, food, etc, unofficial payments. Apart from OOP for medical services, only expenditures on transport was reported by most *Ability to pay* The number of patients who paid in full, partially or could not afford to; reports of denial of treatment because of non or partial payment	Review of records (MF 5) and receipts of sampled patients during exit (OP) or due for discharge (IP) Interviews of sampled users (OP and IP), in addition to reviewing records to determine the total medical cost as described above Interviews with sampled patients regarding denial of services
EXISTENCE AND EFFECTIVENESS OF EXEMPTION AND WAIVER MECHANISMS	Existence, criteria, level of awareness among staff & patients, whether applied according to criteria, number of beneficiaries per year, effect on revenue; fate of defaulters	Key Informant (Med. Supt., Hosp. Admin.) interviews; Review of records (for list of beneficiaries, lost revenue); Interviews with sampled patients
MEANS OF FINANCING	Source of fund (savings for health care, sale of property, etc.	Interviews with sampled patients
EFFECT OF SUBSIDIES OR OOP ON UTILIZATION	Correlation between size of OOP (or tax-based funding) with bed occupancy rate in each hospital	Review of records
PROSPECT OF COMMUNITY-BASED HEALTH INSURANCE SCHEMES	Enrolment (total, number per household); membership dynamics (retention in the scheme); geographic coverage; and contribution to the budget; utilization among members compared with the general population	Review of records, desk review of a findings from a parallel study to contextualize the findings of this study

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TABLE 2 / LIST OF SAMPLED HOSPITALS

HOSPITALS THAT PARTICIPATED IN THE 2002 USER FEES SURVEY	UCMB FACILITIES OFFERING CBHIS
1 ST. LUKE'S HOSPITAL, ANGAL	1 ST. FRANCIS HOSPITAL MUTOLERE
2 COMBONI HOSPITAL, KYAMUHUNGA	2 NYAKIBALE HOSPITAL
3 DR. AMBROSELLI HOSPITAL, KALONGO	3 KITOVU HOSPITAL
4 ST. FRANCIS HOSPITAL, NAGGALAMA	4 NYAMWEGABIRA HC
5 RUBAGA HOSPITAL	5 KITANGA HC
6 KISUBI HOSPITAL	
7 IBANDA HOSPITAL	

FIGURE 1 / TRENDS IN INCOME SIZE FROM DIFFERENT SOURCES, ADJUSTED TO 1998/99 USh

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Legend:
- ■ SHARE OF DIRECT NGO SUPPORT TO HOSPITALS (%)
- ■ SHARE OF GOVT SUPPORT (%)
- ■ SHARE OF OUT-OF-POCKET (%)
- ■ TOTAL REVENUE

Source: Hospital Annual Report, UCMB Kampala

b / **The significance of the various sources has been changing over the years**

Figure 1 shows the trend in the aggregate volume of revenues for all UCMB-affiliated hospitals, from the three major sources over an 8 year period, including the values of all donated goods and services. The following categories of income sources were excluded from the analysis as they did not contribute towards the cost of running the hospitals: government grants to training schools, income from school fees, government grants for health sub-district [1] operation, and income targeted for capital development. All amounts were discounted [2] to 1998/99 Uganda Shillings.

After reaching a peak in 1999/00, the aggregate volume of revenue realised by all the UCMB-affiliated hospitals started to decline until 2001/02. There was a sharp upturn from 2002/03 to 2005/06. This rise was the result of growth in income from EACH of the major sources analysed in this study–i.e. from out-of-pocket, government support and NGO project support. However, this growth was unequal, with the contribution (%) of each source varying over the period reviewed. It is noteworthy that, even though out-of-pocket-payment remained the most significant source of revenue over the period analysed, its contribution to the overall resource envelope progressively declined, from 63% in 1998/99 to 39% in 2005/06. This was made possible by a far greater increase in subsidies accruing from public contribution (government grant and external aids through NGOs). The total public contribution increased from 54% to 61% between 2001/02 and 2005/06, the period during which the total resources envelope increased sharply.

It is also noteworthy that the government contribution to the UCMB hospitals peaked at 37%, way back in 2002/03, and has since been declining. On the other hand, direct NGO/project aid, which had become relatively less significant by 2002/04, has once again increased. In 2005/06, the revenue realised through project/NGO aid overtook the share of the government contribution, and nearly matched that collected through out-of-pocket payments by patients.

In a nutshell, the sharp rise in the total income observed between 2003/03 and 2005/03 is largely attributable to the significant rise in subsidies, rather than to the growth in revenue from user fees. External aid has lately become the most significant form of subsidy to the hospitals.

3.3 / REVENUE STRUCTURES OF SELECTED HOSPITALS

We further examined the income structure of the 7 hospitals sampled for this study. We computed the average total income, and the contributions (%) of the sources, over the period 1997/98 - 2005/06. Again, only income meant for running the hospitals were considered, including the values of goods and services offered in kind (such as essential drugs offered by the government). The hospitals were then grouped into three bands: (a) hospitals whose share of revenue from out-of-pocket payments was low (less than 1/3rd); (b) hospitals with moderate to high levels of revenue (between 1/3rd - under 2/3rd) from out-of-pocket payments; and (c) hospitals highly dependent on out-of-pocket contribution (≥ 2/3rd). This stratification was guided by the observation by Amone *et al* (2005) that, for a private not-for-profit hospital to remain equitable, the contribution of out-pocket payment must not exceed 20% of the resource envelop. The results for the 7 sampled hospitals are summarised in **table 3**. These are the hospitals that were studied in 2000 (Amone *et al.*, 2005).

TABLE 3 / INCOME STRUCTURE OF SELECTED HOSPITAL: AVERAGES FOR 9 FINANCIAL YEARS

HOSPITAL	TOTAL ANNUAL INCOME (AVERAGE)	OUT-OF-POCKET (AVERAGE)	GOVT GRANT (AVERAGE)	EXTERNAL AID (AVERAGE)
AMBROSELLI, KALONGO	925,182,588.38	5%	29%	66%
ST. LUKE'S, ANGAL	454,080,156.63	20%	48%	32%
NAGGALAMA	230,909,505.36	54%	34%	13%
IBANDA	452,953,873.34	65%	31%	4%
COMBONI, KYAMUHUNGA	167,277,267.45	66%	26%	9%
KISUBI	279,989,211.94	66%	16%	16%
RUBAGA	1,613,183,996.18	89%	5%	6%

Source: Hospital Annual Report, UCMB Kampala

It is notable from the table that the hospitals with low out-pocket contributions (large subsidies) are arguably the remotest. The level of fees at Kalongo hospital was afforded mainly because of the large external aid (NGO project support); on the other hand, Angal hospital was largely reliant on government subsidies over the period considered.

3.4 / BURDEN OF FEES ON USERS …

Having looked at the role of the different financing options, and in particular the significance of out-of-pocket payments, the study further sought to underscore the burden of out-of-pocket payments on the users of care. This was necessary in light of the fact that the objective of the private not-for-profit sector, in particular that of the Uganda Catholic Medical Bureau, has been to keep fees low so that the poor are not priced out of health care. In light of this, the burden of fees was analysed along two indicators: (a) the average medical cost to the patients-being the size of the individual's expenditures made in exchange for medical services; and (b) the total cost of care (consisting of both medical costs and non-medical costs).

a / Average cost of medical care: could the growth in income from fees be explained by higher fees?

The amount of out-of-pocket fees paid by a typical patient (median) for ambulatory (outpatient) and for inpatient services was determined for sampled patients during a one-time survey in 2007. The figures obtained during this survey were compared with those of a previous survey (Amone *et al*, 2005) conducted in the same hospitals. The aim was to show the extent to which the cost of care could have increased, for the users, over the years, if at all. For this reason, the 2007 values were adjusted to 2000 values (at 3% discount rate); which means that a shilling in 2007 had the same value as a shilling in 2000, after the adjustment. Hence, the best comparison to year 2000 values are the discounted figures of 2007. Readers are reminded of the findings in section 3.2, where it was noted that, despite the progressive decline in the contribution (%) made by out-of-pocket payments to the hospitals' revenue, the absolute amounts collected from this source increased over the same period. Hence, a second but implicit objective of this analysis was to find out if the growth in the absolute (total) income from out of pocket payment could have been the result of an increase in the prices of services, or if

TABLE 4 / AVERAGE COST OF MEDICAL CARE (OOP) IN 2007, COMPARED TO 2000

HOSPITAL	OUT-PATIENT TREATMENT COST				IN-PATIENT TREATMENT COST				
	IN 2000*		IN 2007		IN 2000*		IN 2007		
			unadjusted	adjusted			unadjusted	adjusted	
	N	Median	N	Median	N	Median	N	Median**	
AMBROSELLI, KALONGO	26	1,100	17	100	81	8	2,400	20	2,950	2,399
ST. LUKE'S, ANGAL	27	1,700	20	2,600	2,114	7	3,000	23	11,600	9,432
NAGGALAMA	27	3,000	20	3,250	2,643	10	33,750	20	11,000	8,944
IBANDA	27	2,800	20	2,000	1,626	10	23,200	20	29,950	24,352
COMBONI, KYAMUHUNGA	22	7,500	18	6,500	5,285	9	38,000	4≠	13,000	10,570
KISUBI	24	5,750	19	7,000	5,692	10	36,500	21	51,000	41,468
RUBAGA	27	5,800	18	9,150	7,440	10	41,000	19	42,500	34,556
ALL	256	3,000	132	4,000	3,252	88	21,500	127	20,000	16,262

* The cost in 2000 was extracted from Amone *et al*, 2000; ** it refers to the amount already deposited at the time of research. The final payment could have been higher than recorded. ≠ Too few to allow any meaningful comparison.

it could have been the result of an increase in utilisation (number of attendances), or both.

Table 4 shows the size of OOP payments for outpatient and inpatient services at the 7 hospitals in 2007, compared to the values obtained in 2000. Holding the effects of inflation constant, it is noted that all hospitals, with exception of Angal and Rubaga, registered a decline in the amount of out-of-pocket fees paid per patient, for ambulatory services. The most drastic decline in outpatient cost was observed in Kalongo hospital, where it was only 17% of the value observed in 2000, in real terms. Overall, there was a very slight increase in patients' out-of-pocket payment in the OPD, and in fact a decline in real terms, in out-of-pocket payments for inpatient services. The cost of inpatient care seemed to have remained constant, or declined, except in Angal and Kisubi hospitals. However, it should be noted that in the case of inpatient services, the payments captured were "deposits" or down-payments that the patients reported to have made at the time of the survey; the actual cost to the patients could have been higher at discharge. If the fees paid for services declined, or remained constant, or increased only slightly between 2000 and 2007, it could be argued that the growth in revenue from patient fees (reported between 2002/03 to 2005/06) could partially be explained by the increased utilisation of the services over the years (economy of scale).

b / Total cost of care
Table 5 shows the total cost of seeking treatment at the various hospitals, including transport costs. Other non-health care costs,

such as the cost of feeding were not captured. The aim was to appreciate the significance of non-price barriers (particularly transport cost) that patients face when seeking medical care, even where fees are low.

Even though there was no significant increase in the cost of ambulatory care to the patients over the preceding 7 years, transport costs remained a significant additional cost patients had to contend with while seeking care at most of the hospitals, especially in Angal, Comboni and Ibanda hospitals where transport represents at least 30% of total OP care costs. Although transport was not a significant additional burden to those seeking OP care at Kalongo hospital, it was a colossal addition to those seeking in-patient care in the same hospital; and quite a significant one too at Angal and Comboni hospitals, too.

3.5 / ... AND THEIR ABILITY TO PAY-UP

a / Number of paid-up patients
Ability to pay was assessed by way of different parameters. The first was through establishing the number of patients who had paid for their treatment at the time of the survey, either partially or fully. In other words, inability to pay referred to total failure to pay any amount of money for patient' treatment. All the inpatients surveyed had made some payment at the time of the survey. Only 2 patients (out of 29), and another 2 (out of 20) were unable to pay any amount for outpatient care at Comboni and Angal Hospitals, respectively.

TABLE 5 / THE TOTAL COST OF HOSPITAL CARE TO PATIENTS*

HOSPITAL	OUT-PATIENT SERVICES			IN-PATIENT SERVICES		
	N	TOTAL COST	TRANSPORT SHARE	N	TOTAL COST**	TRANSPORT SHARE
ANGAL	14	6,000	47.8 %	13	21,800	30.7%
COMBONI	8	11,250	31.0%	3≠	26,000	50.0%
IBANDA	3≠	3,600	39.8%	18	36,950	14.0%
KALONGO	13	2,000	0.0%	11	15,400	80.0%
KISUBI	8	8,850	22.2%	21	57,500	5.9%
RUBAGA	5≠	12,000	14.2%	15	44,000	9.1%
NAGGALAMA	2≠	5,000	19.4%	15	14,500	17.2%
ALL	89	7,000	17%	96	32,650	17.1%

* Treatment and transport costs only; ** Treatment component refers to the amount deposited at the time of the research, not the full treatment costs. ≠ Too few to allow any meaningful comparison.

b / Denial of treatment or incomplete treatment because of inability to pay

Ability to pay was also looked at in terms of the number of patients who had been denied treatment, or received partial treatment, at any hospital during the 3 months preceding the survey. Only 2.8% of outpatients (out of 141 surveyed), and 4.3% of inpatients (out of 131 surveyed) reported they had been denied, or given partial treatment, because of shortage or lack of money at any hospitals in the preceding 3 months.

3.6 / EXISTENCE AND EFFECTIVENESS OF EXEMPTIONS/ WAIVER PROVISIONS

a / Existence of exemptions and waiver mechanisms

For the purpose of this study, exemption was defined as the decision not to charge a patient for a service, based on some clearly laid-down criteria/policy, which was known *a priori* to the billing officer. With an exemption, a patient was excused from paying even if s/he could afford the bill, as long as s/he qualified for it on the basis of the set criteria. A *waiver* was a provision where a patient, billed the full amount, could have been excused from making the full or part of the payment when deemed necessary, often because of inability to pay.

Kisubi hospital did not provide data on this aspect of the study. Comboni hospital did not have any provisions for excusing patients from any payment, whereas Ibanda hospital had a waiver system in place but not an exemption provision. The rest of the hospitals provided both exemption and waiver systems. "Poverty" was the basis for both exemptions and waivers across all the hospitals that reported the existence of these mechanisms. The clearest bases for exemptions were age (Angal hospital), health condition (normal deliveries in Kalongo, TB in Naggalama), and being an employee of the hospital (Naggalama).

b / Effectiveness of waivers

Generally, the staff seemed keen on applying the criteria for exemption in all the hospitals where the policy existed, but rarely applied waivers (probably because the need had not arisen).

The data on the number of beneficiaries of these schemes were incomplete in a number of hospitals. The largest number of beneficiaries was reported at Kalongo hospital, at 3,707 in one financial year, including those described as "escapees" [3].

We also investigated the existence and effectiveness of exemption schemes by interviewing patients receiving treatment during the survey. Overall, about 15% of all patients interviewed reported they had been exempted from payment; about 20% of all outpatients, and about 10% of all inpatients reported to have

FIGURE 2 / RELATIONSHIP BETWEEN SHARE OF USER FEES AND BOR
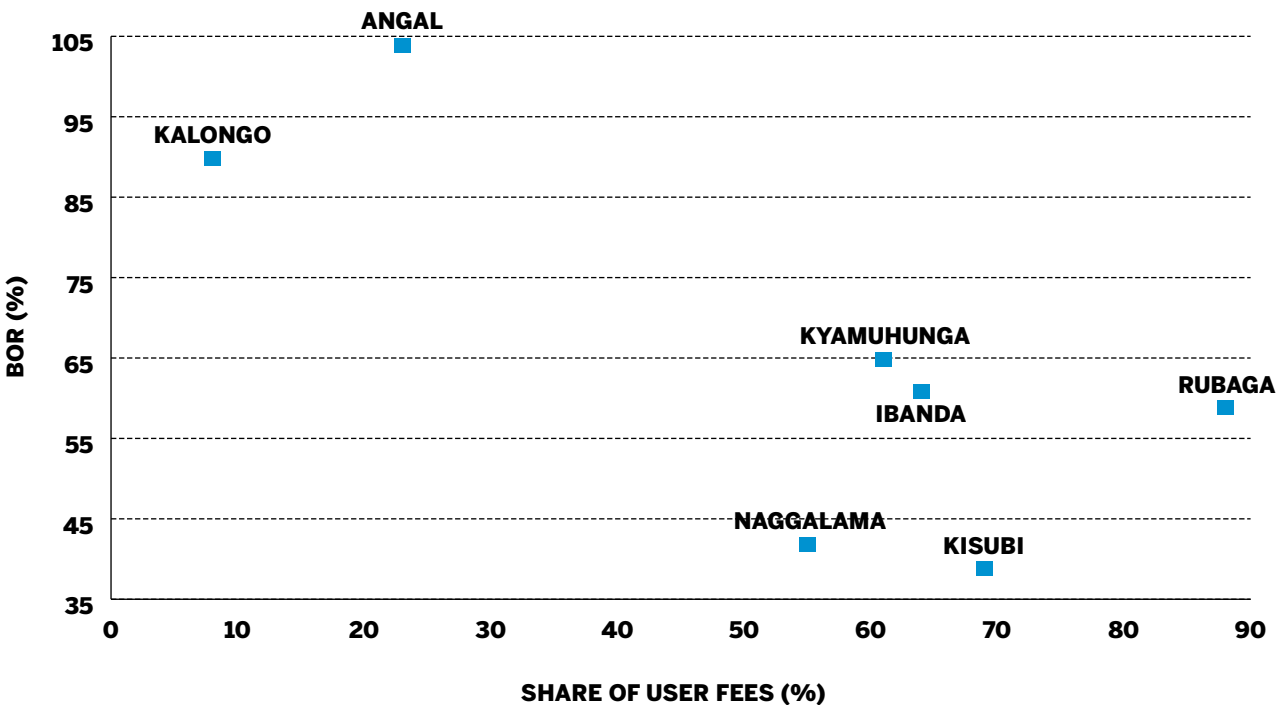
Source: Hospital Annual Report, UCMB Kampala

been excused from making any payment. The largest number of exempted patients was found at Comboni hospital. No patient was exempted from Ibanda hospital where such a provision was reported to not to exist.

c / Financial implication of exemptions and waivers

The amount of revenue reported to have been lost by the hospitals because of these provisions ranged from a low of 2,256,301/= in Kalongo Hospital, accruing from a combined total of 3,707 in- and outpatients in 2006/07, to a reported high of 20,653,432/= in Rubaga hospital (from both IP & OP) in the same year.

3.7 / MEANS OF PAYMENT

Despite the relatively low fees, many patients still had to either sell their property, or borrow money, or do both, in order to pay the medical bills. Overall, 35.3% of inpatients, and over 28% of outpatients surveyed reported to have either borrowed money and/or sold items to finance their health care. This was true even at hospitals where the burden of fees was observed to be low, such as at Kalongo, and Angal hospitals where the proportions of patients selling their property and/or borrowing money to finance their care were even higher (at least 60% and 50% respectively). Of those who sold property, 53.6% reported to have sold their foodstuffs, while about 40% had sold their domestic animals.

3.8 / LEVEL OF OUT-OF-POCKET PAYMENT AND SERVICE UPTAKE AT SELECTED HOSPITALS

The effect of user-fees or public subsidies was further illustrated by examining the relationship between user fee levels (and by implication level of subsidies) and service uptake at the 7 hospitals sampled. Service uptake was measured in terms of the number of bed-days used up by the patients in a year (bed occupancy rates), which is related to the total number of patients admitted, and the average length of stay on the wards. The values presented are for typical patients (median values), over a period of 9 years (1997/98 – 2005/06). The share of out-of-pocket fees was computed out of the total revenue meant only for routine operations (as defined in the previous sections). The relationship is demonstrated by **figure 2**.

The graph shows that service uptake (bed occupancy rate) was high (85%+) where out-of-pocket payment contributed less than 30% of the total revenue, as for example at Angal and Kalongo hospitals. On the other hand, utilisation was lower (only 65% of occupancy and below) where out-of-pocket fees accounted for higher shares (above 55%) of the hospitals' revenue. This, once again, illustrates the fact that wherever out-of-pocket payment was the mainstay of financing care, the demand for health care was lower. Conversely, the higher the level of public financing (government support and external aid) was, the higher was the level of service uptake too. The effects of other variables (e.g. the quality of care) were not considered in this analysis.

3.9 / THE PROSPECT OF COMMUNITY-BASED HEALTH INSURANCE SCHEME

To answer the question whether community-based health insurance schemes are a viable option to out-of-pocket mode of payments at facilities charging for services, we evaluated the performance of some of the existing schemes along 4 major parameters, namely:

a / Coverage of the schemes or enrolment rate.

b / Effect of scheme on out-of-pocket payment.

c / Effect of scheme on service uptake.

d / Significance of revenue generated by 7 facilities affiliated to UCMB were studied through analysis of reports provided by scheme managers; these were supplemented by data obtained from the users of those facilities, and from separate household surveys in the catchment areas of the selected facilities.

a / Coverage or enrolment rate

To evaluate the extent to which potential users of facilities were covered by, or included into the schemes, we assessed the latters' performances along three indicators:

• *Membership size*: the number of households that had enrolled into the schemes, the number of individuals within each household who were scheme members and the number of patients at health facilities who were scheme members.

• *Membership "dynamics"*: basically the ability of the schemes to retain their members over time.

• *Geographical coverage*: how wide the catchment area was, or how far away from facilities the members lived.

Membership Size

Membership size was determined through a household survey, for 5 schemes, 3 of which were hospital based, as summarised in **table 6**. Less than 10% of households had enrolled into the scheme, except in the catchment area of Nyamwegabira. There were about 5 individuals per household (except, again, in Nymwegabira where the number was quite high). According to the household heads and the scheme managers, members enrol as whole family units, with all the household becoming members. The average household size in the areas studied was about 5. There were various reasons why some households were not members of the insurance schemes, the main ones being that either the premium was considered to be too expensive, or households were not aware of the existence of the schemes.

Membership "Dynamics"

The graph (**figure 3**) illustrates the changes in the individual enrolment status over the years at four facilities, according to the records presented by the scheme managers.

The average annual membership at Nyakibale hospital and Nyamwegabira HC was below 2000 individuals. Membership was higher at Kitanga HC and at Mutolore hospital, at an annual average of over 3500. However, at all the schemes, the trend was such that the initial enrolment was followed by a drop in membership, before the number slowly began to pick up again. According to the scheme managers, the subsequent rise was a reflection of the progressive increase in the level of awareness about the schemes and their benefits, among the general population. Unfortunately, the data available did not permit analysis of re-enrolment or of the "retention" rate (the number of previous members who had re-enrolled), which is a measure of members' confidence in the schemes.

Geographical coverage

We further examined the geographical location of household members (in terms of distance from the facilities) during the

TABLE 6 / ENROLMENT IN LOCAL INSURANCE SCHEMES (HH SURVEY)

LOCATION	ENROLMENT	
	NO. HOUSEHOLDS ENROLLED	NO. OF INDIVIDUALS PER HOUSEHOLD IN THE SCHEME (MEDIAN)
KITOVU HOSPITAL	5.1%	4.5
NYAKIBALE HOSPITAL	7.3%	5.0
MUTOLORE HOSPITAL	6.2%	5.0
KITANGA HC	3.7%	4.0
NYAMWEGABIRA HC	11.1%	8.0

Source: UMU & ITM, 2007

FIGURE 3 / MEMBERSHIP DYNAMICS
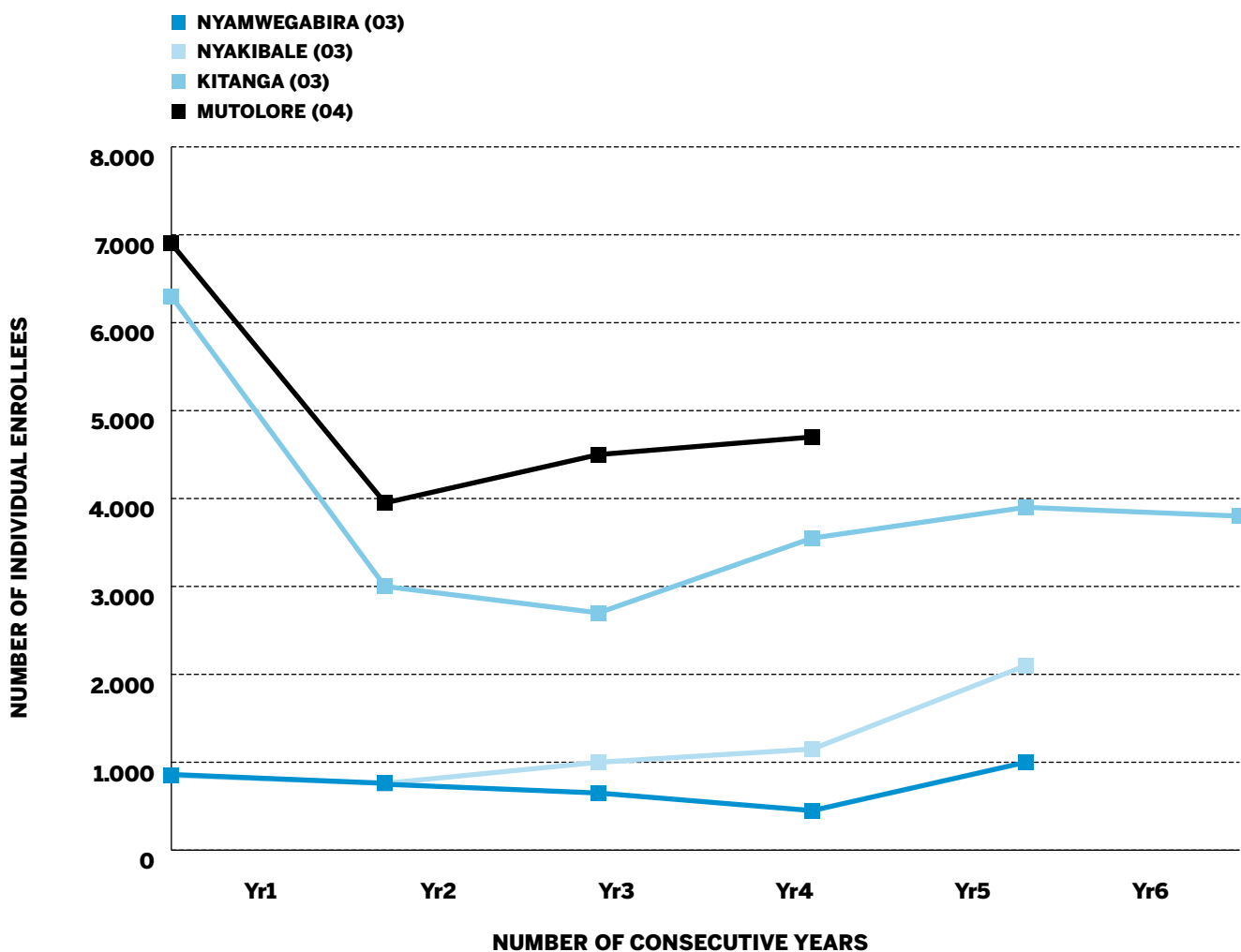
TABLE 7 / TOTAL OUT-OF-POCKET (OOP) AT ALL SITES ≠

SERVICE	MEMBER			NON-MEMBER		
	N	Median Amount	IQR	N	Median Amount	IQR
OPD	17	2000	750 - 12500	64	6100	2200 - 18750
DELIVERY	1*	5000	-	21	18000	7950 - 77625
ADMISSION	13	15000	4000 - 25500	65	30000	15000 - 62925

≠ The total payment includes both healthcare and non-healthcare expenditures such as transport
* A single is not a reliable comparator in this case
Source: UMU & ITM, 2007

household survey. The aim was to determine how wide the coverage of the schemes was—whether people enrolling into the schemes were those closest to the health facilities.

It was found that both enrolled and un-enrolled households were located within walking distance (5 km) of the facilities studied; although a survey of users of outpatient services indicated that scheme members appeared to come from much closer distance (2.5 km) from the health facilities than the non-members (5.5 km).

b / Effect of insurance on out-of-pocket payment

We compared the amount of out-of-pocket fees paid for healt care by users who had sought care for illness 30 days prior to the survey. The total out-of-pocket payments summarised below include both health care and non-health care expenditures (on items such as transport and food). In this section we present the results of the household survey of members at all the sites studied. **Table 7** shows the total out-of-pocket expenditures typically made for various services by members and non-members of the schemes.

The results show that, overall, scheme members appeared to spend much less (OOP) on treatment than non-scheme members.

c / Does being insured increase demand for care?

To answer this question, we compared the annual per capita utilisation of services among members and non-members. Only two schemes provided data which could allow for these computations.

Per capita utilisation was obtained by dividing the total attendance of the beneficiaries by the total number of registered beneficiaries for the respective years. The attendance data were an aggregate for all the services (OP, IP, deliveries), although the vast majority of them were outpatients. The per capita utilisation of the non-scheme members could not be calculated from the data provided, as the denominators were unclear. Hence, the per

capita utilisation for the districts from which the facilities were drawn was used instead. The results are presented in **table 8**.

At Nyamwegabira, the service uptake by scheme members was generally lower than that by the general population; only 40 – 60% of the beneficiaries accessed services during the first 4 years the scheme was in operation. In 2007, the service uptake matched that of the general population. At the Kitanga scheme each member consumed health care at least once a year during the period considered, except during the first year. However, the members' attendance levels were still lower than those of the general population.

Although the members' attendance rates were notably lower than the district averages, it is also noteworthy that the best comparison would have been the general users of the sampled facilities where the schemes were housed, rather than the district averages. This is because the utilisation by non-members at the sampled facilities (where they charge for services) could have been much lower, when compared to the rates at the public facilities (the majority of the facilities) where they do not charge fees; thereby masking the possibility that scheme members could have used services more than non-scheme members, as anecdotal evidence (discussions with the managers) suggested.

d / How significant is the revenue from community-based insurance schemes to hospitals and other facilities?

Unfortunately, we were not able to have access to the financial details of most facilities studied, let alone the related schemes. We present data from Kitanga HC only, summarised from data submitted earlier for a different purpose. Below is a breakdown of the income from this facility during the year 2006.

The income from insurance corresponds very much with the amount disbursed by the scheme as claims for treatment for the said period. This shows that this facility, with a large membership, relies significantly on income from the insurance scheme. As already seen above, the per capita utilisation at this facility is very high.

TABLE 8 / PROPORTION OF THE POPULATION SEEKING HEALTH CARE PER YEAR: SCHEME MEMBERS COMPARED WITH THE GENERAL (DISTRICT) POPULATION

YEAR	NYAMWEGABIRA HEALTH CENTER, KANUNGU DISTRICT		KITANGA HEALTH CENTER, KABALE DISTRICT	
	Scheme Members	District average' 07	Scheme Members	District average' 07
2003	61%	100%	54%	140%
2004	65%	100%	113%	140%
2005	42%	100%	131%	140%
2006	51%	100%	99%	140%
2007	100%	100%	114%	140%

TABLE 9 / INCOME STRUCTURE FOR KITANGA HC IN 2006

SOURCE OF INCOME	AMOUNT (USH)	% SHARE
INSURANCE	25,005,100	76%
NON-INSURANCE	7,872,100	24%
TOTAL	32,877,200	100%

Source: Kitanga HIMS, 2006

4 / DISCUSSION

Amone *et al.* (2005) observed that a UCMB hospital service was likely to remain fair to the population if its share of income from out-of-pocket payment was below 30% of annual recurrent costs. On the basis of this equity-orientation test, a typical UCMB hospital fell short of providing a fair service to its population during the period analysed. Of the 7 hospitals sampled, only St. Luke's hospital, Angal, and Dr. Ambroselli hospital, Kalongo, passed this test, thanks to large subsidies. Both hospitals are typical of many others in rural and remote locations, which provide services to people who otherwise would have limited access to publicly funded services.

However, there has been steady progress towards that (< 30%) target by the sector as a whole, due to increasing subsidies com-

plemented being by a deliberate and independent initiative to reduce and flatten fees across the whole PNFP sector.

Passing the equity-test was also associated with optimal use of resources; hospitals whose share of income from OOP payments exceeded 30% had very low bed occupancy rates. The optimal level of bed occupancy rate in developing countries is 80 – 90%. This finding is consistent with those of 2000, where it was noted that only hospitals whose income from OOP was 9.5% to 24.5% of the annual running cost were operating within the efficiency range (BOR of 86% - 95%) (Amone *et al.*, 2005).

A previous experiment by the UCMB showed that it was possible to achieve both efficiency and equity in access by reducing fees in a targeted way (e.g. for vulnerable groups such as children and women); in which case, demand picks up very fast, and economies of scale come into play, such that income is maintained or

even increased, and at a much higher level of efficiency (Odaga and Maniple, unpublished). However, it is noteworthy that this has only been possible because grants from the government and other sources had boosted confidence.

Considering that Government subsidies that had come in as a relief are now declining, it means that, to keep fees low, the sector has to increasingly solicit external aid to fulfil its equity goals; external aid is often erratic and short-lived. In any case, sourcing for external aid also means spending considerable time away from routine management issues. All these make longer term planning difficult, especially in the context of equity. Already, undocumented evidence suggests that a number of private not-for-profit hospital managers have either raised fees or are planning to do so, as well as introducing other cost-containment measures, including laying off some staff. Higher levels of fees, inefficiency and deprivation of the underprivileged are foreseeable outcomes.

This study also shows that even at low levels of fees, a large number of users still had to sell off their property, or were driven into debt, in order to finance their health care bills. This was presumably because of the requirement of having to pay cash at the time of needing care; coupled with the fact that most of the rural-based users do not have tradable goods, or disposable income anyway, and so any level of fees is probably going to be difficult for them to pay. This is where an insurance scheme, including a community-based health insurance scheme would, in theory, be beneficial.

A community-based insurance scheme basically re-channels would be out-of-pocket payments into a pre-payment scheme, thereby removing the requirement to pay cash at the time when one needs health care. This cushioning has the effect of increasing the demand for health care. However, this cushion is diminished or removed where the users still face significant out-of-

pocket payments in terms of co-payments, and non-health care costs (especially transport costs, when patients are unable to walk to the hospitals).

As of now, only 4-7% of households are covered by CBHIS, where they exist; and nearly all of these are found within walking distance (5 km) of the facilities where these schemes are located. There was not enough evidence from this study to show whether scheme members used services more than non-scheme members. A previous household survey showed that scheme members seemed to use services more often than non-members (Uganda Martyrs University and Institute of Tropical Medicine, 2008).

The Kitanga example shows that revenue from community-based insurance schemes could be significant, especially at peripheral facilities, if most users enrolled into the schemes. This is possible where the schemes have matured enough and, especially, where sufficient awareness has been raised about insurance generally, and about the operations and benefits of such schemes (Uganda Martyrs University and Institute of Tropical Medicine, 2008).

5 / CONCLUSION

This study focused on the UCMB-affiliated hospitals to provide insight into the implications of the prevailing financing mechanisms for the equity objectives of the PNFP sector as a whole.

The key message here is that, despite its obvious regressive effect, user fees (out-of-pocket) remains an inevitable evil in UCMB-affiliated facilities, and in the PNFP sector as a whole. The challenge is how to keep them low. It is impossible to keep them low, and to meet equity objectives, without someone else, the public, footing the bill, either through government grants or through external direct assistance.

COMMENT ON THE STUDY
"SUSTAINING EQUITY IN THE PRIVATE NOT-FOR-PROFIT SECTOR IN UGANDA: A PUBLIC RESPONSIBILITY"

By: Giovanni Putoto and Peter Lochoro / Doctors with Africa CUAMM

The study carried out by the Faculty of Health Sciences, Uganda Martyrs University, at Nkozi in Uganda as part of the European project "Equal opportunities for health: action for development" on access to hospital care in the NFP (Not-for-Profit) sector has confirmed much of what has already been described in the literature. The user charges (or user fees) system is iniquitous. Effectively, poorer social classes and groups have greater difficulty in accessing medical care and often find themselves having to pay catastrophic sums for treatment. In order to obtain medical help these persons, already poor, may be pushed further, into extreme poverty. This is the so-called "medical trap", into which an estimated about 100 million people have already fallen [1]. The study also revealed another reality: hospitals that received the highest public and private subsidies have lower tariffs for treatment, thus are more accessible for the general population. The

Commission on the Social Determinants of Health, set up by the World Health Organisation, has suggested that that all countries should seek to achieve universal cover in order to improve equality of access to health care and services [2]. Thus removing these tariffs is an essential step towards removing inequities [3]. Some countries, for example Uganda, Niger, Ghana and Kenya have sought to eliminate tariffs as part of a health policy decision. The result has been that these populations have begun to use the available health services more. This is certainly a good thing. In some cases, however, this operation has had some undesired effects too, which should be carefully studied: for example, inadequate re-imbursements to health structures, deterioration in the equality of the service supplied, loss of motivation among the staff, the fact that the poorest citizens are not benefitting as much as it was hoped they would [4]. This is mainly the result of

leadership problems and/or of there being insufficient or inadequate technical competencies available: both of which problems should be taken into account even in the earliest phases of planning [5].

In the specific case of the Uganda NFP hospitals, there are other difficulties, such as the marked reduction in subsidies and other public funds resulting from the government's fiscal stabilisation policies [6] and the crisis in the public-private partnership relations based on contracts [7]. Yet again, these are problems of a political-institutional and technical nature.

However, eliminating user fees is, in itself, not enough to improve access to health services and so improve the general health of the population. In sub-Saharan Africa there are many other types of costs, especially indirect costs, that weigh heavily on poorer families [8-9]. The most onerous of these hidden costs are the cost of transport, but also loss of earnings, informal payments and the complexity of the treatment in question.

Then there are also obstacles such as lack of information, cultural barriers that negatively affect behaviour especially in relation to women's decisions regarding health care [10].

So, what is to be done? There are many actions that can be undertaken, starting from the place where interventions are underway, the work place. The actions below offer a sort of agenda for operations.

○ Above all the health policy of the country must be overhauled, up-dated. An increasing number of African governments are adopting health policies that seek to remove user fees, in some cases, universally, in others offering payment exemptions for health treatments to the most vulnerable groups only, for example, to pregnant women and to children.

○ Once the national situation has been evaluated, the next step is to construct a profile of equity in the area where one is operating. This entails knowing which groups use and which do not use hospital services, and identifying the barriers to access and utilisation of medical treatment and care.

○ Both primary and secondary sources of information can be used for evaluations.

Primary sources of information could be obtained using a health care seeking behaviours survey; alternatively, good secondary sources are demographic and health surveys which reveal the main reasons for barriers to health care access through regional data on social groups.

○ Once the user catchment area is known and the equity profile, the next step is to start by making some essential treatments

free of charge, such as obstetric or paediatric emergencies (e.g. Caesarean section). Obviously the real costs will still have to be calculated and alternative funding, public, private or mixed contributions) found to cover.

○ Another fundamental step is to intervene on indirect costs. In many areas of Africa, transport costs are a real, often insurmountable, barrier for a family seeking health care. In this case the creation of a fund to pay the costs of transport to hospital, for example for pregnant women and seriously ill children, could help overcome this barrier.

○ The financial mechanisms adopted to cover direct costs (health services) and those of indirect costs (transport costs etc.) can and will vary in relation to the context and to the resources available: these range from national health insurance to conditional cash transfers, from forms of community-based health financing to mechanisms such as equity funds created ad hoc. Each of these mechanisms has its advantages and its disadvantages when in operation and its own impact on access to health care.

○ Which criteria are adopted when allocating resources will depend on what has been revealed by the equity profile which could help identify areas of greater deprivation, those that require intervention to affect all social categories or, those suitable for targeted interventions, i.e. when the problem is restricted to a few specific groups.

○ In order to maintain, or increase, demand for health care the population must be informed and educated about their rights and about the resources and services that are available to them, and also pressure must be put on the local political community.

○ The impact of this type intervention should be carefully monitored and evaluated in terms of the cover, quality and equity it achieves either through periodical surveys or through systemic gathering of data that include the so-called "equity stratifiers" (age, gender, ethnic origin, level of education, income, residence, etc.) at the level of the structure supplying the service.

○ Lobbying and advocacy both of the local authorities and among the donor community, together with a culture of considering results (performance) are the core competencies that should be looked for in human resource development.

○ Technical assistance, capacity building interventions and working on-line with local institutions (e.g. supporting the Hospital Board of Governors, Hospital Management Team, District Health Team, National Health Bureau, local centres for training and research etc.) should be considered and managed with great care, so as to ensure that the results will be sustainable.

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APPENDIX: SAMPLE SIZE CALCULATION

Sample Size of the patients selected for the survey (to determine fee burden) was calculated using Veckveisser formular:

• $n = s^2/e^2$; where n= the desired minimum sample size; s = standard deviation (SD) of the user fee paid as determined during the last exit interview (by UCMB) in 2006, and e = the desired sampling error (SE).

• From the previous survey (UCMB hospital records, 2006), the mean fee paid was 2170/= with a SD (s) of 1238/=

• Assuming a margin of error of 500/= at 95% Confidence Level, then SE(e) = 250/=

• Therefore, $n = s^2/e^2$
$$= 1238^2/250^2$$
$$= 24.5223$$
$$= 25$$

Given that the ratio of Out Patients (OP) to Inpatients (IP) is about 3:1, the respective number of cases to select would have been 18 OP and 7 IP. We chose to interview 20 OP (half of whom were to be children) and 20 IP (medical, surgical, paediatrics and maternity in equal number), giving a total of 40 patients per hospital. All the OPs were selected systematically. Only IPs due for discharge were considered (5 from each ward).

FOOTNOTES FOR SUSTAINING EQUITY IN THE PRIVATE-NOT-FOR-PROFIT SECTOR IN UGANDA

1 A health sub district is a health management/coordination zone below the district level. Some of the PNFP facilities have been given this responsibility, accompanied by a separate budget.

2 The value of a shilling in 1998/99 was the same for the subsequent year, assuming an interest rate of 3%.

3 Those who escape from the hospital before paying or completing payment; they also include those who request to be released to look for money so they can pay later, but never do so.

FOOTNOTES FOR COMMENT ON THE STUDY SUSTAINING EQUITY IN THE PRIVATE-NOT-FOR-PROFIT SECTOR IN UGANDA

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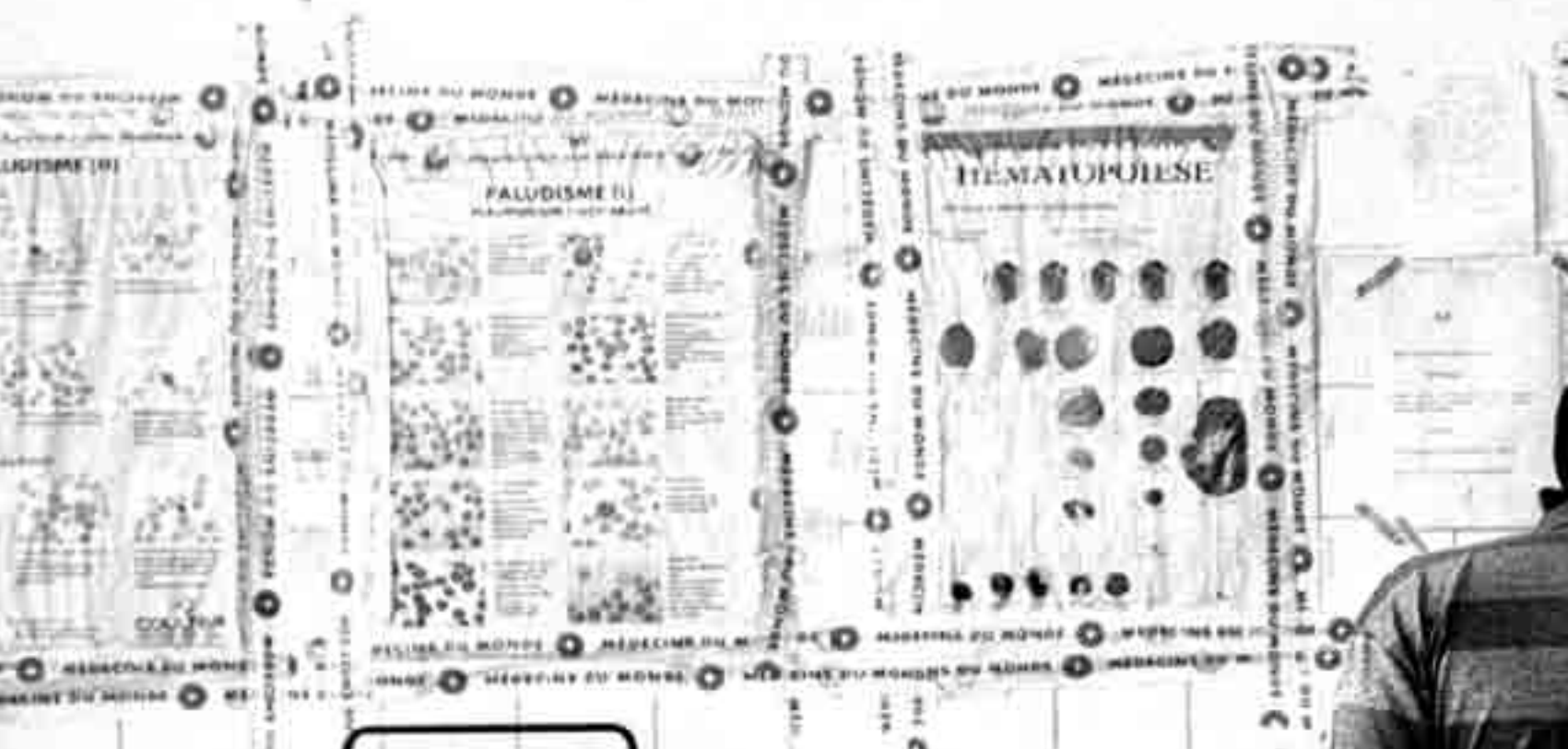
EQUAL OPPORTUNITIES
FOR HEALTH
ACTION FOR DEVELOPMENT

INTERNATIONAL CONFERENCE

"EQUAL OPPORTUNITIES FOR HEALTH: ACTION FOR DEVELOPMENT" A PLAN OF ACTION TO ADVOCATE AND TEACH GLOBAL HEALTH

03-04 April 2009, Padova, Italy
Aula Magna, Department of Sociology, University of Padova, Via Cesarotti, 12

FRIDAY 03 April 2009

10.30 - 11.00
Registration of participants

PLENARY SESSIONS
Moderator: Agostino Paganini, Director Advisor, Doctors with Africa Cuamm

11.00 - 11.30
Opening remarks
Vincenzo Milanesi, Chancellor, University of Padova
Flavio Zanonato, Mayor, Municipality of Padova
Amedeo Bianco, President, FNOMCeO
Roberto Ridolfi, Head of Unit Central Management of Thematic Budget Lines
Dante Carraro, Director, Doctors with Africa Cuamm

11.30 - 11.50
Global Health: an essential component of public health teaching
Walter Ricciardi, Director, Department of Public Health, Catholic University of Rome, President of S.It.I Scientific Committee

11.50 - 12.30
Health inequalities and state of world's health: Global Health challenges for the health community
Sam Okuonzi, Director, Regional Centre for Quality Health Care, School of Public Health, Makerere University (Uganda)

12.30 - 13.00
Health professionals as effective opinion makers and "Global Health advocates": the project "Equal opportunities for health: action for development"
Giovanni Putoto, Strategic Planning Advisor, Doctors with Africa Cuamm

13.00 - 13.30
Discussion

13.30 - 15.00
Lunch break

15.00 - 15.30
Preparation for Working Groups sessions: background information, objectives, proposed plan of action
Adriano Cattaneo, Epidemiologist, Institute for Child Health IRCCS Burlo Garofolo and Italian Global Health Watch

WORKING GROUPS
15.30 - 18.00
WG 1 - Teaching Global Health at Schools of Health and Human Sciences
Facilitator: Angelo Stefanini, Health Programme Coordinator, Italian Office of Development Cooperation in Jerusalem - On leave from the University of Bologna

WG 2 - Life-long learning of health professionals on Global Health
Facilitator: Maye Omar, Senior Lecturer, Nuffield Centre for International Health and Development, University of Leeds

WG 3 - The role of international health cooperation in advocating, teaching and implementing Global Health
Facilitator: Fabio Manenti, Head of International Projects Department, Doctors with Africa Cuamm

WG 4 - Strategies for mobilising and sustaining financial and human resources to advocate and teach Global Health
Facilitator: Jean Pierre Unger, Head of Unit of Public Policy and Management, Institute of Tropical Medicine of Antwerp

18.00
Closing of Day 1

SATURDAY 04 April 2009

WORKING GROUPS
09.00 - 11.00
Working Groups continued: commitment paper preparation

11.00 - 12.00
Coffee break

PLENARY SESSION
Moderator: Maye Omar, Senior Lecturer, Nuffield Centre for International Health and Development - University of Leeds

12.00 - 13.00
Presentation of commitment paper

13.00 - 14.00
Closing remarks

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is the coordinator of the Unit for Research on Health Services and International Health at IRCCS Burlo Garofolo, Trieste, Italy, a Who collaborating Centre for Maternal and Child Health. He has spent most of his professional career in developing countries, working as WHO/EURO consultant for different national programmes and projects on maternal and child health in Moldova, Uzbekistan and Turkmenistan and currently coordinates projects in collaboration with WHO and UNICEF. He teaches university courses in Italy and abroad and develops material for training and formation courses. He holds a MD degree from the University of Padova and a MSc degree from the London School of Hygiene and Tropical Medicine.

Fabio Manenti
is the Head of the Project Department of Doctors with AfricaCUAMM.
He holds a specialisation in Emergency Surgery and Emergency Medicine. Since 1991, he has been working in international health cooperation projects and programmes with Ngo Doctors with AfricaCUAMM, first as volunteer in Uganda, then as Head of the Surgery Department and Health Director of Matany Hospital, Uganda (1997-2000), and as Health Director of St. Luke Hospital in Wolisso, Ethiopia (2003 – 2008).
In Italy, he worked as surgeon in the Clinic S. Francesco in Bergamo (1994-1997), as Head of the Emergency Division of the Hospital of Treviglio, Bergamo (2000-2001) and as Head of the Emergency Surgery Division of the Hospital of Milano (2001-2003).

Sam Okuonzi
teaches Health Policy, Health Systems and Health Economics at Makerere University, Uganda Christian University and Uganda Martyrs University. He has workes as Health Policy Advisor to Uganda Ministry of Health for 10 years. He was also the Secretary General of Uganda National Council for Children, a body that monitors and advocates for the welfare of children. Before moving to African Centre for Global Health (ACHEST) in February 2009, he was Director of Makerere University Regional Centre for Quality of Care, which provides leadership in training, research and promotion of quality of health care in the Africa region. He has written health policies for Uganda, Lesotho, Malawi and Mozambique. He holds a MD with a master's degree in Health Economics MSc Econ and 14 diplomas in health policy and management.

Maye Omar
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Agostino Paganini
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Giovanni Putoto
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Angelo Stefanini
teaches International Public Health at the University of Bologna. He worked for several years in rural Africa (Uganda and Tanzania) as a general duty medical officer and, later, as the director of public health programmes. He also spent a number of years as a lecturer at the Nuffield Institute for Health, University of Leeds, UK, and at Makerere University, Kampala, Uganda. In 2002 he was based in Jerusalem as Head of the WHO Office for the Occupied Palestinian Territory. In 2006-2007 he was the Team Leader of a EU-funded technical assistance project at the Ministry of Health, Syria. Throughout his professional career he has carried out numerous short term assignments for international organisations in Africa and the Middle East. His main interests are international health policy and global health issues.

Jean-Pierre Unger
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DOCTORS WITH AFRICA CUAMM

Doctors with Africa CUAMM is an Italian non-governmental organisation committed to promote the right to health and ensure that health care services are accessible to anyone and particular the most vulnerable sections of African populations. To fulfil its mission, Doctors with Africa CUAMM currently works in seven African countries (Angola, Ethiopia, Kenya, Mozambique, Sudan, Tanzania, and Uganda) where it operates with a long-term developmental perspective aiming at strengthening local health systems by delivering an adequate mix of effective services at hospital, district, and community/family levels, by training human resources for health, by establishing public-private partnerships and by advocating equitable financing.

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