WE MUST BE DOING SOMETHING GOOD,
when so many people come together to
celebrate the organisation’s 25th anniversary;
when so many of our members are prize
winners: Jan de Maeseneer is the first
WONCA 5-Star Doctor, Henk Schmidt
was awarded the Swedish Karolinska
Institute Prize, and the Catholic University
Mozambique and Gadjah Mada University
received their Wynand Wijnen Incentive
Awards. And now there is also a Network:
TUFH Award, named after our Founding
Father: the Tamas Fülöp Award;
when we can offer you so many interest-
ning articles on new projects of our mem-
ers: a project in Nigeria to identify and
address (health) needs of elderly women
in the community, a Brazilian institute for
developing and disseminating innovations
and creative solutions for health
professions education, health
management, and primary care.

You can read about this, and much more,
in this issue. Finally, we wish all of you a
very good 2005! And remember,
deadline for the next Newsletter is
April 29, 2005.

Marion Stijnen and
Pauline Vluggen
Editors
We were shocked at the news of one of the world’s greatest natural disaster, an earthquake and tsunami striking Southeast Asia and East Africa. As of this writing, over 120,000 are estimated to have perished. The Network: TUFH has helped put a human face on this unspeakable tragedy. Sri Lankans, South Indians, Indonesians, Thais, East Africans and many others that are involved in this disaster are our brothers and sisters - they have shared their innovations with us, we have visited as friends and professional colleagues, and they have hosted Network: TUFH Conferences. The magnitude of this disaster is such that all countries must quickly mobilize to help at a level of co-operative planning never before seen. It is our fervent wish that in this time of ethnic, religious and political intolerance and conflict across the globe, this natural disaster will serve as a wake-up call that our future lies in throwing our lot in with each other rather than against each other.

*Arthur Kaufman | Secretary General*
For the first time, the recent Network: TUFH annual Conference in Atlanta was co-sponsored with a sister organisation, Community-Campus Partnerships for Health. It was a great success: the 400 plus attendees found common ground and a great deal to learn from one another.

The Conference attracted the most diverse group of health professionals I've ever seen. Titles of the didactic sessions, mini-workshops, story sessions and thematic poster sessions reflected this new reality: Reducing Child Trafficking in Benin, The Harlem Children's Zone Asthma Initiative, Building a Culturally Competent Health Workforce, and Preventing Child Abuse: the Case for Interprofessional Education. The Conference had as theme Overcoming Health Disparities, and it was fitting that it had so many unique features.

It was also fitting that taskforces were energised and grew - Women's Health, Multiprofessional Education, and Integration of Public Health and Medicine come to mind.

The Student Network Organisation was particularly effective this year, coming up with new ideas (including the creation of their own poster session, which will become a regular feature of annual Conferences).

Keynote addresses this year were varied and informative - from the welcoming remarks on health disparities by David Satcher, former Surgeon General and Director of the National Center for Primary Care at Morehouse Medical School - to remarks by Nelson Sewankambo, Dean of Makerere University in Uganda, describing the creation of a visionary, community-based education programme, to a presentation by Andrea Cruz, a community organiser for Latino farm workers in Southeast Georgia. We were also successful in attracting Tim Evans, Associate Director General of WHO in Geneva, to give a keynote address and Edwina Yen, of the regional WHO/Pan American Health Organisation, to be a panellist. Both gave valuable insights into WHO’s programmatic directions in the future. A ‘donor’s panel’ was new this year, offering perspectives from the W.K. Kellogg Foundation, the Social Sciences and Humanities Research Council of Canada and PAHO.

The community site visits were particularly effective. I joined a group that visited the Jonesboro Public Housing Projects, a public housing community for low-income people. There, under the tutelage of Dan Blumenthal, Chair of the Department of Community Health and Preventive Medicine at Morehouse, I watched his medical students lead a focus group of residents in identifying their priority concerns and action steps they planned to take. It demonstrated to me the power of moving from classroom theory to community action.

And finally, newer members sought ways to become involved. For example, John Norcini, Director of the Foundation for the Advancement of International Medical Education and Research, had ideas for his international fellows to become linked to The Network: TUFH, including establishing links to regional Network: TUFH institutions and submitting articles on their research projects for publication in Education for Health.

On a sad note, about 150 who planned to attend the Conference were unable to obtain visas due to the international conflicts which make unwelcome intrusions on our lives. Though Conference planners worked with State Department officials, in too many cases we were unsuccessful. We are hopeful many of our membership who could not come to Atlanta will be able to make the 2005 Conference in Vietnam.

Arthur Kaufman | Secretary General
Email: akaufman@salud.unm.edu

Dr. Sarena Seifer, Executive Director CCPH, and Dr. Arthur Kaufman, Secretary General The Network: TUFH
On a warm October day in Atlanta (USA), approximately 80 people came together to celebrate the 25th anniversary of The Network. A warm day not only in degrees Celsius/Fahrenheit, but also with regard to feelings of closeness and friendship - many warm friendships have been shaped during the past 25 years, and you saw that on this day.

A day with a lot of laughter in the air as well. You would expect laughter in the afternoon, when we supported two soccer teams (the Young All Stars vs. the EC Dream Team) in action and played the FUN Games. Many people have told me that they - playing all those funny games like the wheelbarrow race - felt like a child again, and that felt great.

But also a lot of laughter during the 'more serious' morning programme: a brainstorming session on the question "What will The Network: TUFH look like five years from now?". Brainstorming took place in three sub-groups where many issues were raised. Most of these referred to the relation of The Network: TUFH with health systems. Topics suggested to be addressed included: effects of globalisation, assessment of the impact of graduates from member schools on the health system, and the integration of public health and medicine. All subgroups discussed possibilities to expand The Network: TUFH and to improve its functioning at local, regional and global level. Suggestions included increasing the visibility and improving the marketing of The Network: TUFH, and further expansion of alliances with like-minded organisations. An inspiring conclusion of one subgroup's presentation was the statement: "We are the agents".

The day ended between elephants and flamingos: a BBQ buffet at the Atlanta Zoo. Here the Secretary General, Arthur Kaufman, presented an anniversary CD-ROM that included among others 50 articles of the Network’s publishing past. With a head filled with great memories, a stomach filled with good Southern food, and hands filled with two anniversary presents (the CD-ROM and an anniversary t-shirt with the ‘play dates’ of all Conferences over the years), the partygoers went back to the hotel. Filled with energy for the Conference that would start the following day.

Pictures say more than a thousand words; please have a look at our photo gallery on www.network.unimaas.nl/conferences/usa/
Dr. Ron Richards announces the Tamas Fülöp Award

At the occasion of our organisation’s 25th anniversary, the Executive Committee has installed the Tamas Fülöp Award (TFA). The TFA will be handed out once every two years at the Network: TUFH General Meeting to a person/organisation/insti-
tute for recent outstanding contributions to The Network: TUFH. Apart from a cer-
tificate, the TFA will consist of an economy ticket to travel to a future Network: TUFH Conference (to be filled in within three years from the year of award), space in the Newsletter and a world-wide announce-
ment through our hlt-net Alert.

The Committee that will look into the procedure for the TFA will consist of the Secretary General (Arthur Kaufman), Executive Director (Pauline Vluggen) and a representative of a Full Member from a developing country (Fernando Mora, Facultad de Medicina, Universidad Autónoma Metropolitana Xochimilco, Mexico).

The TFA was announced at the Anniversary Day in Atlanta GA, USA by Ron Richards (like Tamas Fülöp, one of the Founding Fathers). Unfortunately Tamas Fülöp could not be present at this event, but he has let us know that he feels heart-warmed and honoured. "I am really touched and feel quite small in front of this Award. Many thanks to all those who honoured me with this distinction, my deepest gratitude!"

"The Conference has given me such a refreshing outlook on my profession and on what I can do. I can’t wait to implement and start making a difference."

"The collaborative nature of the Conference made active participants from the people."

"I want to thank you for the interesting discussions.... and for listening."

"We students are still emailing severely! It was great to meet, to interact and to support each other."
Dear Diary...

Wednesday
I have arrived in Atlanta! It’s time again to attend the Network: TUFH Conference...
I am so excited! Last year, in my home country Australia, it was a great Conference for me. I wonder what experiences it will bring this year!

In the evening we went to the opening ceremony at Morehouse School of Medicine (a historically Black school, established in 1975). One of the highlights for me was definitely dining there: it was great to mix and mingle with so many new people. The opportunity to forge new friendships and make contacts is always a fantastic point of the Network: TUFH’s Conferences. And later that evening, Dr. David Satcher (former Surgeon General of the USA, and Director of the National Center for Primary Care at Morehouse Medical School) gave a truly inspiring address on health disparities.

Thursday
What a day! I attended a poster session, and presented a poster, on building a culturally competent workforce – it was fantastic! I just love the poster sessions. They are such a great opportunity for presenting and discussing new ideas and I always learn so much.
I also had the opportunity to double my knowledge and awareness during the afternoon session with WHO’s Tim Evans. Without fail The Network: TUFH brings impacting and informative addresses through keynote speakers in each Conference. Not only was Tim Evans a keynote speaker, but also others included a student speaker from India and the director of the Southeast Georgia Communities Project. I guess that is why I keep coming back!

Friday
Today we had the opportunity to go on various community site visits and see healthcare in action. I always find it such a valuable experience to be able to witness the healthcare systems of other nations and cultures. The exposure to such facilities inspires me and shows me that people all around the world are working for the common good.

The Conference dinner/dance was spectacular! The food was great, the wine was ‘beaut’, and the music was just plain fun! I am always so impressed and cheered to see people of all races and cultures seated at the same table to share a meal and conversation. The Network: TUFH Conferences bring together so many different nations and show us what humanity is truly about.

Saturday
My last event for the Conference: the poster cocktail session. This is one of my favourite sessions as it provides the opportunity to showcase so much upcoming talent and important projects. The posters displayed tonight were of such a high quality. I have met many amazing and committed people here; it is a shame it is coming to an end...
I guess now I will just have to look forward to next year’s Conference in Vietnam!

Lorencia Purcell | Student, Faculty of Health, University of Newcastle, Australia
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“I’m still aglow from Atlanta!”
The Atlanta Conference  
In Retrospect

“This was an excellent Conference; great work” and comparable statements were written by 12 out of the 170 attendants that filled out an evaluation form after the joint Network: TUFH and CCPH Conference held in Atlanta. These statements were corroborated by the responses to the closed items (scored on a five-point Likert scale) where all but three out of the 33 items received mean scores over 4.00!

The top score of 4.72 went to the ‘services provided by the Conference secretariat’. When asked for their best appreciated experiences, no less than 51 respondents spontaneously mentioned “networking and sharing among like-minded colleagues/students, from all over the world”. The Evaluation Committee’s impression was that CCPH participants benefited more from the contributions from non-Americans colleagues than the reverse. Moreover, Network: TUFH participants perceived this Conference as ‘less focused’ than usual, due to different topics inserted by CCPH. Other elements often spontaneously praised were community site visits (19x) and thematic poster sessions (14x). Some Network: TUFH participants recognised story-telling sessions as a new and well-appreciated format.

Of course there were also critical comments. It was a sad fact that some 150 non-American colleagues who had intended to join us in Atlanta could not timely receive a US visa. As a consequence, the Conference was quite strongly dominated by the American setting, which some participants perceived as a drawback (5x).

On the other hand it was noted that there were hardly any American students participating. Participating students from abroad, however, were not sure about their expected role in the Conference. To avoid that to happen again in future meetings, they proposed to schedule a meeting of all student participants and some faculty ‘mentors’ in the very beginning of the meeting.

Some of the participants regretted the Conference’s dominant structure featuring several parallel sessions that forced them to choose (11x) and others complained about the low temperature setting of the air-conditioning in the meeting rooms (11x).

Although many individual session moderators were commended for the good job done, some apparently had not read the hand-out for moderators and neither attended the moderators instruction session. Those failed to structure the discussions and to control the time schedule (7x).

Furthermore, some respondents would have liked the Conference organisers to include a tour of Atlanta in the time schedule (8x).

The Network: TUFH might consider another joint meeting with CCPH in about six years. Assuming Canada at that time to be less restrictive with issuing visas for Conference participants, a venue in that country might be considered for such meeting. In the meantime both organisations could try to find a format by which they can monitor continuation of their co-operation, e.g. at their respective conferences.

This report was based on the participants’ inputs in the written questionnaires distributed by the end of the Conference (for more results, see www.the-networktufh.org/conferences/previousconferences.asp) and personal observations by the members of the Atlanta Conference Evaluation Committee: Kate Cauley, Margaret Gadon, Hiske van Ravesteijn, Inger Sandström, Dan Blumenthal, Mohamed Moukhyer and the undersigned.

Gerard Majoor | Chair Conference Evaluation Committee  
Email: g.majoor@oifdg.unimaas.nl

“I have never been surrounded by so many individuals from around the globe who are striving for such wonderful things. Everyone was so helpful and friendly.”

“I liked the interactions between the different disciplines and between professionals and students.”
2005 Conference in Vietnam

Date: November 12 - 17, 2005
Venue: Ho Chi Minh City, Vietnam
Theme: Making Primary Health Care Work: Challenges for the Education and Practice of the Health Workforce

In November 2005 The Network: TUFH will organise the annual Conference in collaboration with the University of Medicine and Pharmacy at Ho Chi Minh City, Vietnam.

On Saturday November 12 a number of pre-Conference workshops will be offered in Ho Chi Minh City.

The main Conference commences in Ho Chi Minh City on Saturday, November 12, in the evening with an opening ceremony and a welcome reception. The Conference will continue until Thursday, November 17, 17.00 hrs.

After the Conference there will be an optional excursion to the University of Medicine and Pharmacy, Can Tho, Vietnam (November 18 - 20, 2005). This excursion departs from Ho Chi Minh City at 08.00 hrs. To facilitate your participation, a bus from Ho Chi Minh City to Can Tho will be included in the Can Tho registration package.

Participants will stay for two nights in Can Tho and return to Ho Chi Minh City on November 20 around noon.

Introducing...

After a turbulent recent history in which Vietnam gained independence from France and the war between North and South Vietnam (supported by respectively the USSR and the USA), in 1976 the country was reunited as the Republic of Vietnam. However, rather than clinging to some dogmatic communistic doctrine, the government has opened up the country to international participation in industry and trade. As a consequence Vietnam became one of the 'Asian Tigers' that experienced a booming economy in the nineties of the last century.

The University of Medicine and Pharmacy at Ho Chi Minh City (UMP-HCMC) was founded as Saigon UMP in 1947. It has currently seven Faculties (with a total annual enrolment of approximately 2000 undergraduate students): Basic Sciences, Medicine, Traditional Medicine, Odonto-Stomatolgy, Pharmacy, Nursing and Medical Techniques, Public Health.

Curricula are conventional but some offer integrated clinical skills training programmes and community-based training opportunities.

Postgraduate training programmes educate students for Master and PhD degrees and offer internships and training for first and second degree of specialisation for medical graduates. In any academic year UMP-HCMC has approximately 2300 post-graduate students enrolled in the programmes mentioned above. The University Medical Centre is UMP’s major clinical teaching facility. It comprises four 300-bed hospitals located in different districts of HCMC. Affiliated hospitals include Cho Ray Hospital, the Pediatric Hospital, Tu Du Gynaecology and Obstetrics Hospital and the Institutes of Odonto-Stomatolgy and of Traditional Medicine and Pharmacy.

The University’s mission has been formulated as five assignments:
• To provide training at all levels for health workers serving Vietnam’s southern provinces and the country as a whole.
• To lead basic scientific research and research on the application of modern medical technologies.
• To provide health services to the population.
• To train the University’s staff.
• To promote linkages with the community.

The last assignment is specified by focusing research and training activities on the development of the rural areas, where 80% of Vietnam’s population is living. One of UMP-HCMC’s research themes has focused on the prevention of various diseases common in Vietnam’s communities.

Can Tho University of Medicine and Pharmacy (CT-UMP) developed from the School of Medicine of Can Tho University (established in 1979 and in the nineties expanded with Dentistry and Pharmacy). In 2003 CT-UMP became independent from Can Tho University. CTU-UMP offers 4-year undergraduate programmes in Dentistry, Pharmacy, and Medicine, next to a 6-year programme in Medicine. Annual uptake is about 250 students with approximately 100 students enrolling in the 6-year medical programme. The latter programme offers an integrated, organ systems-oriented curriculum with conventional teaching. The School pioneered clinical skills training in a skillslab and student participation in community-based education in health posts and district hospitals in the Can Tho and neighbouring districts.
Potential Participants
Faculty, administrators and students of educational institutions for health and social care professions (for example, medicine, nursing, dentistry, odontology, pharmacy, nutrition, public health, environmental health, physiotherapy, medical radiation science, speech and occupational therapy, health and patient education, social work, health policy, health administration, library and information sciences), and health care providers constitute one set of participants in this Conference. The other target population encompasses representatives of communities, local health organisations, societies of health professionals and authorities who are (or would like to become) involved in increasing the accountability of academic health institutions towards community health by guiding health professions and institutional agendas.

General Outline Conference Programme
The Conference programme will predominantly be based on contributions by participants. In thematic poster sessions, the Conference organisers will try to bring together reports addressing similar issues (see ‘Thematic poster sessions’ under Conference Formats below). Furthermore, the organisers will invite external experts and some participants to give a plenary lecture, to conduct a didactic session or to organise a mini-workshop.

To stimulate active participation and discussion, access to all but one type of non-plenary sessions will be limited to 40 participants. (The exception pertains to didactic sessions that may cater for up to 80 participants). Consequently, medium-size group sessions have to be held in parallel to accommodate all Conference participants. One day of the Conference programme will be devoted to visits to field training sites involved in the training of students beyond the university teaching hospitals.

Conference Topics
The Conference organisers welcome any contribution relevant to promotion and fostering of partnerships for health of educational institutions, communities and health services through innovative education, services and research. The following topics have been coined to address the Conference theme: Making Primary Health Care Work: Challenges for the Education and Practice of the Health Workforce. Sessions will be organised addressing the following topics:

- On health workforce education and training: Student-centred learning formats
  Curriculum and course development
  Faculty development
  Computer-assisted learning
  Clinical teaching
  Community-based education
  Multiprofessional education
  Community-oriented post-graduate education
  Clinical skills training in skillslabs
  Student assessment

- On community-oriented health services
  Primary health care
  Health provision in rural areas
  Health research
  Women and health
  Care for children and adolescents
  Care for the elderly
  Occupational health
  Health care in case of disasters

- On partnerships
  The art of establishing partnerships
  Partnerships for health promotion
  Partnerships for health professions education
  Partnerships for health care delivery

- On health policies
  Optimising the professional mix in the health workforce
  Stemming the brain drain or educating for export?
  Integrating public health and individual care

Conference Formats
The Conference language will be English. Keynote addresses and didactics will simultaneously be translated in Vietnamese. The dominant Conference formats are chosen to encourage active participation by all Conference attendees. The Conference formats will be ‘Brown bag lunch sessions’, ‘Didactic sessions’, ‘Field training site visits’, ‘Keynote addresses’, ‘Mini-workshops’, ‘PEARL sessions’, ’Poster hall’, and ‘Thematic poster sessions’. There will be no more than two short plenary sessions per day for keynote addresses or plenary discussions.

‘Brown bag lunch sessions’. Participants are invited to attend one of the informal discussions offered during lunchtime. A box lunch will be ready for all participants.

‘Didactic sessions’. If experts on an emerging new topic are available, it may be of interest to many participants to hear about the latest insights and developments. In which case the conductor(s) of the session might give a presentation on the topic after which there will be ample time to ask questions and share your own experiences pertinent to the topic.

‘Field training site visits’. One Conference day will be devoted to visiting field-training sites in the community. You will learn about the involvement of the community in these training activities, the students’ work and their opinions about that, and the faculty’s problems with design, organisation, sustainability, and evaluation of this type of training.

‘Keynote addresses’. Discussion among Conference participants for example in ‘Thematic poster sessions’, is most fruitful if all attending have some relevant experience to share. On certain topics, however, expert knowledge may only be held by a few participants. Some of these experts on content areas relevant to the Conference theme will be invited to give short keynote presentations.
A Four-Year Experience with the Female Community Health Workers Training Programme in Pakistan: Achievements and Challenges

N. Huda1, S. Khan2 and T. Kazmi2
1Department of Medical Education, Ziauddin Medical University, Karachi, Pakistan; and 2Department of Community Health Sciences, Ziauddin Medical University, Karachi, Pakistan

Context: The health status of women in Pakistan is linked directly to the societal structure. Social restrictions on mobility, socio-cultural norms that undervalue women as individuals and as a group and limited or non-existent financial autonomy have all combined to make the health status of Pakistani women even worse than the unenviable one of their male counterparts.

Setting: The Female Community Health Workers Training Programme (FCHWTP) was initiated in the site of Ziauddin Medical University’s community-based education programme. This is a conservative Pakhtun community with a population of 20,000, 48% of whom are females. The FCHWTP has a two-fold objective of providing trained human resources for the University’s centre-based and outreach health services and to address the gender-based limitations of women’s access to health care. A supplemental benefit is that this training equips female members of the community with the necessary technical expertise that will help them find a sustainable source of livelihood and an initial step towards empowerment.

Objectives: To describe the experience with the Female Community Health Workers Training Programme (FCHWTP) between 2000-2004 and to identify potential barriers to training and retention of these workers.

Design: Review of relevant data from the programme records, interviews with trainers and female community health workers (FCHW) and focus group discussions.

Main outcomes: Number of FCHW enrolled each year, number of FCHWs successfully completing training, trainees’ perception of the programme, follow-up of trainees for their chosen career paths, community perceptions of FCHWs and of the training programme. Themes arising from interviews and focus group discussions.

Session: Women and Health

ANNUAL INTERNATIONAL CONFERENCE

‘Mini-workshops’. Faculty may have been saturated with theoretical information on possible innovations in curriculum construction, educational approaches or building partnerships, but how to put things to practice? At mini-workshops, a small panel of experts will organise hands-on experiences for the participants that will enable them to proceed with the implementation of changes at their home institutions. After a plenary introduction you will participate in a small group given the assignment to design some elements, which might be implemented at any institution. Eventually small group products will be compared and commented upon by your fellow participants from other groups and the expert panelists.

‘Pearl sessions’. This format is a variant of the medium-size mini workshops described above. It is based on the format of ‘PEnorlAly ARranged Learning Sessions (PEARLS) as described by P.L. Schwartz & C.J. Heath (British Medical Journal 1985, 290, 453-4). The key difference with other formats is that any participant may take the initiative to ask for a session on a certain topic or to announce his or her interest to lead a session on some topic.

‘Thematic poster sessions’. This format restricts the time allotted to formal lecture-type presentations and encourages an active role for Conference participants. The Conference abstract booklet will be divided into various themes. For each session, a maximum of five contributions will be selected. Contributors are requested to prepare:

• an abstract for the abstract booklet (to be submitted before August 1, 2005),
• a poster (width x height = max. 85 cm x 100 cm) summarising the key issues (to be carried to the Conference),
• a highly condensed oral presentation of the poster’s conclusions, not exceeding three minutes,
• a full paper to be considered for publication in Education for Health (optional).

At thematic poster sessions the use of overheads, slides, PowerPoint presentations, etc. will not be permitted.

At the Conference, contributors and participants will meet in groups of about 45 persons for two-hour sessions. These two hours include about 30 minutes to inspect the posters, another 20 minutes for oral summaries and one hour to discuss issues common to the posters presented. To direct this discussion, a moderator will chair the session. The moderator will invite the participants to bring forward their questions and to share experiences pertinent to themes brought up in the posters.

Social Programme

Arrangements will be made through local tour operators for visits to local areas of interest.

Call for Abstracts

The organisers invite abstracts containing empirical, theoretical or descriptive studies relevant to the field. The abstracts submitted may contain a report of research undertaken, a description of a new partnership, a new programme, course or curriculum that may be instructive for other participants, or an innovative solution to an old problem. Any contribution reflecting progress or containing new ideas in the areas mentioned will be considered.

Abstracts should be submitted electronically and before August 1, 2005 through Internet: www.the-networktufh.org/conference/abstracts.asp. Abstracts should not exceed 300 words and should follow the example given below and on the website. The quality and comprehensibility of an abstract may be enhanced if the author adheres to the structure of an abstract typical for that required in a scientific paper. Elements to be considered (but not all need be used) are context, setting, objectives, design, subjects, interventions, main outcome, results, findings, measures, conclusions. As an example, see right a modified version of an abstract submitted for a past Network: TUFH Conference.
We encourage you to submit your presentation as a full paper to be considered for publication in The Network: TUFH’s peer reviewed, MEDLINE-indexed journal, Education for Health: Change in Learning & Practice. To do so, please submit the full text electronically in one of two ways: either as an electronic file sent to us as an attachment to an e-mail message or on a diskette (along with two paper copies). In either case, the paper should be double-spaced and should not contain more than 2500 words, exclusive of Abstract and References.

The electronic file can be sent to the journal office at: efh@network.unimaas.nl
The diskette (and two paper copies) should be sent to The Network: TUFH Office.

Before finalising your paper please review the full set of the journal’s Instructions for Authors. It is available on our journal website at: www.the-networktufh.org/publications_resources/authorinstructions.asp or, write to The Network: TUFH Office to have a copy of the Instructions sent to you.

Registration
Participants have two options: to register exclusively for the Ho Chi Minh Conference, or to register for the Ho Chi Minh Conference plus the Can Tho post-Conference Excursion (this programme is only available for a limited number of participants)

Students are encouraged to attend the Conference and post-Conference Excursion and contribute to it.
Registration of accompanying persons is possible.
We advise you to regularly consult our Conference website www.the-networktufh.org/conference/

Conference Secretariat
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An Essential Reference
Textbook in PBL

Book Review of: Problem-Based Learning: A Research Perspective on Learning Interactions
Dorothy Evensen and Cindy Hmelo

This review has been published before in Education for Health, Volume 17, no. 1.

Primarily a research publication directed at medical and health professional education, this first edition of Problem-Based Learning: A Research Perspective on Learning Interactions has a table of Contents, a Foreword by Howard Barrows of Southern Illinois University, a Preface, Acknowledgments, two pain Parts-The Group Meeting and Self-Directed Learning, 13 Chapters with references, 14 Figures, 27 Tables, an Epilogue, author index, a subject index and a list of Contributors. Brief biographies of the editors and the contributors are given in the list of Contributors. It would be useful to move the list of contributors to the front sections of the book to leave the subject index as the last section of the book. The book has no list of figures, list of tables, suggested further reading, list of abbreviations or a glossary. The latter may have been very useful and could be considered for future volumes or related works. The textbook’s concise writing style makes it easy to read and to refer to as a reference textbook. It is well researched, fairly consistent, and systematic in its presentation.

Problem-based learning (PBL) has become central to the modern medical curriculum in a large number of medical schools. Problem-Based Learning: A Research Perspective on Learning Interactions incorporates and discusses recent research into PBL thus providing a more evidenced-based approach to its incorporation into the medical curriculum, as well as providing

Problem-Based Learning: A Research Perspective on Learning Interactions gives good coverage of research into PBL both in terms of group work and self-directed learning (SDL). In the Foreword, Howard Barrows indicates that PBL is not a single method of health professional education but in fact comprises a variety of ‘species’ and ‘mutations’. He indicates that the book will be useful for anyone “designing a PBL curriculum or who is responsible for maintaining and improving a PBL curriculum”. Particular highlights of the book include Groups in PBL (Chapter 7), which provided useful information for those possibly confronting the inevitable group work in PBL discussing the evidence for their inner workings and as well as reviewing likely outcomes. An excellent review of the contribution of PBL to SDL is given in Chapter 9. This is an important chapter for anyone to read who is seeking evidence for PBL promoting SDL for an upcoming accreditation review. The self-reflective health professional educator will also be interested in the review of research concerning small group learning, particularly those aspects that make a more effective tutor (Chapter 2). Even the epilogue is gives a valuable description of assessment for the ‘proactive lifelong learner’.

The editors are both academics in the field of education. Both editors are based in the USA. Multiple contributors have authored 11/13 (85%) of the 28 chapters. There are 20 contributors from three countries, although most of the contributors appear to be listed as based in institutions of higher learning in the USA (15/20) with the remainder coming from the Maastricht University in the Netherlands (3/20) and the University of Toronto in Canada (2/10). Most of the contributors to Problem-Based Learning: A Research Perspective on Learning Interactions have indicated they are active in educational research, particularly in the context of the medical curriculum. Perhaps future editions will tap into the PBL experiences of researchers in other countries, especially in Australia.

The intended audience for Problem-Based Learning: A Research Perspective on Learning Interactions is “both researchers and practitioners”. It is an essential reference for those working professionally in health professional and medical education, particularly in PBL environments. The book will also appeal as a reference textbook for health professionals, especially those who are called upon to contribute to PBL sessions on a regular basis. Academic and research departments of health professional education and medical education should also consider the book as a required reference textbook for their libraries and also for advanced postgraduate courses. This first edition of Problem-Based Learning: A Research Perspective on Learning Interactions is a worthy addition to the exclusive international portfolio of standard textbooks in PBL, edited by health professionals with noteworthy research backgrounds in education.

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For reviews of Network: TUFH books, go to www.thenetworktufh.org/publications_resources/books.asp
One of the primary goals of the journal *Education for Health* is to communicate what is going on by helping authors to tell their story. We are a group of ‘doers’ rather than ‘writers’. The problem, of course, is that in order to communicate widely, we must write about what we are doing. As indicated extensively in the editorial of issue 17-2 of the journal, our philosophy is to help doers to write. We do that in several ways; before a manuscript is sent to peer reviewers a judgement is made as to whether with some work this could be a good paper. Sometimes, if the paper is not quite good enough for publication, we provide authors with a list of what we call ‘mentors’: volunteers who have published, know English, know the subject, and can better structure the paper. From that point, it is up to the author(s).

Aside from actually attending Network: TUFH Conferences, the only way to get one’s ideas communicated to others is to have an article published in the journal. The Network: TUFH’s Secretary General, Arthur Kaufman, is fond of saying - without hesitation - that some of the best things that they put into practice comes from others.

Not many years ago I was asked to help answer the Minister of Health’s question: “Does community-based education of health professionals make a worthwhile difference to societies?” In other words, what evidence is there that the more expensive community-based education for health professionals makes any difference over the less expensive traditional approaches? One of the ways we can answer that question is to collect evidence about what we do, write it up, and get it published.

Are you a doer? Take some time and write down what you are doing. And, of course, ask us some questions along the way. Remember, doers can be writers also.

Ron Richards | Editor EfH
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**IMPROVING HEALTH**

**YELLOW PAPERS**

Between those outstanding publications that were already published in leading journals, and some preliminary notes scribbled on the last page of an agenda, there are also papers or reports that belong to the in-between (‘grey area’) category. Papers that, for whatever reason, have not been published before. Within this ocean of ‘grey’ papers, there are some which by content are most relevant to the Network: TUFH’s mission and aims. We will pick those pieces of gold from the ‘grey’ ocean, change their status to ‘yellow’ (because we can’t print in gold) and publish these in this section. Below you will find a contribution by G. Lule (†), J. Tugumisirize, and A. Moses of the Department of Community Health and Department of Psychiatry, College of Medicine, University of Malawi, Malawi.

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**Drama Health Education by the Community, to the Community**

**Introduction**

The College of Medicine, University of Malawi runs a community-based course. Many teachers of community health have tried to improve on the participation of communities in the training of doctors, in order to move the learning and experiences of medical students even nearer to the rural communities and to ensure that communities benefit from their participation in the training of the medical students.

**Traditional Media**

In the development of the curriculum for teaching community health in a community-based medical school, questions were asked as to how the communities themselves would be directly involved in the training of the doctors in Malawi, and at the same time have direct benefits. The first elements included in the curriculum were the traditional community surveys, generally referred to as ‘community diagnosis’. Although that approach has stood the test of time (Wood et al. 1985), of late it has become clear that the communities do not get obvious direct benefits. This lack of appreciable benefits soon leads to a ‘Community Fatigue Syndrome’. This is a state whereby the communities eventually either refuse to cooperate with the students or become hostile.

Next, the Department of Community Health introduced the idea of involving the community members in health education through drama. The primary objective of this experience was to influence the health seeking beliefs and practices of Malawian villagers in the fields of infant mortality, infant nutrition, maternal mortality and the transmission of Sexually Transmitted Infections (STIs) including HIV/AIDS, and to develop local (village-based) ‘ownership’ and direction of a health education continuing process. The secondary objective was to explore and develop the role of medical students and members of the community in the transmission of health knowledge in a culturally acceptable way.

In 1999 nine selected villages were invited through their chief to select a topic for discussion. These topics were developed into drama, music, song and dance, performed to the public by medical students, community members, and village bands.

**Results**

There were positive changes among the communities in regards to the knowledge, attitudes and practices on topics that were covered during the drama.

Both the students and the communities appreciated the importance of their involvement. Communities were very keen to participate in health activities.

One interesting point came up on the students’ comments: many students felt quite strongly that it is not the health professional, or the village health worker, or the people themselves who are most powerful agents for behavioural change, but the village headman. They repeated the view that stronger knowledge and leadership from him (her) would achieve a great deal.

**Acknowledgements**

Acknowledgements must surely go to the Staff of Chilomoni Health Centre, Drama and Music Groups, the villagers, community leaders and the students of Malawi College of Medicine. For nothing would have been possible without their enthusiasm and inventiveness.

**References**


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**THERE WERE POSITIVE CHANGES AMONG THE COMMUNITIES IN REGARDS TO THE KNOWLEDGE, ATTITUDES AND PRACTICES ON TOPICS THAT WERE COVERED DURING THE DRAMA.**
First WONCA 5-Star Doctor: Jan de Maeseneer

At the three-annual world conference for family doctors organised by the World Organization of Family Doctors (WONCA) in Orlando, USA, the first WONCA International Award for Excellence in Health Care - the 5-Star Doctor has been given to Jan De Maeseneer, Family Physician, full professor of Family Medicine and Primary Health Care at Ghent University.

The origin of this award is related to an initiative of the World Health Organization (WHO): the Alma Ata programme Health for all by the year 2000. For WHO, the way to achieve this goal was the development of primary health care. In the field, it became obvious that in order to make the global strategy health for all successful, there was a need for a new type of 'doctor'. This doctor of the future needed to fulfil at least five essential functions:

- Assess and improve the quality of care by responding to the patient’s total health needs with integrated preventive, curative and rehabilitative services and by considering the patient as an integral part of a family and a community.
- Make optimal use of new technologies, bearing in mind ethical and financial considerations and the ultimate benefit of the consumer.
- Promote healthy life-styles by skilfully communicating with individuals and groups and empowering them for their own health protection.
- Reconcile individual and community health requirements, striking a balance between patients’ expectations and those of society at large, both short-term and long-term.
- Work efficiently in teams, both within the health sector and across the health sector and other socio-economic sectors influencing health.

Charles Boelen, Chief medical officer for educational development of human resourc-es for health at WHO at the time, called this ‘ideal doctor’ the ‘5-Star Doctor’.

WONCA launched in 2001 the idea to create a WONCA International Award of Excellence in Health Care - the 5-Star Doctor. A nominee for this award should be a serving physician, with the following characteristics: cared provider, decision maker, communicator, community leader and team member. Candidates need to be active physicians who have developed innovative methods of health care delivery, are involved in international co-operation and are active at academic level (research, training and quality assurance).

The first family physician to be honoured with this award is Jan de Maeseneer (member of The Network: TUFH). De Maeseneer became a medical doctor at Ghent University in 1977. Together with his wife Anita De Winter, he started a family medicine practice at the ‘Botermarkt’ in Ledeberg, a deprived area in Ghent. The practice grew quite quickly to a multidisciplinary community health centre where actually some 4200 patients are cared for in a capitation system. The practice did evolve with the local population, and actually cares for patients from more than 50 nationalities.

Since 1991 he is the head of Department of Family Medicine and Primary Health Care, a department of 50 people. In 1997 he became chairman of the Curriculum Development Committee, with the mission to reform fundamentally the undergraduate medical curriculum. The principles of the ‘5-Star Doctor’ guided the reform and contributed to the preparation of the new doctor for the 21st century.

De Maeseneer presented at more than 100 national and international conferences. He is active in several organisations and participates in many administrative boards, e.g. the Platform for Health Care Delivery to Asylum Seekers and Illegal People. Internationally, De Maeseneer participates in different projects, supporting the development of family medicine. He was also involved in research on different projects and the findings were reported in many publications, both nationally and internationally.

In all these projects, De Maeseneer works to contribute to the reduction of unhealthy inequalities and the realisation of more ‘equity’ in health care, based on solidarity. De Maeseneer said about this in his acceptance speech: “Looking back, it is clear that the driving force for our efforts has been the commitment to ‘equity’ and ‘social justice’. This orientation is part of a long European tradition of solidarity. That hopefully will resist the attempts to introduce market principles and profit driven enterprises in the health care system.”

The Network: TUFH would like to congratulate Jan de Maeseneer with this honourable distinction.
GUIDANCE ON GLOBAL NURSE COMPETENCIES

Today’s global market includes the free movement of professionals between countries and regions. As a result, there is growing interest in common standards and competencies of nurses.

In response to world-wide demand for direction on professional nursing competencies, the International Council of Nurses (ICN) published the first such guidelines last year: the ICN Framework of Competencies for the General Nurse.

ICN is a federation of 124 national nurses’ associations representing millions of nurses world-wide since 1899.

The competencies were derived following a comprehensive review of literature from many countries and a series of consultations. The framework is sufficiently broad to apply internationally, yet specific enough to provide guidance to countries developing their own competencies. Countries may wish to build upon the ICN framework, while developing additional competencies that reflect the current country-specific requirements of the nursing workforce.

Since the publication of the Framework last year, ICN has received many inquiries from different parts of the world, including nurses working in hospital settings who were keen to use the competencies as part of their appraisal and development framework.

ICN recently published the Family Nurse Competencies, which build on the generalist nurse framework. ICN is also in the process of developing the telenursing competencies, which they plan to publish early 2005.

Despite the success in the 1990’s in expanding geographical coverage of healthcare services in Peru via poverty mapping and the Programa de Salud Básica para Todos, only 50% of the population has adequate access to institutional healthcare services, and 25% has no access.

**SERUMS**

To reduce inequity, since the 1970’s, the SERUMS (Servicio Rural y Urbano Marginal de Salud) strategy compels young health professionals to work for one year in rural and peri-urban areas.

Health promoters play an important role by volunteering to do outreach work in communities. New programmes, including Campaña de Atención Integral and ELITES (Equipo Local Itinerante de Trabajo Extramural en Salud), target excluded communities through visits with multidisciplinary teams. The former provides local health services and activities focused on human dignity and cultural integrity; the latter involves anthropologists aiming to create a healthy environment.

Health posts are the least staffed health establishment. Technical nurses and/or SERUMS fill some health posts and the former dispense medicine. In these circumstances the confidence of the local population may be reduced. One proposal of new decentralisation deploys general physicians and nurses in health posts (Ministerio de Salud, 2002). Some health centres integrate psychologists and nutritionists in all health activities.

**Horizontal Relationship**

Traditional dominance of paternalistic physicians is gradually evolving into a more horizontal relationship within health teams and with patients, family and community. According to anecdotes and observation (partly through author’s visit), community participation in resource management (CLAS: Comunidad Local de Administración de Salud) encourages less entrenched views, attitudes and behaviour of health personnel, especially physicians, towards a population-centred - and more collaborative and disciplined - manner (Díaz, 2004). This is partly because the CLAS programme increases public accountability. For further holistic care, qualitative indicators should be introduced in the goals of health personnel. Although the number of CLAS has increased since their inception (1994), from 2000 the central Ministry of Health has reduced its financial support. This constraint has influenced interprofessional relationships and their services. Some CLAS associations increased their tariffs of services and reduced promotive and pre-
ventive care to overcome financial pressure (Díaz, 2004) (Díaz, 2001).

**Human Resource Development**

Historically, Peru lacked progressive human resource development. The main obstacles are financial constraint, weak commitment to equality and stewardship at central level, frequent changes of key officials, mismatching of people in decision-making mechanisms, inadequate planning due to limited information systems, little harmonisation between institutions resulting from a closed organisational culture, and incomplete implementation due partly to lack of quality assurance. Primary health care is often overlooked and some general physicians prefer to work abroad despite their newly acquired status. Little attention is given to continuous training and evaluation.

Under the new decentralisation, a pilot programme *Educación Permanente en Salud* (EPS) promotes permanent training in poorer regions. EPS pursues problem-solving in multidisciplinary teams and a client-centred approach. This can motivate health personnel through personal development and professional competence. And it can build close relationships (professional socialisation) to enhance the effectiveness of team-work, encourage a change of organisational culture and promote joint working with communities. EPS is promoted through a multi-institutional approach, involving a new Institute of Human Resource Development, the regional health authority. Regional level plays a leading role in coordinating activities (Institute de Desarrollo de Recursos Humanos, 2004).

**Conclusion**

The map of interprofessional relationships is further complicated by complex contract forms. To promote interprofessional care, increase motivation, reduce conflict and non-collaborative attitudes, the problems of different salary levels, benefits schemes and delayed reimbursement for a newly integrated health insurance must be addressed.

**References**


This article is mainly based on a project International Primary Care Development led by Geoffrey Meads, at the University of Warwick, UK. (Some data were also collected during the author’s field study in Peru)

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Conclusions

Through campus-community partnership, a collaborative effort has provided a model for addressing social and psychological needs of elderly women. While the Department of Health Sciences helped identify some of the problems of elderly women through research, partnership with BetterLife led to action in addressing the needs.

Resources required to address needs of the elderly are enormous. The contributions of Babcock University and BetterLife are not enough. To sustain this laudable initiative, it is necessary to obtain support from both public and private agencies.

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Steps to Partnership

- Babcock University initiated a survey to find out what the children of elderly women thought were the needs of their mothers.
- A table of findings was developed.
- Results were shared with BetterLife.
- BetterLife followed up using focus group discussion approach to amplify the survey findings.

Survey Findings

- Needs as Defined by the Children of the Elderly.
- Needs as Defined by the Elderly.
- Money for food and medicine.
- Occasional visits.
- New dresses at festive periods.
- Occasional visits to the city (trading, farming, visiting, etc).
- Regular interaction.
- Communication with loved ones.
- Sharing stories on age-long customs and traditions.
- Mobility.
- Home health care and Malaria prevention.
- Involvement in community decisions.
- Friendly facilities.

Action Plan Based on Findings

- Monthly meetings to create a stronger voice.
- Monthly ‘take a walk’ programme.
- Periodic elders’ forum to support younger women on issues related to HIV/AIDS.
- Weekly visiting days/voluntary home help/health advice/information sharing.
- Provision of insecticide-treated bed nets at a subsidised rate.

Introduction

Global attention has been drawn to the increasing number of male and female population aged 70 years and above, especially in developing countries. It has been reported that “Nigeria will be among the countries in Africa that will experience very large increases in [the] group of the elderly, most of which will include women” (WHO/AFRO).

While efforts are being made at international and national levels, local institutions, organisations, corporations and local communities need to join hands to swiftly address this pertinent issue. The main objective of this article, therefore, is to share how an institution (Babcock University, Nigeria) collaborated with BetterLife (a community NGO located within the same city) to identify and address some of the physical, social and psychological needs of elderly women in the community.

The Partners

Babcock University (formerly Adventist Seminary of West Africa, established in 1959) is one of the first private universities in Nigeria, granted charter in 1999 by the government of the Federal Republic of Nigeria. It is situated in Ilishan-Remo, Ogun State, southwestern Nigeria. Current student enrollment is about 3000, and it employs 150 faculty members. These students and faculty members are distributed among three faculties: Science and Technology, Management and Social Sciences, and Education, Arts and Humanities. Fifteen programmes are currently being offered, including a Bachelor of Science degree in Public Health, and a Bachelor of Nursing Science.

For over four decades, the institution has had a rich history of community health through meeting the health care needs of people outside the campus walls.

BetterLife was founded in 1994 with a membership of 130 women. Their goal is geared towards promoting the health needs of women through information, education and communication.

Women Responding to the Needs of Elderly Women

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Improving Health: Women’s Health

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What Would I Change if I Were Minister of Health?

If I were Minister of Health in Brazil I would not change much, as we are already working towards important achievements in this field. In Brazil health is considered a citizen right, something that has to be provided to all Brazilians by the State. So, since 1988, through our democratic Constitution, we have a public National Health System, called SUS, which provides all kinds of health services to our population. There are private services as well, but they have to be complementary and work under the orientation of SUS.

We have progressed since then, but still have to face many problems. Now most of the 175 million Brazilian people attend SUS facilities (only 25 million use mainly private services). Though we have guaranteed the access to health services for the whole population in a very short period of time, we still have a lot to do in terms of quality.

Emphasizing Family Health is the strategy that is used for the reorientation of primary health care, and with outstanding results. We have a health team (family doctor, nurse, nurse tech and community health agents) responsible for the health of 1500 families. They are responsible for health promotion, disease prevention, clinical care, and public health procedures. Community agents play a key role in this team, establishing a strong connection between population and health professionals, facilitating the communication between and commitments of both sides.

Family Health made it possible to improve the quality of care, leading to better results and more satisfaction of people. We still have difficulties, though, with the expansion of this strategy in the bigger cities (where doctors, mainly, are more difficult to ‘catch’ for an 8 hours’ job – as there are many other job possibilities) and also with the necessary connections between family health teams and the secondary level health unities.

We also developed strong qualities in the tertiary level of attention, as the public system is responsible for 100% of the organ transplants (and Brazil is the second or third in the world in this kind of procedure), cancer therapy and so on. However, we still have challenges on guaranteeing proper access in the appropriate time according to people’s needs.

We have progressed in the field of health professions education. There is a recent agreement between the Ministries of Health and Education, which leads to sharing responsibilities in the orientation of health professionals education. There are many initiatives in course:

• Teaching hospitals are offered better contracts as they establish better and more important commitments with the national health system.
• There are permanent education circles putting together health system and health units managers, health education institutions, health councils and social movements in order to establish priorities and build formative initiatives for health professionals development. Their activities are funded by the national health system.
• There is a national incentive for changing health professionals education, supported by the Ministries of Health and Education. Diversification of teaching-learning scenarios, practice in the community along the whole course, multiprofessional activities, improvement of clinical abilities in terms of quality of attention are some of the targets. Financial and technical support is being offered by the government for the mobilised institutions.
• Evaluation standards for the educational institutions in the field of health are being elaborated by the two Ministries and their teams.

These strategies promise more improvements to improve even more our interesting National Health System, for we will have health professionals with a more adequate profile and more important social commitment.

IN BRAZIL HEALTH IS CONSIDERED A CITIZEN RIGHT, SOMETHING THAT HAS TO BE PROVIDED TO ALL BRAZILIANS BY THE STATE.
Viewing Health as a Complex Cultural Entity

The biomedical model of healthcare - 'medicine', as we have come to know it - has achieved tremendous technological advances during recent times, achieving cures for many illnesses and diseases. Yet, one vital aspect which this mode of healthcare fails to incorporate is the consideration of the patient as an individual in disease treatment and prevention considerations. That is, an individual with beliefs, concepts, and a unique cultural appreciation of illness, disease, and treatment.

Health Focus International
In an endeavour to revolutionise the current model of healthcare, a group of health professionals and academics are working on the establishment of a new medical school in Chile, South America, which bears a new vision of healthcare delivery that integrates the patient, doctor and the community. The project is auspicated by the Australian based organisation Health Focus International (HFI) which seeks to bring about health equity and social justice in the global community. Heraldo Povea-Pacci and Lórencia Purcell of HFI are the directors leading the international project team, which has developed collaboratively with interest from various countries around the world.

International School of Anthropological Medicine
The school, planned for development in the city of Valparaíso, Chile, will teach a curriculum of ‘anthropological medicine’, thereby dubbing it The International School of Anthropological Medicine (ISAM). The aim of the proposed and novel curriculum is to embed the biomedical concepts of illness, disease, and treatment in relevant perspectives derived from sociological and anthropological considerations of health and culture, in order to deliver a medical education with foundations in a holistic context of healthcare.

ISAM will be an international school conceived to train medical doctors who are ‘healers’, that is, doctors who have an integral and pluralistic understanding of medicine. ISAM graduates will be doctors trained to view their practice from a sociological/anthropological perspective, viewing health as a complex cultural entity, with a focus on the patients and not simply on the diseases which they encounter in their patients.

Indigenous and Disadvantaged Communities
The medical education programme at ISAM will focus on training doctors to be culturally sensitive, holistic practitioners, who will be skilled in health advocacy and health promotion. The curriculum will aim to teach and endorse issues such as medical ethics, human rights, social justice, health advocacy, and health equity, and graduates will be expected to be competent in the knowledge, promotion, and advocacy of these issues.

The school, in addition, will maintain a specific interest in the area of healthcare facilitation in indigenous and disadvantaged communities. ISAM’s breed of doctors as ‘healers’, or ‘anthropological practitioners’, will receive specialised training designed to capacitate them for practicing in diverse settings and cultures, particularly those of indigenous and disadvantaged nature.

The election of candidates for this specialised form of medical education shall reflect the inherent equitable focus of the school; with a minimum of 50% of the annual student intake being selected from indigenous and disadvantaged communities. Full scholarships shall be provided for these candidates for the duration of their studies, with the proviso that the students will re-pay the monetary support upon graduation by committing to practice in a disadvantaged or indigenous community for an obligatory period of six years.

The school is intended to open officially in June 2006, with the first intake of students into the semester long preparatory course.

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Joint Efforts for Changes in Medical Education in Brazil

A movement towards changes in medical education in Brazil has grown over the last few years. Awareness that changes are urgently required has increased. Recent guidelines provided by the Ministry of Education set up a renewed curriculum for doctors' training. The Ministry of Health has provided financial support for the schools engaged in innovations. Despite recent advances, medical education reform has faced enormous challenges, and comprehensive, in-depth changes are still restricted to a small group of schools. Different barriers have contributed to that. One of them is the poor availability of faculty development programmes and technical support for implementing changes. Overcoming these constraints is crucial to strengthening innovations.

Innovations

The Innovare Institute, a non-profit, non-governmental organisation founded in 2003, has contributed to face these challenges. Its mission is to develop and disseminate innovations and creative solutions for health professions education, health management and primary care.

The founders of the Innovare have been engaged in works in the field of health professions education over the last years, and they have had the opportunity to attend to postgraduate programmes in internationally recognised universities. Activities carried out by Innovare are guided by some key values. They are oriented towards community needs and long-term changes in social and organisations’ contexts. Interventions are drawn from a search of the best evidence available, and customised according to singularities of clients and contexts. The institute is committed to conceive innovative solutions based on exploration of alternatives and application of advanced, relevant knowledge to real-life problems. High quality standards are pursued through quality assurance guides and peer review processes. Finally, the Innovare’s team is engaged in learning from experience through ongoing reflection on practices.

New Medical School

The Innovare has established partnerships with institutions committed to innovations to provide support for their implementation. These initiatives involve technical assistance for curriculum construction, design of assessment and evaluation systems, management of educational institutions, planning and implementation of faculty development programmes. The Innovare’s current project is the design and development of a new medical school in Belo Horizonte, in the state of Minas Gerais, Brazil. It started in 2003, when the Jose do Rosario Vellano University (UNIFENAS) decided to found an innovative medical school that would adopt Problem-Based Learning (PBL) as its educational philosophy. The Innovare was asked to provide technical assistance for the curriculum design, selection and training of teachers to be hired, design of assessment and programme evaluation methods, and continuing support to put plans into reality.

Renewed Medical Education

The new UNIFENAS medical school adopts PBL and an integrated curriculum, structured in thematic blocks. Learning is organised around problems addressed in tutorials groups. Other educational strategies – skills training, team projects, seminars – aimed at different learning goals are used to integrate basic and clinical sciences, disciplines, and learning strategies.

The school has a strong community orientation. Problems relevant to community health have priority in the curriculum and emphasise health system policies. Since the first year, Medical Practice in the Community, a key educational strategy, is implemented. Students have weekly activities in primary health care centres. Centres are selected and physicians trained to work as preceptors through partnership with health system managers.

Students’ activities are guided by block books, and learning goals emphasize health system functioning, health promotion and prevention and primary care. Teachers provide regular supervision, and engage in students’ assessment together with preceptors. In agreement with health managers, the university is presently building a complex outpatient centre, which will provide additional learning environments and supply gaps in healthcare in the region.

Despite enormous challenges, a new school emerged, consistent with the ideals of a renewed medical education. Innovative solutions have been conceived and tested. Strategies to work with the community and the health system, approaches to curriculum design and to enhance integration, and solutions for continuous faculty development have arose. Sharing experiences with other institutions may now contribute to changes in medical education in Brazil.

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The Social Accountability of Medical Student Organisations

There is an appeal for medical schools to be socially accountable. As major stakeholders in education, students are also challenged to be socially accountable in (possibly) all their undertakings. Medical students can formulate their own measurement of social accountability for the convenience of their organisations. I wish to expound on the social accountability model, and apply it to medical student organisations (or health student organisations for that matter).

Medical Schools
Social accountability of schools goes beyond social responsiveness. It implies that the school consults society to jointly identify priority health issues and expectations. The school then seeks evidence that it addresses these issues and expectations with a view to obtaining short-term and long-term benefits, in part for the local community and in part for the country as a whole. Educational institutions should voluntarily be socially responsible, but they should also expect to be held to account by society for what they do, particularly if they are supported by taxpayer funds (Boelen, 2000).

Specifically, social accountability of medical schools is defined as: "the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and nation they have a mandate to serve" (Boelen & Heck, 1995). With as its core values: relevance, cost-effectiveness, quality, and equity.

Medical Student Organisations
Being part of the medical school which is encouraged to be socially accountable, so must medical student organisations be. Being medical students supported (or not) by taxpayer funds, and being students who hone their skills and expertise from contact with people/patients in the community, students are expected to be socially account- able, or actually volunteer to be socially accountable. The ‘physicians-under-construction’ - or students - have a vital role and impact on the health of society, even as students. They don’t possess this role only when they graduate, practice and become full-fledged physicians.

Social accountability of medical student organisations can be stated as: “the obligation to actively direct their governance/leadership/student representation, general programme of action/student-oriented activities, service activities (for its members, the school and the community), and school participation (especially curricular involvement) towards molding responsive members/students and schools that would address the priority development and health concerns of the community, region, and nation they have a mandate to serve”.

Measuring
Since the medical schools are part of the medical school, it is suggested that the students adhere to the tables on Defining and Measuring the Social Accountability of Medical Schools (Boelen & Heck, 1995) for reference and guide. They have a role, not only as contributors but also as constructive critics, in how the school abides by and realises its commitment to be socially accountable. Activities by the student organisations imply orientation to four target groups as much as possible: the members/studentry, the organisation itself, the school, and the larger community. Service activities of students are best when focused on Primary Health Care.

As members of the academic institutions and in the larger picture of collaboration, students are part of the Network: TUFH pentagon. Promoting social accountability with the Network: TUFH stakeholders is a huge opportunity, even when being students. Medical students can formulate their own practical definitions and measurement of social accountability for the convenience of their organisations. I provide some general ideas in Tables 1 and 2.

Table 1. Defining the social accountability of medical student organisations: Some general guidelines

| Domains: Governance/Leadership/Student Representation, Curricular Involvement, Service, Student-Oriented Goals/General Programme of Action |
|---|---|---|---|
| Defining | Planning Phase | Doing Phase | Impacting Phase |
| Core values: Relevance, Equity, Quality, Cost-Effectiveness (REQC) | Students possess the vision, dedication and commitment to influence relevant, qualitative, cost-effective, and equitable healthcare in all organisational functions, namely governance and student representation, curricular involvement, service, and student-oriented projects; and in all levels of involvement: students, organisation, school, and community | Infuse all activities and functions: governance and student representation, curricular involvement, service, and student-oriented projects with the values of REQC whenever possible | Leaders/members are constructively critical of school, organisational and community programmes/activities; and have the initiative to push for relevant, cost-effective, quality, equitable healthcare |
| | | Students participate actively and maximise each occasion to promote REQC in school, in the community and in whatever opportunity; contribute to the school/institution’s fostering of REQC in its domains: education, research, service | Members develop a habit of practicing the REQC values |
| | | Enjoin members and the whole organisation to a long-term commitment to pursue and direct efforts to the attainment of relevant, cost-effective, quality, equitable healthcare in the community | The institution/school to which the students belong also develop the habit of incorporating REQC values in service, research, education |
| | | Students participate actively and maximise each occasion to promote REQC in school, in the community and in whatever opportunity; contribute to the school/institution’s fostering of REQC in its domains: education, research, service | Priority health concerns of the community, region, and nation are addressed; high quality healthcare delivery is promoted; cost-effective healthcare is realised; healthcare delivery to the underserved and marginalized is encouraged. |
Conclusion

Directing student organisations’ efforts to become more socially accountable is a wise move. Students are malleable in their formation, and social accountability is a noble concept to accept and be infused with. As an institution, universities emphasizing social accountability will graduate physicians imbued with the core values of relevance, cost-effectiveness, equity, and quality. Hence, a culture of social accountability is engendered.

A guide on becoming socially accountable will be helpful. Who will have the interest in measuring the social accountability of medical student organisations? Greatly the students! But the more apt answer is everyone, as everyone is also concerned with bannering the social accountability of the institution which they are part of and shaping.

References


Ryan Camado Guinaran | Student, UP College of Medicine, Philippines; Past Regional Representative for South East Asia of SNO
Email: docryan02@yahoo.com

Table 2. Measuring the social accountability of medical student organisations: Some general guidelines

<table>
<thead>
<tr>
<th>Core values: Relevance, Equity, Quality, Cost-Effectiveness (REQC)</th>
<th>Planning Phase</th>
<th>Doing Phase</th>
<th>Impacting Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intent for advocating relevant, equitable, cost-effective, high quality healthcare and active participation in that pursuit is emphasized in the organisation’s oath of office, leader’s code, principles, mission-vision, constitution and by-laws, goals, declarations, manual of standard operating procedures, policies, tasks, agenda, and action plans</td>
<td>Setting a forum for institutionalisation of genuine student representation and participation in school’s domains of education, research, service and proposing such participation if no such venue exists</td>
<td>Evidence of increasing number of students/organisations committed to REQC values</td>
<td></td>
</tr>
<tr>
<td>Preparation of well-studied and student-initiated resolutions, project proposals dealing with organisational domains and school domains (quantity and quality)</td>
<td>Attendance in meetings/activities of the organisation and of the school especially when agendas are in line with the REQC goals; regular workshops, orientation, trainings for promoting and practicing the REQC values</td>
<td>Administrators/educators recognise value of working with students (and vice versa) in teaming up for sustaining REQC in institutional domains</td>
<td></td>
</tr>
<tr>
<td>Drafting of a standard policy of the organisation (and adherence to it) on how to best represent students and how to effectively communicate student inputs in service and curricular matters for the REQC goals</td>
<td>Adoption of student-friendly and student-oriented policies that facilitate student programmes geared on REQC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quantity and quality of proposed reforms, proposals or changes from students that emphasize REQC which gain acceptance/approval from all stakeholders</td>
<td>Health indicators on REQC in the community are promising and improved</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AS AN INSTITUTION, UNIVERSITIES EMPHASIZING SOCIAL ACCOUNTABILITY WILL GRADUATE PHYSICIANS IMBUED WITH THE CORE VALUES OF RELEVANCE, COST-EFFECTIVENESS, EQUITY, AND QUALITY.
During the first three years of the medical curriculum of Maastricht University, all students have simulated patient encounters in pairs once every three weeks. However, in that wealth of experience few contacts deal with intercultural communication. The Skillslab, where these encounters are organised, have very few simulated patients from other cultures, which is a pity for the nineteen medical students that participate in a longitudinal elective (International Track in Medicine) addressing international aspects of health care.

The international Master of Health Professions Education programme (MHPE) exists in the same school. Although this programme is largely conducted as distance education, two units of six weeks take place in Maastricht. In the second of these units the students address skills training and the way skills can be integrated in the other aspects of a curriculum. The teaching format Simulated Patients is an important aspect of that unit.

Patient-Doctor Role Play

To be consistent in our approach to experiential learning, we offered the Master students the opportunity to experience what it is like to be a simulated patient. The roles were played by four Master students (Linda Prescott Clemens from the UK, Ibrahim Durak from Turkey, Akshaya Gautam from Nepal, and Claudio Owino from Kenya), while the second year medical students from the Internationalisation elective played a doctor.

The Master students/simulated patients played two roles in two different weeks. The first scenario involved their own interpretation of the flu. I am a foreign student of a prestigious Master programme, stuck in Maastricht for six weeks. I am only in the second week. I don't feel well at all. The culture is different, I miss my family. Variation A: can I see a specialist? Variation B: should I go home? Variation C: can you help me write a note for the course director? Variation D: please give me antibiotics or anything else that will help me get rid of the flu quickly.

The second scenario had pneumonia as diagnosis. The ‘patient’ now was an employee of a big firm, living with his/her family in the Netherlands for nine months. The cultural differences between home and the Netherlands were well noticed. The individual variations were: A: I want to see a specialist; B: I want a prescription; C: I am very much afraid that these symptoms indicate AIDS; and D: can you help me find a temple where I can offer to the Gods to relieve my symptoms.

The students conducted doctor-patient encounters by themselves, while these were recorded on video. During the week after the consultations the videos were individually seen by all students and two teachers. This way, the students could compare the cultural aspects that coloured the presentation of the complaint. In two meetings, one week after each consultation, these cultural aspects were discussed.

Results

After the first encounter the students remarked that the ways of presenting were actually not so different from the variation in Dutch patients. The main outcome was that they had practised conducting a consultation in English. The more subtle cultural differences in presentation had not been recognised. After the group discussion, in the second consultation, these were recognised and very well handled. The students reported a large learning effect of the two consultations.

The students gave the following formal feedback:

<table>
<thead>
<tr>
<th>Simulated Patients</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Played their roles very well.</td>
<td>4,05</td>
<td>1,03</td>
</tr>
<tr>
<td>Provided useful feedback.</td>
<td>4,00</td>
<td>0,88</td>
</tr>
<tr>
<td>Provided constructive feedback after the role-plays and tapes.</td>
<td>4,58</td>
<td>0,61</td>
</tr>
<tr>
<td>Stimulated discussion about psychological/communication skills.</td>
<td>4,26</td>
<td>0,81</td>
</tr>
</tbody>
</table>

The Master students reported that this experience helped them to appreciate the level of preparation, empathising, feedback skills and debriefing opportunity that has to be realised when organising simulated patients encounters in their own schools.

All involved feel that this has been a worthwhile experience, in which both the medical student (‘doctors’) and the MHPE students (‘patients’) benefited equally. We look forward to next February when this small project will be repeated.

Jan van Dalen | MHPE Coordinator, Maastricht University, the Netherlands
Email: j.vandalen@sk.unimaas.nl
How do students from all over the world perceive the educational programme at their Faculty, or the educational system in their country? How do they see the future, for their nation and for themselves? And what changes would they make, if they had the chance? We wanted to know. Therefore every Newsletter December edition we ask a student five questions. The extended version of this interview has been published in Volume 17, No 3 (November 2004) of the Network: TUFH journal *Education for Health*.

**The Big Five**

This interview was conducted with Thelma John, 3rd year medical student at the Christian Medical College in Vellore, India.

**Why did you choose to study medicine?**
In my country, if you want to be a professional, you need to plan a career like medicine. When you are 15 years old you must decide between a Science and an Art Stream. I have always liked science better, so I chose Science. Because I liked biology, I chose medicine.

In medicine as a profession I could find a place to work and be useful. As a doctor you can probably get a job anywhere, but I would like to find a job that is especially satisfying. You don’t just do the work because it pays well, the reward is in more than money. I think I will find the interaction with patients the most gratifying part.

**Do you ever get in touch with the community?**
Our curriculum includes a big community health component. For example, at the end of the first year, we have a one-month posting where we go out in the village. Along with staff members, we went house by house and collected data by interviewing about 1800 people. When you see the people in their home settings, you learn things you never see when they come to the hospital.

In addition to the home visits, we do vacation postings in more rural areas. The school environment can be very protected, compared to the real world. But eventually we will work in ‘the real world’. Our school didn’t want reality to be a big shock for us, they wanted to prepare us for the real world. They decided to send us to nine hospitals all over India, some as far as 3000 km away. In the vacation time we went to these rural places, poorly developed areas and hospitals all over India. These were mainly smaller hospitals, most without equipment like CT scans. We analysed the health situations that caused health problems. We directly observed the situation there and we helped to intervene. And we worked at different hospitals, so that we could also observe the differences. It was a very good way of learning.

I think we should always incorporate community health in our work. Only 30% of the patients in India live in cities. All others have a rural background. We have to realise that, or else our health care system will suffer.

**What part of your study was the most educational to you (e.g. internship, research or being ill yourself)?**
So far I liked the clinical study best. We could use the preclinical subjects at the bedside, while being with the patient. Getting to know the patient, appreciating the patient’s problem, learning about the kind of help the patient needs - for me that is the best part of medicine.

**What would you change if you were Dean of your Faculty?**
Medical schooling in my country is quite organised. The students don’t go out into the community so much, so we don’t know much of what is happening outside. Our College is quite big, and we are welcome in many places, but we don’t go out to many programmes. I cannot really call it community-based. And I would like to introduce more research into the curriculum. I would like to conduct curriculum research in the community. We should publish more. I witnessed at the Network: TUFH Conference, that students can actually influence their institutions.

We do have feedback programmes, and the administration responds. They do ask us about different things and they respond to us. But it could be more outgoing, more relaxed.

Imagine if you were to choose: to work in a city hospital or in the community. What would you choose and why?

I would like to go into clinical medicine, to be with patients. I want to look at different specialities, which I can do in the next two years. Even though I would like to work in the community, the choice between the hospital and the community will depend on what direction I will take. If for example I choose to go into surgery, I will have to work in a hospital. But I haven’t decided yet. If I would go to work in a hospital I would choose a smaller hospital. A smaller hospital is like a big family.
Diary 2005

23 - 28 February, 2005, Khartoum, Sudan
First International Conference on Medical Education Reform. Organised by Educational Development Centre for Health Professions (EDC), Faculty of Medicine, University of Khartoum, Sudan. Further information: fax: 249-183-778570; email: crdmed@ismailia.ie-eg.com

24 - 25 February, 2005, London, United Kingdom
International Conference: Higher Education in Developing Countries: With a Focus on Muslim Contexts. Organised by the Institute for the Study of Muslim Civilisations ans Aga Khan University. Further information: email: conferences.ism@aku.edu; Internet: www.aku.edu/news/seminars/hedc

7 - 13 March, 2005, Ismailia, Egypt
19th International workshop on "Community-based Education incorporating Problem-based Learning” Innovative Approaches. Organised by Faculty of Medicine, Suez Canal University, Ismailia, Egypt.
Further information: fax: 2-064-329448; email: org@edc-sudan.org; Internet: www.edc-sudan.org/conf/conf.htm

17 - 18 March, 2005, Maastricht, the Netherlands
International Visitors Workshop: A Primer on the Maastricht Approach to Medical Education. Organised by Faculty of Medicine, Maastricht University. Further information: Workshop Secretariat, Office for International Relations, Faculty of Medicine, Maastricht University, PO Box 616, 6200 MD Maastricht, the Netherlands; tel: 31-43-3881524; fax: 31-43-3885639; email: m.stijnen@oifdg.unimaas.nl; Internet: www.fdg.unimaas.nl/bib/workshop

2 - 3 April, 2005, Boston MA, United States of America
Unite for Sight 2nd Annual International Conference - Eyes on International Collaboration: Promoting Health from Campus to Lab to Field. Organised by Unite for Sight, USA. Further information: email: jstaple@uniteforsight.org; Internet: www.uniteforsight.org/2005_annual_conference.php

3 - 6 April, 2005, Miami FL, United States of America

31 May - 3 June, 2005, Washington DC, United States of America

6 - 9 June, 2005, Lathi, Finland
International Conference on Problem-Based Learning. Organised by Lahti Polytechnic in collaboration with Tampere University. Further information: Mr. Timo Ahonen, Organizing Committee, tel: 358-3-8282062; fax: 358-3-8282066; email: Timo.Ahonen@lamk.fi; Internet: www.lamk.fi/pblconferene

20 June - 5 July, 2005, Maastricht, the Netherlands
Summer Course: Expanding Horizons in Problem-Based Learning in Medicine, Health and Behavioural Sciences. Organised by Faculty of Medicine, Faculty of Psychology and Faculty of Health Sciences, Maastricht University. Further information: Summer Course Secretariat, Office for International Relations, Faculty of Medicine, Maastricht University, PO Box 616, 6200 MD Maastricht, the Netherlands; tel: 31-43-3881524; fax: 31-43-3885639; email: m.senden@oifdg.unimaas.nl; Internet: www.summercoursepbl.org

30 June - 3 July, 2005, Beirut, Lebanon
Centennial Nursing Conference: 100 years of Nursing Education at AUB - Pioneering Achievements and Global Vision. Organised by American University of Beirut, Beirut, Lebanon in collaboration with University of California, University of Michigan, University of Pennsylvania and Villanova University, United States of America. Further information: Infomed International for Events, Abi Rached Center, 3rd floor, Jisr El Bacha P.O. Box 90-361, Beirut, Lebanon; tel: 961-1-510881; fax: 961-1-482116; email: medinfo@cyberia.net.lb; Internet: www.infomedweb.com

3 - 5 November, 2005, Vancouver, Canada
International Conference: Where’s the Patient’s Voice in Health Professional Education? Organised by the University of British Columbia. Further information: Internet: www.health-disciplines.ubc.ca/DHCC

4 - 9 November, 2005, Washington DC, United States of America
AAMC (Association of American Medical Colleges) annual meeting. Organised by Association of American Medical Colleges. Further information: Internet: www.aamc.org
Diary 2006

5 - 9 November, 2005, New Orleans LA, United States of America
APHA (American Public Health Association) annual meeting. Organised by American Public Health Association. Further information: Internet: www.apha.org/meetings/

Annual International Conference of The Network: Towards Unity for Health 12 - 17 November, 2005, Ho Chi Minh City, Vietnam
International Conference on Making Primary Health Care Work: Challenges for the Education and Practice of the Health Workforce. Organised by The Network: TUFH and the University of Medicine and Pharmacy at Ho Chi Minh City
Post-Conference Excursion on Community-Based Health Professions Education 18 - 20 November, 2005, Can Tho, Vietnam
Organised by The Network: TUFH and Can Tho University
Further information: Network: TUFH Office, P.O. Box 616, 6200 MD Maastricht, the Netherlands; tel: 31-43-3881524; fax: 31-43-3885639; email: secretariat@network.unimaas.nl

24 - 25 November, 2005, Maastricht, the Netherlands
International Visitors Workshop: A Primer on the Maastricht Approach to Medical Education. Organised by Faculty of Medicine, Maastricht University.
Further information: Workshop Secretariat, Office for International Relations, Faculty of Medicine, Maastricht University, PO Box 616, 6200 MD Maastricht, the Netherlands; tel: 31-43-3881524; fax: 31-43-3885639; email: m.stijnen@oifdg.unimaas.nl; Internet: www.fdg.unimaas.nl/bib/workshop

Diary 2007

21 - 24 May, 2006, New York NY, United States of America
12th Ottawa International Conference on Medical Education. Hosted by C3NY The Clinical Competence Center of New York and SUNY Downstate College of Medicine, USA. Further information: Mark Swartz, Director, Ottawa in New York 2006, C3NY, POB 4568, Grand Central Station, New York, NY 10163-4568, United States of America; email: mswartz@c3ny.org; Internet: www.c3ny.org

Annual International Conference of The Network: Towards Unity for Health 9 - 14 September, 2006, Ghent, Belgium
Organised by The Network: TUFH and Ghent University, Faculty of Medicine and Health Sciences. Further information: Network: TUFH Office, P.O. Box 616, 6200 MD Maastricht, the Netherlands; tel: 31-43-3881524; fax: 31-43-3885639; email: secretariat@network.unimaas.nl

27 October - 1 November, 2006, Seattle WA, United States of America
AAMC (Association of American Medical Colleges) annual meeting. Organised by Association of American Medical Colleges.
Further information: Internet: www.aamc.org

4 - 8 November, 2006, Boston MA, United States of America
APHA (American Public Health Association) annual meeting. Organised by American Public Health Association.
Further information: Internet: www.apha.org/meetings/

24 - 28 July, 2007, Singapore
18th Wonca World Conference: Human Genomics and its Impact on Family Physicians. Further information: fax: 65-6222-0204; email: rccfps@pacific.net.sg

Annual International Conference of The Network: Towards Unity for Health November 2007, Omdurman, Sudan
Organised by The Network: TUFH and Ahfad University for Women, Faculty of Medicine. Further information: Network: TUFH Office, P.O. Box 616, 6200 MD Maastricht, the Netherlands; tel: 31-43-3881524; fax: 31-43-3885639; email: secretariat@network.unimaas.nl

2 - 7 November, 2007, Washington DC, United States of America
APHA (American Public Health Association) annual meeting. Organised by American Public Health Association.
Further information: Internet: www.apha.org/meetings/

It is possible to add events to this International Diary from behind your computer. Information inserted in our website database (www.the-networktufh.org) will be automatically included in the International Diary in the Newsletter.
I think that I met him for the first time in an elevator. Jacobus ‘Co’ Greep was at that time Professor and Chair of the Department of Surgery at Maastricht University in the Netherlands. I was smoking a cigarette. “Whenever we cut open a smoker in the operating theatre, his lungs turn out to be entirely black of tar”, he said to me, looking at my cigarette. A couple of days later I quitted smoking.

Yes, Co could be quite persuasive, and used this skill with great effect as Secretary General of The Network. When he came into office in the beginning of the eighties, it was a small organisation of 20 medical schools dedicated to the idea of making health professions education more relevant to the needs of the population. When he left office, in 1987, The Network had grown to consist of more than 100 member schools. The organisation initially had some support of the World Health Organization, but its means were so limited that it could barely survive. Co ensured adequate funding of the organisation’s secretariat, provided by Maastricht medical school. This arrangement has proven so well entrenched that it still exists, 25 years later. As an educational innovator, Co Greep proved to be particularly successful in the Easter-Mediterranean region and on the Arab peninsula. Several new schools, notably in the United Arab Emirates and in Egypt, initially solicited his help with the development of their curricula and are now educational leaders in their own right.

On the home front he was equally influential. He has been involved in the development of Maastricht University from its very beginning in 1974 and is considered one of its founding fathers. In 1978 he became Dean of the medical school. His relentless support for the educational innovation pursued by his school has highly contributed to its national acceptance and later international fame. Yet his greatest success is considered to be his turnaround of the regional and conservative St. Annadal Hospital in Maastricht into a truly academic hospital.

We will sorely miss Jacobus Greep. Not only because he was such talented innovator. Not because he had that imposing personality that made his ‘Co’-workers work their heart out to help him accomplish his goals. Not because he took himself very seriously (which he did). But also because he was a man full of self-depreciating humour, witty, light-hearted, and caring for those around him. Our thoughts are with Nel, his wife.

Henk Schmidt | Former Secretary General
The Network: TUFH, the Netherlands
Email: schmidt@fsw.eur.nl

Obituary of
Dr. Jacobus M. Greep

The EC has formed a Strategic Planning Committee to propose guidelines to enhance the Network: TUFH to better meet its mandate. The Strategic Planning Committee will consist of the following EC members: C. Boelen, L. Feuerwerker, P. Frazzica, T. Harsono and will be chaired by the Secretary General A. Kaufman.

The Network: TUFH Membership application forms have been adapted. New versions are available through www.the-networktufh.org/home/form.asp

Constitution and By-laws
At the last General Meeting held in Newcastle, Australia the EC presented slightly modified versions of the Constitution and By-laws. However, the Full Members expressed their preference to change the composition of the EC to represent the (WHO-defined) geographical regions of the world. Therefore, the proposed texts were withdrawn to allow for the preparation of new ones, to be subjected to voting by postal ballot. In its subsequent meeting the EC added its preference to also confer voting rights to Associate Members.

In a postal ballot - that was organised in the Summer of 2004 - the Full Members (until the only members with voting rights) have adopted these Constitution and By-laws. Constitution and By-laws as approved by the Network: TUFH members are now available at www.the-networktufh.org/about_us/missionstatement.asp

For those who do not really enjoy reading this sort of literature we have tried to summarise those changes that are not just semantic.
Summary

Constitution

The potential membership categories of The Network: TUFH have been expanded to encompass ‘individuals, groups, institutions and organisations’. The Network: TUFH’s aim focuses on ‘health in the communities’ through advancing ‘the performance of health services, development of health policies, health professions education and research related to these areas.’ (Article 2)

International conferences are considered just one of the means to attain the Network: TUFH’s objectives. Hence the gist of the former Article 5 of the Constitution was included in Article 2 of the By-laws.

Next to Full Members also Associate Members will have voting rights (Article 5.1). The remaining prerogatives of Full membership have been listed in Article 3.5 of the By-laws.

Apart from the Officers the EC is proposed to be composed of members representing the seven regions of the world as determined by the World Health Organization (WHO; Article 8.2). Therefore, the maximum number of EC members has been expanded from six to seven. However, in theory a region may fail to present a candidate or an elected EC member may withdraw between elections. Hence the minimum number of five EC members (Article 8.1).

Decision-making in a General Meeting or in a postal ballot by representatives of Full and Associate Members occurs as follows.

Ordinary Decisions

In a General Meeting (if correctly announced according to Article 5.2) no quorum is required. Decisions can be taken by a simple majority of votes. In a postal ballot at least 50 per cent of the Full and Associate Members must cast their vote. The proposal presented can be accepted by a simple majority of votes (Article 5.6).

Changes in the Constitution and Dissolution of the Association

Decisions pertaining to these issues can only be taken by the General Meeting (which may decide to do so by postal ballot). In both cases a quorum of at least 50 per cent of the (representatives of) Full and Associate Members is required. Among those casting their votes a two / thirds majority of votes is required to accept the proposal (Articles 12 and 13).

By-laws

The objective addressing health services and health policy development was rephrased as: To improve community health by promoting socially accountable health systems that pursue quality, equity, relevance, and cost-effectiveness (Article 1).

Means to attain the aims (Constitution Article 2) and objectives (By-laws Article 1) of The Network: TUFH have been expanded by incorporating those previously formulated by TUFH (Article 2b-f) and the organisation of international conferences (Article 2g; former Constitution Article 5).

The criteria for acceptance of Full and Associate Members have become the same and therefore had to be restricted as compared to the criteria previously applied to Full membership applications (Article 3.6). However, applications for Full membership are examined by the EC; those for Associate membership by the Secretary General who may consult the EC member from the pertinent WHO region (compare Articles 3.3 and 4.3). Furthermore, every fifth year Full Members will be subjected to a reassessment procedure (Article 6).

The assets of Network: TUFH membership for each category of membership are: ‘Common assets’ for Individual, Associate and Full Members are (Article 8.4a-d): free subscription to The Network: TUFH Newsletter; announcements of Network: TUFH meetings and conferences; e-mail alerts; access to Network: TUFH listservs; in addition to these common assets Individual Members are offered reduced subscription fee to the Network: TUFH journal Education for Health.

Associate Members have: voting rights; one free subscription to Education for Health; free on-line access to Education for Health for two individual staff members (Article 4.4).

Full members have: voting rights; two free subscriptions to Education for Health; free on-line access to Education for Health for four individual staff members or through an Internet Protocol (IP) domain for the whole institution, organisation or group; Full Member certificate; inclusion in the Network: TUFH’s catalogue; external audit in the framework of the Full Member reassessment procedure and Network: TUFH accreditation; eligibility to host a Network: TUFH General Meeting plus conference (Article 3.5).

The specified option to invite e.g. representatives of WHO Regional Offices as observers to the meetings of the EC was eliminated (former Article 11.1).

Production of an annual statement of accounts has been linked to the drawing of a budget plan (11.1d); the provision of a biennial report of activities was eliminated (former Article 11.2f).

It has been formulated now that the Executive Director co-ordinates the daily activities of the Office (Article 16.1).
MEMBER AND ORGANISATIONAL NEWS

MESSAGES FROM THE EXECUTIVE COMMITTEE

To learn more about the personal believes, motivation and goals of our EC Members, we have invited Paul Grand’Maison - Undergraduate Medical Education Dean at the Faculty of Medicine, University of Sherbrooke, Canada, and EC member of The Network: TUFH since 2002 - to share his thoughts with us.

EC Intelligence

Regarding the practice of Medicine, I strongly believe in the importance of primary healthcare as the central focus of any healthcare system. Primary care practitioners - and more specifically family physicians - have a pivotal role to play in order to ensure optimal patient-centred care to individuals and their families, as well as community-oriented care to populations. They foster community-based and comprehensive care, health education and disease prevention, interdisciplinary teamwork, and integration of public health to medical care.

Medical education should be socially accountable. It should be student-centred and focussed on the student’s development of competency and problem-solving skills. Innovation in curriculum and community-based education are necessary to ensure the relevance of medical education and the development of graduates’ capabilities to respond to the needs of individuals and communities they will serve. Faculty development is an essential prerequisite to attain these objectives.

My philosophy regarding academic administration is epitomised by terms such as daring in vision, wisdom in decision, determination in action, and rigor in evaluation. Responsibility, accountability, teamwork, partnership, lessons learning and sharing are other characteristics of medical education.

N is for Network

During the last Network: TUFH Conference, we celebrated the 25th anniversary of The Network. Participants also reflected on the future five years of The Network: TUFH. At the end of the discussions, we tried to summarise this future. Participants who were there may remember that I presented my vision of what should be The Network: TUFH in the next five or ten years, using each letter of the word NETWORK to identify one orientation. Even though this might be a repetition for those people who were at this meeting, let me use again this approach to convey what I think should be the future of The Network: TUFH.

N for Network – Networking has been one of the major strengths of the organisation. This should continue to be so in the future. Bringing people from different backgrounds together, having them to collaborate, developing specific interest groups, ensuring mutual support from members of the organisation, and optimising links among them, are just a few of the actions that should be done by our organisation.

E for Evaluation – Our organisation should rigorously assess the impact of its activities, actions, partnerships, projects, et cetera. This assessment should cover process and outcomes, including the impact of the activities on the healthcare system and on the health of people served. It is only through this rigorous assessment that the credibility of our organisation will be maintained - and even increased - among its members and partners.

T for Team – The Network: TUFH should promote, foster and implement working in teams among its members, but also with other like-minded non-governmental organisations and stakeholders. Teaming up should be the motto.

W for Wild – The Network: TUFH should not lose the ‘wildness’ that characterised its initial establishment. It should keep its informal and non-traditional nature of working. It should experiment new models of actions, partnerships and of healthcare organisations, and implement creative ideas in concrete actions to face new challenges.

O for Organisation – The Network: TUFH should be organised through confirmation of its mission, engagement towards basic principles, long-term planning, development of policy statements, assessment of actions, etcetera. Links with other organisations should be fostered and nurtured. Membership should be increased.

R for Responsiveness – Being open to identify the needs of individuals, communities or systems that it has to serve, The Network: TUFH should continuously strive to better understand these needs in order to implement more responsive actions. Without responsiveness, any organisation will rapidly become obsolete.

K for Known – The Network: TUFH should become better known to its members (being individuals or organisations), to the members of these organisations and to all other organisations that can become partners. The Network: TUFH should market its role and activities, and has to become more visible at national and international level.

Dr. Paul Grand’Maison

To HLT-Net Listserv

The Network: TUFH Executive Director will look into postings that she receives. If she doubts whether or not a posting can be put on the hlt-net listserv she will consult with the Secretary General and Chairman. If a message cannot be accepted for posting to the hlt-net list the applicant will be informed.
Multiprofessional Education Taskforce: Update

The Multiprofessional Education taskforce convened a PEARL session at the Network: TUFH Conference in Atlanta on October 8, 2004. To our great delight, more than 25 people attended representing a wide diversity of countries and programmes. We used the session to share our educational experiences, and to identify future directions for taskforce activities. Here is a summary of our lively discussion.

We raised questions and concerns about terms currently used (e.g. multiprofessional versus interprofessional). Clarity concerning terminology is needed if we are to foster understanding of programmes and outcomes. Although we are currently called the ‘Multiprofessional Education taskforce’, many of us feel that the interactive and collaborative nature of our interests and programmes is better described by the term ‘interprofessional’, and that is the term that will be used throughout the rest of this update.

We would like to share programme descriptions with each other. Instead of feeling compelled to develop programmes from scratch, we can benefit from each others’ experiences with interprofessional programme designs and activities. We want to describe programmes in a continuum of settings (e.g. everything from early undergraduate educational courses to interprofessional practice teams). Additionally, we discussed the importance of clear, comprehensive programme evaluation instruments and designs.

We recognise the need to identify principles, guidelines, theoretical frameworks and factors that enable, sustain, and/or block development and maintenance of interprofessional education and practice. We raised a variety of questions such as: What research has been done concerning interprofessional education and what is the impact? What is the evidence of its effectiveness? What are the benefits, and to whom? How do particular environments affect delivery or outcomes of interprofessional education and what types of educational methods and systems are the best match?

As one can see, the focus of future taskforce activities is unfolding through sharing and discussion. We hope to identify interprofessional education as one of the themes at next year’s Conference in Vietnam. We also plan to add a page to the Network: TUFH website that addresses interprofessional education. The emphasis will be a discussion board, and links to other pertinent websites and resources. We are fortunate that colleagues around the globe have been studying and writing about interprofessional educational topics. The key is to identify existing resources and determine effective ways to disseminate and make them available to all. You are all invited to participate in the growth and maturation of the taskforce. Please feel free to contact me with questions and ideas.

Betsy VanLeit | Chair, Multiprofessional Education Taskforce; Director, Rural Health Interdisciplinary Programme, University of New Mexico, United States of America
Email: bvanleit@salud.unm.edu

AN OVERVIEW OF THE TASKFORCES
• Women and health (see this page)
• Strategic partnerships
• Rural health/health indigenous communities
• Multiprofessional education (see this page)
• Integrating medicine/public health
• Community-based care for the elderly

WOMEN & HEALTH LEARNING PACKAGE
The Network: TUFH Women & Health taskforce is pleased to announce that the Women & Health Learning Package (WHLP), a collection of innovative women’s health learning modules developed and produced by members of the taskforce, is currently being piloted by health sciences schools in seven countries. This piloting process is the most recent step in efforts to incorporate women’s health and gender issues into medical and health professions education in developing countries.

The Women & Health taskforce, founded more than a decade ago, is comprised of a group of individuals committed to equipping healthcare providers in developing countries with the skills and knowledge necessary to address critical gender-related health issues. At the Network: TUFH annual Conference held in Eldoret, Kenya in 2002, taskforce members decided to use their collective resources and experience to address the need for appropriate curricula on women’s health issues in health professions teaching institutions in developing countries. The WHLP modules, developed by and for professionals in developing countries, focus on the social and economic context of women’s health concerns and prepare healthcare providers to act as well-informed advocates as well as caregivers for women in underserved communities in developing countries.

Modular modules in the WHLP address issues including adolescent health, contraceptive practices, gender and health, violence against women, unwanted pregnancy, and unsafe abortion.

With funding and coordinating assistance provided by Global Health through Education, Training and Service (GHETS), the taskforce conducted a mini-grants competition in 2004 to identify qualified institutions to pilot the WHLP. Pilot sites were selected on the basis of their commitment to working with underserved communities, their dedication to addressing women and health topics and/or gender as part of the instruction of health sciences students, and the extent to which...
the WHLP would be an innovative addition to their existing curriculum.

After a thorough review process, seven institutions were ultimately selected as pilot sites for the WHLP: Ahfad University for Women, Sudan (Farouk Abdelaziz Ibrahim, Dean, School of Medicine), Mahatma Gandhi Institute of Medical Sciences, India (Birshan Swaprup Garg, Professor and Head, Department of Community Medicine), Makerere University, Uganda (Elsie Kiguli-Malwadde, Senior Lecturer, Department of Radiology), Maseno University, Kenya (Rosebella Onyango, Director, School of Public Health and Community Development), Suez Canal University, Egypt (Amany Refaat, Associate Professor, Community Medicine), Universidad Autonoma Metropolitana-Xochimilco, Mexico (Deyanira Gonzalez de Leon, Full Professor, Department of Health Care, Division of Biological and Health Sciences), and Ziauddin Medical University, Pakistan (Sadaf Khan, Assistant Professor, Department of Community Health Sciences).

The seven pilot universities were awarded small grants to help defray the costs of implementing the modules and were also invited to participate in an implementation workshop in Atlanta, Georgia just prior to the annual Network: TUFH Conference in October. The implementation workshop was an opportunity for module authors, representatives from pilot universities and coordinating staff to meet each other, learn from past experiences, and discuss the process of introducing the WHLP at their institutions. The pilot process has already begun at a number of selected sites.

You can get more information about the WHLP on the Network: TUFH website at: www.the-networktufh.org/publications_resources/trainingmodulesdetail.asp?id=6&t=Training+modules/Curricula

Rachel True and Jessica Greenberg | Programme Coordinator GHETS; Executive Director, GHETS
Email: rachel@ghets.org; jessica@ghets.org

The Faculty of Health Sciences (University of Stellenbosch, Cape Town, South Africa) is situated on the attractive Tygerberg Campus in the attractive Tygerberg Campus – some 30 kilometres from the Main Campus in Stellenbosch. The Faculty buildings are adjacent to the Tygerberg Academic Hospital Complex, and the Tygerberg Children’s Hospital, where students in the different branches of the health sciences receive an extensive part of their practical training. From this huge complex, an average of 170 doctors, 50 specialists and 180 graduates in the allied health professions graduate annually, while more than 400 postgraduate students in various fields are registered at the Faculty at any given time.

As we entered the new millennium, the Faculty of Health Sciences has made important paradigm shifts to prepare its students for the demands of today’s health environment, not only in South Africa, but world-wide. The mission of the Faculty emphasizes the importance of outstanding quality of teaching, research and service to our communities in an African and international context.

Teaching

Recent comprehensive revision of the Faculty’s curricula resulted in greater emphasis on primary healthcare and community health. The new Stellenbosch approach to teaching in health sciences is testimony to modern and international trends. The well-designed programmes ensure that the health professionals are competent and well-equipped to hold their own in any situation anywhere in the world. However, it also ensures that they are equipped with specific skills to meet the urgent health needs of South Africa and Africa, especially in rural, under-sourced settings typical of the African context.

Admission to the programmes offered on the Tygerberg Campus is dependent on a selection process. An Academic Development Programme, which includes special remedial and supportive modules, greatly facilitates the successful enrolment of academically disadvantaged students who do not qualify for direct entry into the mainstream programmes. The Faculty offers excellent and exciting curricula to prospective students through schools that embrace various health disciplines at the undergraduate and postgraduate level: School for Basic and Applied Health Sciences (physiology, biochemistry, anatomy and histology, pharmacology, and the various pathology disciplines), School of Medicine, School for Public and Primary Health Sciences (community health, family medicine and primary care, occupational and environmental health, and nursing), School for Allied Health Sciences (occupational therapy, physiotherapy, nutrition, and speech/language/hearing therapy).

Community Service

Our commitment, however, to optimal health is not only reflected in the Faculty’s academic and research programmes, but also in its many services to the communities served by the Faculty and Tygerberg Academic hospital.

Students enrolled in the Faculty of Health Sciences are introduced to community service as early as their second year on the Tygerberg Campus, and they remain involved with community services throughout their studies.

In concert with the University’s holistic training approach to deliver healthcare professionals for South Africa and Africa, the Faculty of Health Sciences offers all its students training in primary healthcare at peripheral hospitals, health centres, clinics, mobile clinics and even home visits in rural communities, by means of the Ukwanda Centre for Rural Health. Through this initiative, all students are provided with comprehensive community-based training and research opportunities within the fields of medicine, nursing, physiotherapy, occupational therapy, speech/language/hearing therapy, and nutrition.

Thailia Cronje | Marketing Manager, Faculty of Health Sciences, University of Stellenbosch, South Africa
Email: tc@sun.ac.za
RE-ASSESSING FULL MEMBERS

Istituto Superiore di Sanità

The Istituto Superiore di Sanità (ISS, National Institute of Health), Italy, is a public institute that, as the technical and scientific body of the Italian National Health Service (NHS), implements research, experimentation, control, consultancy, documentation and continuing education activities in the broad field of public health.

The Ministry of Health, regional authorities, local health authorities and hospital trusts are the foremost national entities that collaborate with, and receive, technical support from ISS. The mission is set by State Presidential Decree within a framework of functions and activities related to health improvement and protection in such fields as promotion of healthy life-styles and disease prevention, treatment, and rehabilitation.

Education

The ISS provides opportunities of continuing education (CE) for health professionals at national and international levels. The vast majority of Italian CE participants work within the NHS community-based services and primary health care.

The institutional educational programme (certified along the norm ISO 9001:2000) is built on the current National Health Plan and the Priority Educational Objectives as defined by the Permanent Conference State-Regions for the country, epidemiological data, and interrogations of local networks.

The ISS offers short courses on community orientation, community-based learning, and problem-based learning (PBL). PBL has been disseminated as an educational method in various NHS structures for the CE of their personnel. The ISS has brought in the PBL know-how and directly collaborates to implement a university post-graduate course for training of trainers in the health sector (Salesian University, SISF-ISRE, Venice). The ISS administers a Masters level course on health services management and a six-month post-graduate course on poverty as a public health problem (in collaboration with the Faculty of Medicine Rome 1, La Sapienza). Training is offered in several formats, ranging from full residential, to full web-based distance education, with different combinations tailored on clients’ needs and opportunities.

Research

The vast majority of research programmes is devoted to health priorities at national (e.g. child obesity), European (e.g. spongiform encephalopathy), and global (e.g. HIV pandemic and other poverty related diseases) levels.

In 2003 all of ISS laboratories and services contributed at different degrees and levels to the institution’s community orientation through continuing education/research/service activities.

Collaboration

The Office for External Relations (Ufficio Relazioni Estere) belongs to the ISS President's cabinet and is responsible for institutional educational activities, external relations (with NHS structures) and international collaborations. It plans for and implements projects at national and international level that focus on capacity building and technology transfer by means of participative and economically sustainable methodologies.

The ISS, according to its mission, collaborates with the main constituencies of the NHS, such as local health units that directly provide services to the general public, the regional and central authorities that keep NHS management and coordination responsibilities, and scientific entities (like universities and teaching hospitals). Strong collaborations are also existing with consumers associations and a specific non-governmental organisation active in health promotion and disease prevention in such fields as car and domestic accidents, drug abuse, tobacco consumption, metabolic disorders, and palliative and end of life care.

Strong links are also kept with similar institutions at supranational level (international projects) such as: the Ministry of Health of China, the Palestinian Health Authority, the South African Department of Health, and several other public health institutions in Canada, Eritrea, the Great Lakes Region (East Africa), the Balkan area, Central Asian Republics, the USA.

The ISS is actively contributing, at national and international levels, towards the unity and synergy of all the entities and persons that maintain and promote the health of communities.

Ranieri Guerra | Head of Office for External Relations, Istituto Superiore di Sanità, Italy
Email: guerra@iss.it
The Wynand Wijnen Award, and the Wynand Wijnen incentive prizes, have all been presented to its winners. The Medical Faculty, Gadjah Mada University, Indonesia and the Faculty of Medicine, Catholic University Mozambique, Mozambique received their incentive prize in the form of a cheque for €500 and a certificate; the Medical Committee Netherlands Vietnam, the Netherlands received a bronze statue, a certificate and a cheque for €13,000.

Stockholm’s Karolinska Institutet (KI) has awarded for the first time a major international science prize (€50,000) in the field of medical education research. The award is designed to stimulate research in the field of medical education, and in doing so, help to improve medical teaching, training and healthcare provision.

On the invitation of KI, universities around the world nominated candidates for the award. The Prize Committee selected the winner from six finalists from Canada, the Netherlands, UK and USA. The decision was unanimous: KI’s Board of Education and the Gunnar Höglund and Anna-Stina Malmborg Foundation have decided to award the prize to Henk Schmidt, Erasmus University, the Netherlands (and Honorary member of The Network: TUFH) for his outstanding research into learning at all levels, from student to medical specialist. His work included studying student-centred learning, problem-based learning, clinical learning skills, and how people acquire specialist knowledge of medicine. The results of his excellent ground-breaking research efforts have changed medical education around the world.

On behalf of The Network: TUFH, congratulations to Henk Schmidt on this prestigious prize.

MOVING ON: CHANGES IN LEADERSHIP

The Secretariat received information about changes in leadership with the following Network: TUFH members. We have listed the names of the former and new (Vice-) Deans/ Directors for you:

- Dr. Munir Gharaibeh, Center for Educational Development, University of Jordan, Amman, Jordan has been replaced by Dr. Darwish Badran
- Dr. Lourdes Manalo, College of Medicine, Mindanao State University (MSU), Pala-o, Iligan City, Philippines has been replaced by Dr. Angelo Manalo

We are proud to announce that one of our members, Dr. Nada Haffadh, has been appointed as Minister of Health of Bahrain. We are confident that she will do a great job and we wish her, on behalf of the whole Membership of The Network: TUFH, all success.
New Members

Full Members

• Course of Medicine/ Course of Psychology, UNIDERP-Universidade para o Desenvolvimento do Estado da Região do Pantanal, Campo Grande, Brazil
• University of Medicine and Pharmacy at Ho Chi Minh City, Ho Chi Minh City, Vietnam

Associate Members

• Centre for Health Stewardship, Australian National University, Canberra, Australia
• Mahatma Gandhi Institute of Medical Sciences, Kasturba Health Society, Wardha, India
• Command Hospital, Rajiv Gandhi University, Bangalore, India
• Faculty of Community Health, Uganda Rural Health Association, Kampala, Uganda

Individual Members

• Dr. Abdelhamid El-Zoheiry, Faculty of Medicine, Cairo University, Cairo, Egypt
• Dr. Rana Khatib, Institute of Community & Public Health, Birzeit University, Ramallah, West Bank, Palestine, Palestine
• Mr. Khalifa Abdelrahman Elmusharaf, Faculty of Medicine, The Academy of Medical Sciences and Technology, Omdurman, Sudan
• Dr. David Percy, NHSU, London, UK
• Dr. John Beasley, Medical School, University of Wisconsin, Madison, WI, USA
• Dr. Jennie Orr, Allina Medical Clinics/ Lutheran Healthcare: Bangladesh, Hastings, MN, USA

Membership Withdrawals

Associate Members

• Health Sciences Center, University of Colorado, Denver, CO, USA

Membership Expirations

Individual Members

• Dr. Kiragga Dithan, World Bank, IDA Project, Kampala, Uganda

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It is with pleasure that we would like to inform you that the following Full Members have been awarded a continuation of their Full Membership up to 2009:

- Faculty of Medicine, University of Helsinki, Helsinki, Finland
- Medical School, University of Ghana, Accra, Ghana
- Faculty of Health Sciences, Ben-Gurion University of the Negev, Beer-Sheva, Israel
- College of Medical Sciences, University of Maiduguri, Maiduguri, Borno State, Nigeria
- Faculty of Health Sciences, University of Ilorin, Ilorin, Nigeria
MEMBER AND ORGANISATIONAL NEWS

ABOUT OUR MEMBERS

The Network: TUFH has always involved many students in its organisation. Many of those students are young professionals now. In this column we check up with those eager young people of olden days: what has become of them, and how do they look back at their Network: TUFH times?

Network: TUFH Alumni

My first memories of The Network: TUFH go back 10 years, when I was a 1st year medical student at Gezira University, Sudan. It was curiosity that brought me to attend the first inaugural meeting of the Gezira Student Network Organisation (SNO). It never crossed my mind that I would ever consider that day as a landmark in my life!

Leadership

I joined the Executive Committee (EC) of Gezira SNO in 1996 and accepted more and more responsibilities over a three years period. I was honoured to conclude my ‘career’ within the Gezira SNO in 1999 by serving as its Chairman.

In 1999 I had the chance to transcend the national boundaries of student leadership and attend my first Network Conference in Linköping, Sweden. There I was elected as the SNO Representative of the Eastern Mediterranean Region. Our challenge was reviving the SNO.

At the next Conference in Bahrain, I became the Chairman of the SNO. It was a challenging, yet interesting, task to be the student voice in the Network EC. Being part of that EC was an eye opener for me for many new wonderful things, and it gave me the opportunity to ‘exercise’ a range of leadership skills that I had developed earlier, thanks to Gezira.

The Network EC and Secretariat were not only encouraging, but also supportive in many respects. During that time, and thereafter, I had to meet some requests, or challenges, from the Network Secretariat: contributing to the Network Newsletter, leading and moderating a pre-conference workshop, facilitating a conference session and participating in a Position Paper discussion group. I was not only honoured by all these requests, but I also learned a lot from my endeavour to meet them.

Glorious Golden Dawn

Following my graduation in 2000, I joined the Federal Ministry of Health (FMOH) as an intern. After successfully completing this internship, I went on for a similar period of National Service. I spend the first nine months doing routine clinical and administrative work in various settings, but I was extremely lucky to be offered a position of Director of Planning and Monitoring in the Directorate-General of International Health at the FMOH after that. The FMOH introduced me to the world of health policy, planning, financing and management.

After finishing the conscription period, I continued on a permanent basis with FMOH at the same position. At the same time, I started a residency in Community Medicine and Public Health. It was a challenge to strike a balance between a full-time study and a full-time job. My frustration grew, but I carried on, as I have always believed in the motto Every dark night of the soul is followed by a glorious golden dawn.

Few months later I got a scholarship from the World Bank to pursue a Master degree run jointly by two institutions of international reputation. My delight was complete when I was able to attend the last Network: TUFH Conference in Atlanta for a ‘family reunion’. And to celebrate with my ‘virtual’ big family the 25th anniversary of our beloved Network: TUFH.

Proud

Being part of The Network: TUFH has broadened my insight and gave me a more differentiated perspective on healthcare and health professions education. At the Network: TUFH Conferences, I managed to make many good friends from all over the world. I am really proud to be an alumnus of this creative and vibrant organisation, and indebted · beyond words · for what I learned in its conductive environment.

Dr. Emam Hassan El-Emam
London School of Hygiene & Tropical Medicine, United Kingdom
Email: emam.el-emam@lshtm.ac.uk

BEING PART OF THE NETWORK: TUFH GAVE ME A MORE DIFFERENTIATED PERSPECTIVE ON HEALTHCARE AND HEALTH PROFESSIONS EDUCATION.
EU-ASEAN Co-Operation

In January 2004, a kick off meeting to start a collaborative project was held in Bangkok, Thailand. The four project partners were: Faculty of Medicine, Thammasat University, Thailand (host); Faculty of Medicine, Maastricht University, the Netherlands; Royal College of General Practitioners, UK; Faculty of Medical Sciences, National University of Laos, Lao People’s Democratic Republic (Lao PDR).

The project entitled Higher and Continuing Family Medicine Curriculum Development for Rural Physicians in Developing Countries was funded by the ASEAN-EU University Network Programme (AUNP). AUNP is an initiative by the European Union (EU) and the ASEAN University Network (AUN).

Objectives
The programme aims to enhance co-operation between higher education institutions in Europe and Asia, to promote regional integration within ASEAN countries, and to strengthen the mutual awareness of European and Asian cultural perspectives.

The two-year project has two main objectives: to train regional doctors of Lao PDR and Thailand to be potential medical educators/facilitators; to develop and implement an In-service Rural Family Medicine Training Curriculum, relevant and applicable to the needs and constraints of rural physicians.

Project Action Framework
The European experts in medical education and General Practice/Family Medicine have trained doctors working in regional or provincial hospitals in Lao PDR and Thailand in the principles and theories of education. They have guided these doctors through the concepts and processes of curriculum development. The doctors will now develop an In-service Training Curriculum in Family Medicine for other rural doctors in the two countries.

The first and second Train the Trainer workshops were held in May and July 2004, in Bangkok and Vientiane respectively. The educators and family doctors from Maastricht University (Gerard Majoor, Niels Chavannes) and from Royal College of General Practitioners (Rosslyne Freeman, Mei Ling Denney) planned and conducted both workshops. The last workshop was in November 2004 with Rosslyne Freeman and Majid Jalil as tutors.

Conclusion
The curriculum developed will seek approval from higher education institutes of Lao PDR and Thailand. The trained regional doctors will be the local facilitators for trainees after the curriculum has been approved and implemented.

With technical support from the two European partners and financial support from AUNP, it is hoped that the appropriate training of rural doctors will improve their professional opportunity (especially the continuing education) and, to some extent, improve the health of rural people in Lao PDR and Thailand. Nonetheless, the project will strengthen co-operation between higher education institutions among the four countries.

Workshop on medical education for ‘trainers’, Bangkok, May 2004

Workshop on curriculum development, Vientiane, July 2004

Nitaya Wongsangiem | Assistant Professor, Family Medicine Division, Faculty of Medicine, Thammasat University, Thailand
Email: nitaya@alpha.tu.ac.th
About Our Members

Occasionally the Network: TUFH Alert is being used for members who are asking for help from the Network: TUFH membership. Here we give you the results from these ‘quests’. Dr. Pham Thi Tam was looking for PBL curricula of universities world-wide.

Members Helping Members

Dear reader,

One of our University’s goals is to qualify medical graduates who will mainly work at district and community level, with an awareness of the common health problems in the region. This in order to provide healthcare to populations effectively. To achieve this goal, the Can Tho University of Medicine and Pharmacy (CTUMP) has revised the six-year conventional curriculum into an organ-system block-teaching curriculum.

Presently the CTUMP leadership has a strong intention to proceed to a Problem-Based Learning (PBL) curriculum in the near future. To achieve this aim, for reference we would like to receive some PBL curricula from universities of different continents (such as USA, Europe, Asia, Australia, and Gulf area).

Pham Thi Tam | Medical Doctor, International Collaboration Office, Can Tho University of Medicine and Pharmacy, Vietnam phamttam@ctu.edu.vn

Dear Dr. Pham Thi Tam,

I read of your request sent through The Network: TUFH. Before I retired in 2001, I was a leader of innovative curricula in the Faculty of Health Sciences, University of Ilorin and College of Health Sciences Lautech Ogbomoso (both in Nigeria).

You have made contact with an organisation that has a reservoir of materials and experience in various forms of innovative curricula. My immediate contributions are as follows: obtaining PBL curricula alone will not be sufficient. Nothing can match or replace experience. I therefore suggest exposure to the operation of a successfully run PBL curriculum in one the schools in your region or nearest to you, or if you have funds as may be recommended by The Network: TUFH. You can then see the curriculum in action, participate in it, collect as much information as you require; I suggest that you add community-based programmes into the community, since you indicated the objective is for the medical graduates to work in district and commune level; whatever you do must be relevant to your setting.

With best wishes.

Olatoye Ogunbode | Retired, Faculty of Health Sciences, University of Ilorin and College of Health Sciences, Lautech Ogbomoso, Nigeria. toyefam@skannet.com

Dear Dr. Tam,

I am happy to hear about the venture to introduce PBL to your curriculum. If there is a determination to do so, you should have no difficulty. It should be implemented while considering the following four questions.

• Are you hoping to structure your entire curriculum on PBL? If so, you are thinking of a series of blocks throughout the 6 years (4-6 weeks maybe) and the entire programme for the 4-6 weeks based on a single or closely related problem. This will integrate your programme vertically and horizontally. This is the more ambitious method of conducting PBL.

• How can you produce problems for the course? This is a difficult area to learn and some degree of creativity is necessary based on the local context. Also the problems should be tailored to suit your resources. Some universities have very elaborate problems.

• How about resources? This is a question for the administration. We in Sri Lanka have had to face several problems because there is a lack of resources. For example, there must be adequate rooms for small group discussions, to house about 10 students each. This means for a university with an intake of say 100 students per year, you are thinking in terms of 600 students needing rooms for small group discussions, self-study and learning resources. The learning resources too have to be written by you to suit your need. Currently most textbooks are based on disciplines and therefore the student has to read many books to integrate his/her knowledge around the problem. Teacher training is extremely difficult, especially because they have been trained in a traditional based curriculum.
• What about management of change? You need expert advice from the management sciences in this. If you are shifting towards a PBL curriculum, you are basically thinking of changing the structure of your university from the standard discipline based departments to a new structure. This is a form of task-oriented management seen in the corporate world. It will be extremely difficult for teachers to function effectively in the PBL curriculum, while sitting tight in their individual departments such as anatomy et cetera. Traditionally, it has been the departments of anatomy, pathology and surgery who have resisted change. This I believe has a historical reason, because medicine evolved from anatomists and dissections, pathology and surgery. This structure-based development is now being challenged by a more functional and integrated approach by PBL.

If you are thinking of getting foreign training for your teachers, the best place to get the educational psychology of PBL is Maastricht in the Netherlands. Regards and best wishes,

Saroj Jayasinghe | Associate Professor, Department of Clinical Medicine, Faculty of Medicine, Sri Lanka
sarojoffice@yahoo.com

Dear members of The Network: TUFH,

Shortly after my request was launched I received many supporting emails from you. You not only shared with me your experience in PBL - and encouraged me to proceed in PBL - but you also provided me with a lot of electronic and hard materials. I highly appreciate your assistance, enthusiasm and friendliness. I found that to be a member of The Network: TUFH offers good possibilities to share and to learn from each other, regardless how far we are from each other. My sincere thanks for all the support that I have received from you.

Pham Thi Tam

"I salute the important work that you are doing - and have done during your 25 year history - for improving the health of communities through work in health services, education of health professionals and research."

Daniel López Acuña | Pan American Health Organization, United States of America

"Being an inhabitant of Saudi Arabia, it was impossible for me to get a visa to the USA. I was deeply sad to miss the Network: TUFH Conference and the 25th anniversary celebrations. I would like to take this opportunity to congratulate The Network on its marvellous achievements during the past 25 years. The Network has contributed significantly to the scientific and systematic foundation of educational approaches as PBL and CBE. The pillar goals and ideas of The Network are now widely disseminated and adopted by various educational institutions all over the world. Congratulations!"

Mohi Eldin Mohammed Ali Magzoub | Faculty of Applied Medical Sciences, King Saud University, Saudi Arabia
I am forwarding this story, because I think this is the way we all should move forward. Otherwise, it is a ‘dog eat dog’ situation today.

Parag Mankeekar | Project Officer, Jnana Prabodhini Medical Trust, India.
Email: Parag@NeetiSolutions.com

A CANDLE LOSES NOTHING BY LIGHTING ANOTHER CANDLE

The story as it happened:
A few weeks ago the National Institute of Mentally Handicapped (NIMH) in Hyderabad (a city in eastern India) had conducted a sports meeting for all the physically and mentally handicapped children at National Stadium Hyderabad.

Nine contestant - all physically or mentally disabled - assembled at the starting line for the 100-yard dash. At the gun, they all started out, not exactly in a dash, but with a relish to run the race to the finish and win. All, that is, except for one little boy who stumbled on the asphalt, tumbled over a couple of times, and began to cry.

The other eight heard the boy cry and slowed down to look back. Then they all turned around and went back... every one of them. One girl with Down’s Syndrome bent down and kissed him and said “This will make it better”. Then all nine linked arms and walked together to the finish line.

Everyone in the stadium stood up, and the cheering went on for several minutes. People who were there are still telling the story. Why? Because deep down we know this one thing: what matters in this life is not winning for ourselves, what matters really is helping others win, even if it means slowing down and changing our course.

If you pass this on, we may be able to change our hearts as well as someone else’s. A candle loses nothing by lighting another candle.