



**XXVII ANNUAL ASPHER
CONFERENCE
2005**



PROCEEDINGS

EDUCATING THE PUBLIC HEALTH WORKFORCE:
DEVELOPMENT PERSPECTIVES FOR THE
EUROPEAN AND MEDITERRANEAN REGIONS

Yerevan, Armenia, September 17-20, 2005

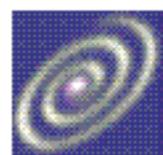


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OPENING CEREMONY

Public Health: **An Armenian Perspective**

1. Introduction

As I was getting ready for this talk, I realized the challenges of speaking in front of such a distinguished audience by presenting something that is new to most of you, has information value, is appropriate for the occasion and more important is not boring. Following some deliberation, I decided to make it personal since you can tell some stories that your audience has not already heard, and make it appropriate by using the country and its people to illustrate some relevant concepts. Thus, the Armenian in my title refers to both the nation and my family name. As a public health professional and researcher my journey over the past 40 years has been weaved with a lot of things Armenian.

Public Health is about people and we hope that over the next few days, you get to be introduced to this country and its people, you may find out about the following facts:

- Armenians have a very rich cultural and written heritage of over 2000 years
- As a country at the crossroads of civilizations it has been a battleground of all super powers throughout history. and as a result the nation has been subjected to a continuous series of massacres and deportations (An invasion every 6 months for over 100 years starting in the seventh century). As in a travelogue, McLean says, Armenians as a nation have developed the art of becoming rich between two massacres.
- The nation has developed one of the oldest Diasporas in world history spanning all major centers of civilization. Examples include the Armenian Kingdom of Cilicia that

turned out to be a most wonderful Mediterranean expression of Armenian culture for over 1000 years before the country was wiped out of its Armenian inhabitants in the First World War. Also, the Diaspora developed major centers where the culture thrived in Amsterdam, Vienna, Venice, Paris, Moscow, Isfahan, Madras, Calcutta, Jerusalem, Cairo, Beirut, etc.

- Thus, despite the tragedies it has faced, this nation has been a major catalyst and contributor to world civilization and the world economy.

As a person, I am the product of the Armenian Diaspora. I was born in Beirut and privileged to get some of the best schooling available in Armenian, French, English and Arabic.

Over the years, whether with my mentors, colleagues, or my own students, I have noted different pathways that led them to choose epidemiology as a career. My choice for a career in public health and epidemiology was made as a medical student in the mid 1960s at the American University of Beirut. In the summer of 1965, I joined a small group of my fellow second year medical students on a research assistance ship with Dr. Nadim Haddad in field studies of the epidemiology of trachoma and its vaccine trials in the southern border villages of Lebanon. This experience was critical for my choice of public health and epidemiology. As one of the first ophthalmologists ever to become an epidemiologist, Nadim was able to get us excited about the whole field and its potential over sandwiches under an olive tree close to the villages where our field surveys and vaccine trials were taking us. I was soon to realize that epidemiology was as “scientific” as what we were exposed to in biochemistry and physiology. This experience had the congruence of fieldwork and a committed mentor and it was definitely more effective than all the lectures on epidemiology and public health that we had in the classroom.

Following graduation from medical school and later from the Department of Epidemiology at Johns Hopkins University with Abraham Lilienfeld as my advisor and a host of leaders in the field as my professors, I was back at the AUB as a chronic disease epidemiologist. Within a year the civil war erupted in Lebanon. The public health and other issues related to the war were very acute and serious. That is when a shift of interest towards the use of epidemiologic methods for studying war related issues as well as disasters started to assert itself in our professional reality. In an active professional life at times you do not have much choice as to the problems you are engaged in. So in an era where education of public health professionals is becoming more specialized, I still believe a general background is necessary for every graduate from our schools.

It was during this period that I developed an outlook in my personal and professional life for difficult times: how to turn a moment of adversity into positive achievement. An adverse and horrible situation like the civil war around us had led many of our colleagues into a long period of professional retrenchment. With Huda Zurayk and other colleagues we developed systems for assessment and investigation of health problems during the war.

In 1988, the massive earthquake in Northern Armenia was an opportunity for the Gorbachev Soviet Union to open up to Western assistance. As part of a diasporan Armenian assistance group we were in Yerevan within 3 weeks of the earthquake. In the absence of any effective health monitoring system in the country, we initiated a rapid case-control study of determinants of hospitalized injuries from Leninakan (Giumri), and within a year we were monitoring the health of about 35,000 people from the earthquake region, as a cohort, for the long term health effects of this major disaster. This latter longitudinal cohort approach was unique not just for Armenia and the Soviet Union but also had not been done on this scale in previous earthquakes. This was also an

opportunity to introduce a number of modern epidemiologic methods to a country in the Soviet Union where epidemiology had a very traditional infectious disease-microbiology base.

In both Beirut during the civil war and in post earthquake Armenia, our investigations were part of surveillance and monitoring systems of the health of the population and would serve the needs for decision making of public health programs in addition to generating a very rich research database. War and disasters are an opportunity to study extreme situations and their effect on disease and health.

During the rest of this talk I will develop the idea that although many of the problems in public health are global, our understanding of the local situation will definitely help us understand and deal with our global problems. My examples will be from the Armenian historical and current context.

A Historical Perspective

I will start my historical retrospective by presenting two Armenians who antedated their time by being at the forefront of public health.

A. Hovannes Tutunji:

Hovannes Tutungi, also referred to as the "oriental" and "Tutunji from Van" in the XVII century Armenian sources, is an unusual priest with an adventurous life story. The word Tutungi in Arabic-Persian means someone who sells or deals in tobacco.

He is probably born in the first quarter of the XVII century since in 1650 he is already a full-fledged priest. In 1650, he is in Constantinople most probably to collect funds for the

reconstruction of the churches of Vaspurakan (Van) region following the earthquake there. In 1662, he is sent as an envoy by the Catholicos of Echmiadzin to collect funds from the Armenian communities of Poland to pay the debts of the Catholicossate. Having made his collection Tutungi goes to Constantinople and gets nominated as the Armenian Patriarch there on two occasions (1663-4 and 1665-7).

In 1678 between September 17 and 27 he appears in Cairo, Egypt, where he is getting ready for a voyage to Ethiopia. On September 27, 1680, having spent exactly two years in Ethiopia, he is back in Cairo and Alexandria and soon he reaches Livorno, Italy, by sea. His travelogue to Ethiopia is one of the most valuable accounts of the time about that region. He is probably one of the earliest non-Africans to have visited and described the sources of the Blue Nile (This travelogue is preserved in two manuscripts in Matenataran-Yerevan and in the Armenian Catholic monastery of Bzommar-Lebanon) *reference*.

Based on a number of references to his name, he probably spends the years 1680 and 1681 in Italy and France. On February 2-12, 1683, he is in the Versailles as a member of an Armenian delegation that meets Louis XIV to solicit support for the liberation of Armenia from the Ottoman rule. (He describes how he accompanies the king in a visit to the gardens of Versailles under construction at the time).

In 1692, Benoit de Maillet, the French consul of Egypt reports to Paris that Tutungi is back in Cairo and provides an account of his earlier two year journey to Ethiopia. In 1698, Tutungi is in Trebizond on the Black Sea where he probably stays as a bishop until his death in 1703.

Two poems from the seventeenth century titled "About Tobacco" and "The Story of Filthy Tobacco" decry the harmful effects of

tobacco in the classical Armenian literature. These poems are unusual in their denunciation of tobacco use. The author of the first poem is identified as Hovannes or John while the second poem is anonymous but also probably authored by Hovannes because of similarity of content and style.

We present here the poem “About Tobacco” that has Hovannes as its author. The clear arguments against the use of tobacco developed by Hovannes in his own time, contain a strong prevention message, more than 250 years prior to any association being established about the relationship of tobacco to major morbidity and mortality. Overall the poem develops a strong argument to stop smoking on religious, moral, economic, and esthetic grounds.

In this brief presentation of what we know about Hovannes Tutungi, we realize that his life was as exciting and interesting as his work. His voyages probably gave him a more universal human perspective than most of his colleagues. He is probably the first person to describe addiction to tobacco and for our purposes his activities spanned all the continents covered by this Conference.

JOHN II
ABOUT TOBACCO

If you ask the Holy Scriptures,
Tobacco is ugly and hideous,
Like bees that escape smoke,
Angels shun its horrid stench.

Any one hooked on tobacco,
Does untold harm to the soul,
Harm to the soul and woe to the flesh,
Sacking his home with his own hands.

Many are forlorn and faltering,
Their homes are bare, nook and cranny,
They have no money to save their soul,
But they do borrow to buy tobacco.

Some remind you of starving dogs,
That roam around from house to house,
Sniffing around to find tobacco,
Their heads covered with ashes.

Others are used to tobacco,
They are sleepless as lepers,

All day, all night or morning,
They can never stop smoking.

The heart blackened in the belly,
The soul deprived of light,
He disregards the day of death,
And does not pray for eternal life.

Many are those who for its sake,
Would set fire to all they own,
steal from home to buy tobacco,
And smoke it in the company of dogs.

They blow smoke from their noses,
Like a black snake from the mouth,
A thousand woes upon their souls,
For carrying out devil's orders.

Some, when sitting at the table,
Do bring forth the tobacco,
And willingly smoke with the Infidel,
Adulterating orally with alien folk.

You, miserable, infirm person,
Do not incinerate your innocent soul,

Do not disavow the wisdom of light,
Reconsider, do not smoke tobacco.

If one foregoes all evil deeds,
Adultery and profanities,
And if one stops smoking tobacco,
One will quickly find redemption.

He who really loves to pray,
And offers alms to the orphans,
Will escape the eternal fire
And inherit the Heavenly Kingdom.

While those with no redemption,
Will never find absolution,
Their sons will eat no other food,
Than what they had with tobacco.

But you, children of the Kingdom,
Do not reside with malevolence,
Smoking the tobacco of corruption,
If you want to remain in Communion.

Because the mouth used to that filth,

That inhales the tobacco of sin,
Is not worthy of Holy Communion,
Such is the evil of addiction.

Many blessings of the Divine
Will descend on those persons
Who will disown that affliction,
And pray to enter into the Kingdom.

Oh John, floating on sin,
Remain awake with your prayers,
Whoever you see smoking tobacco,
Voice your wailing to that person.

Worms will have taken over his soul,
When it is time for the Judgment Day,
Where all creatures will be gathered,
To give account to the last Court.

Standing there, facing Christ
And all twelve apostles,
And church fathers all together,
Ruling on matters concerning all.

The non smoker, the one who repents,

Will be blessed by the righteous hand,
Will hear the voice of the Father,
And will reside with
Abraham.

Translated into English by Haroutune Armenian and Tatoul
Sonentz

B. John Hovannes Wortabet

The second Armenian figure I want to highlight lived about two hundred years after Tutungi. John Wortabet was the son of an Armenian preacher in nineteenth century Lebanon. In 1870, he was one of the professors of medicine at the newly founded medical school of the American University of Beirut. He was probably the first officially recognized epidemiologist from the Middle East, since he was elected to the London Epidemiological Society. His early investigations of epidemics of trichinosis at the sources of the Jordan river were published in the Lancet in the 1880s. He was a model of the physician who went beyond the narrow boundaries of clinical medicine of his time. He developed one of the earliest Arabic-English dictionaries and wrote a series of articles in Arabic in the popular magazines and publications of the time trying to educate the larger population groups in public health and prevention. He also investigated a major epidemic of typhoid fever with a few thousand victims in the city of Beirut following the establishment of a piped water distribution system in the city.

Some Historical Epidemiology and parish records.

One of the problems in public health program development, planning and policy setting that we face in (much of the world outside) areas outside Western Europe and North America is the

absence of valid and dependable vital records that will allow defining priorities and reviewing time trends of demographic, mortality and morbidity indicators. Fortunately, alternatives to state run databases have been identified that could provide such information. One such alternative are the records of church parishes.

Armenian churches have recorded information about deaths, marriages and baptisms for over 300 years from about two-dozen countries of the diaspora.

Beginning in the early 1980s we conducted a series of studies of patterns of infant mortality, general mortality trends and epidemics using these parish records as our primary source of data. The small communities of the diaspora served as a microcosm that reflected what was occurring in the larger societies that surrounded them. Thus, we were able to identify 2 epidemics of what was probably influenza in the small Armenian parish of Belgrade in early 18th century, 3 epidemics of cholera in the Armenian Catholic parish records of Kutahya, Turkey, in the mid-nineteenth century when Snow was investigating cholera in London. We were able to get an estimate of the speed with which the great influenza pandemic progressed from Dakka in the Bengal to Cairo, Egypt, in 1918 using again the Armenian parish records.

The short and long term effects of genocide and war were also studied using these records. We were able to show that during the post World War I period and in the Armenian refugee populations of Lebanon and Palestine infant mortality were 2 to 3 times larger than in the non-refugee Armenian groups. Thus, these survivors of the genocide continued to pay the price of the massacres and deportation with higher mortality rates for another 25 years. In the Armenian parish records of Thessalonica, Greece, and during the Nazi occupation in World War II, we observed massive mortality in the community as a result of famine and slaughter. Again

reflecting in a small way what was happening in the population at large.

One of the most poignant public health stories from the genocidal period of World War I are the experiments conducted by Professor Wilson from the Medical School of the University of Cairo. In 1916 a French battleship was able to rescue the survivors of the Armenian villages of Musa Dagh in the Northeastern corner of the Mediterranean. These refugees were brought to Port Said, Egypt. Within a few weeks of their arrival in Port Said a major epidemic of pellagra developed in this refugee population. Wilson, who was experimenting with nutritional interventions to control the disease in the Cairo asylum, initiated a controlled trial in these Armenian refugees comparing the regular rations with a ration that was high in protein. The results were so dramatic that Wilson had to cancel his experiment and start everyone on his high protein diet. Confirming the hypothesis that pellagra was a nutritional disease.

ISSUES OF HEALTH SERVICES AND PUBLIC HEALTH IN ARMENIA

The above brush strokes hopefully gave you a feel of things Armenian in Public Health. Next, I would like to give you a brief overview of a more current situation of public health and health services in Armenia.

In February 1991 and on the eve of independence, I published an article in an Armenian paper in Boston about health care issues of Armenia.

The article started with a premise that the health care system like almost all other economic sectors of the Armenia was part of the greater Soviet health care system and had a high level of dependence on that larger system.

The major health problems of the country included; Major destruction of health care facilities following the December 1988 earthquake in the country, endemic diseases such as the familial paroxysmal polyserositis, and some infectious conditions, inadequate services, poor health care funding, issues of quality of care and the lack of private health services. Other problems inherited from the Soviet system included a highly medicalized structure where the focus of public health was primarily on sanitation and infectious diseases.

After about 14 years of effort and assistance from various international agencies, some of the same problems persist in the system. Priority issues include:

1. Since independence Armenia has striven to assimilate into the Western reality and the market economy.
2. Despite this high regard, health services still lag far behind Western standards and represent a specialist driven, highly inefficient system.
3. Due to lack of resources at both the individual and governmental level, health services, especially primary care services are woefully underutilized.
4. Many health professionals are under-employed; facilities are underutilized and quickly becoming antiquated.
5. There is a desperate need for revitalized health care financing and delivery systems founded upon the current and future economic and political realities of Armenia.

FUTURE PERSPECTIVE

As we project towards the future of health services in Armenia it is imperative that:

1. A more entrepreneurial approach is developed in developing the system.
2. Solutions need to be discovered at the local level.
3. All problems need to be monitored in order to have action that is responsive to the needs both locally and nationally.
4. A culture of quality needs to be developed at all levels.
5. The shadow - under the table - health care economy needs to be eliminated.

Some years ago one of our faculty members at Johns Hopkins visited a country in Eastern Europe. Upon his return to Baltimore he was asked about his impression about the health care system. He responded:

-The system has got the right anatomy but little physiology.

In Armenia and in many of the countries of the region, currently, we are not just dealing with a lack of physiology but the anatomy is also structurally not able to stand on its own.

As I visit various services of the health care system in Armenia, I am surprised at the continuing diligence of the health care professionals who are on their jobs despite their pitiful pay. I have asked a number of times as to what keeps them working? My answer to that question is the dignity of having a job.

Beyond all the assistance from international donors and agencies, the health care system of Armenia has been running primarily on a capital of dignity invested by the health care professionals. A dignity that has become second nature when your history is pot marked by generations of repression and destruction and you have that continuing urge to survive and move forward .

Haroutune K. Armenian
September 16, 2005

Public Health: An Armenian Perspective

Haroutune Armenian

Armenians

- A very rich **cultural heritage** of over 2000 years
- Armenia a **battleground** of all super powers throughout history - the nation subjected to invasions, massacres and deportations
- One of the oldest **diasporas** in world history spanning all major centers of civilization. Armenian Kingdom of Cilicia, Amsterdam, Vienna, Venice, Paris, Moscow, Isfahan, Madras, Calcutta, Jerusalem, Cairo, Beirut, etc
- Major **catalyst** and **contributor** to world civilization and the world economy

A Personal Viewpoint

- Congruence of fieldwork and a committed mentor more effective than all the lectures in the classroom.
- In an active professional life at times you do not have much choice as to the problems you are engaged in. A **generalist background** is necessary for every graduate from our schools.
- How to turn a moment of **adversity** into positive achievement.
- War and disasters are an opportunity to study extreme situations and their effect on disease and health.

Hovannes Tutungi

- 1650 Constantinople – Armenian Patriarch 1663-4, 1665-7
- 1668-70 Ethiopia and Egypt
- 1680-3 Italy and France – Louis XIV
- 1692 Cairo – Egypt
- 1698 Trebizond
- 1703 Death

ABOUT TOBACCO 1

1670s

- If you ask the Holy Scriptures,
- Tobacco is ugly and hideous,
- Like bees that escape smoke,
- Angels shun its horrid stench.

- Any one hooked on tobacco,
- Does untold harm to the soul,
- Harm to the soul and woe to the flesh,
- Sacking his home with his own hands.

- Many are forlorn and faltering,
- Their homes are bare, nook and cranny,
- They have no money to save their soul,
- But they do borrow to buy tobacco.

ABOUT TOBACCO 2

1670s

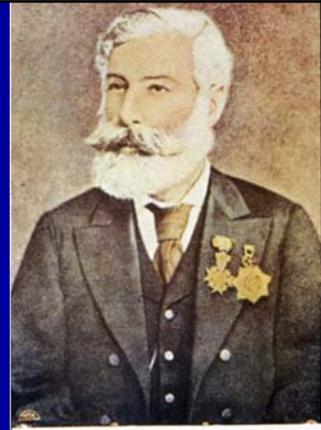
- Many are those who for its sake,
- Would set fire to all they own,
- Steal from home to buy tobacco,
- And smoke it in the company of dogs.

- Oh John, floating on sin,
- Remain awake with your prayers,
- Whoever you see smoking tobacco,
- Voice your wailing to that person.

- The non-smoker, the one who repents,
- Will be blessed by the righteous hand,
- Will hear the voice of the Father,
- And will reside with Abraham.

John Hovannes Wortabet

- Son of an Armenian preacher in nineteenth century Lebanon.
- Founding professor of the American University of Beirut, School of Medicine
- Member of the London Epidemiological Society
- Epidemics of trichinosis at the sources of the Jordan river - the Lancet in the 1870s
- Articles in Arabic in popular magazines



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DR. WORTABET: AN OUTBREAK OF TRICHINOSIS.

454 THE LANCET,] [MARCH 19, 1881.

AN OUTBREAK OF TRICHINOSIS (1) FROM EATING THE FLESH OF A WILD BOAR.

By JOHN WORTABET, M.D.,
PHYSICIAN TO ST. JOHN'S HOSPITAL, BEYROUT.

THE village of Khiam, where this disease has recently broken out, lies not far from the principal sources of the Jordan, which, losing themselves in the plains of El-Huleh, form a large marsh. From the thick jungles of papyrus which occupy that marsh a large wild boar was shot and brought to Khiam on the 25th of November. This was a great treat to the poor villagers, who can rarely afford to indulge in butcher's-meat, and many of them ate the flesh, partly raw and partly half-cooked. The meat was observed

THE LANCET,]

[AUGUST 4, 1883. 183

ANOTHER EPIDEMIC OF TRICHINOSIS NEAR THE SOURCES OF THE JORDAN.

By JOHN WORTABET, M.D.,
PHYSICIAN TO THE HOSPITAL OF THE KNIGHTS OF ST. JOHN, BEYROUT, SYRIA; CORRESPONDING MEMBER OF THE EPIDEMIOLOGICAL SOCIETY, ETC.

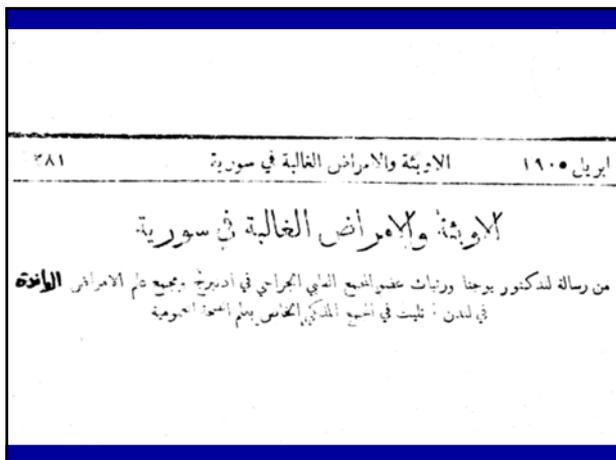
In a paper which appeared in THE LANCET, March 19th, 1881, I gave an account of an outbreak of trichinosis from eating the flesh of a wild boar, near the sources of the Jordan. Two hundred and sixty-two persons ate of the animal (November 25th, 1880), and when I visited the place

الامراض المعدية والوقاية منها

الامراض المعدية والوقاية منها
لجناب العالم العامل الدكتور بوحنان ورتبات

قوانين الصحة في المشرق

من مقالة تليت على المجمع العلمي الجراحي في ادمرج وطبعت في مجلة ادبيرج الثمانية
بقلم الدكتور بوحنان ورتبات احد اعضاء ذلك المجمع



Historical Epidemiology in Armenian Church Records 1

- **Lack of vital records** antedating the XX century for most countries.
- **Alternative sources** include parish records.
- Armenian diasporan church records studied in 16 countries - over 300 years
- A **microcosm** of the larger society

Historical Epidemiology in Armenian Church Records 2

- Epidemics of influenza in 1700s Belgrade
- Cholera in Kutahya in the 1800s
- Influenza pandemic of 1918
- World War I – genocide and refugees in Lebanon and Palestine
- Wilson and Pellagra in Musa Dagh refugees
- World War II – Thessalonica, Greece

ISSUES OF HEALTH SERVICES AND PUBLIC HEALTH IN ARMENIA

February 1991

- High level of **dependence** on the greater Soviet health care system
 - Highly **medicalized** system
- Many factors in favor of a potential for an **independent** system
- Need for well defined policy and plans:
 - **System changes** that will occur in stages and at all levels of the health care system.
 - Retraining and **re-education** of health care personnel
 - Development of modern physical **facilities**.
 - Development of a management **information system**.

14 Years later - Priority Issues in Armenia:

- Health services still lag far behind Western standards - *specialist driven, highly inefficient*.
- Health services, especially primary care services are woefully *underutilized*. Many health professionals are under-employed; facilities are quickly becoming *antiquated*.
- Need for revitalized health care *financing and delivery systems*
- Level of *corruption* as well as lack of concern for *quality of care*.

FUTURE PERSPECTIVE

1. A more *entrepreneurial* approach in developing the system. Solutions need to be discovered at the local level.
2. All problems need to be *monitored* in order to have action that is responsive to the needs both locally and nationally.
3. A *culture of quality* needs to be developed at all levels.
4. The *shadow* health care economy needs to be controlled.

Outcomes

- 1960s ***“The system has got the right anatomy but little physiology.”***
- 2000s - a lack of physiology but the anatomy is also structurally not able to stand on its own.
- The dignity of having a job has to be transformed into the dignity of achieving healthy outcomes.

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The Association of Schools of Public Health in the European Region

Aspher is the key independent organisation in Europe dedicated to strengthening the role of public health through the training of public health professionals for both practice and research.

Founded in 1966, ASPHER has over 70 institutional members. These are located in most member states of the European Union (EU), the Council of Europe (CE) and the European Region of the World Health Organisation (WHO).

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THE INTERNET JOURNAL OF PUBLIC HEALTH EDUCATION

I-JPHE -The Internet Journal of Public Health Education - pursues the systematic development and evaluation of public health and health sciences education and training.

I-JPHE is the scientific forum of professionals, scientists and decision makers, interested and involved in the training for public health practice and research.

I-JPHE is an exclusively Internet-based publication. It serves the rapid exchange of information essential in modern public health work but, nevertheless, follows strict rules of scientific peer review.

I-JPHE is the journal of the Association of Schools of Public Health in the European Region (ASPHER); it takes, however, a global perspective and is open for contributions from all-over the world.

The I-JPHE organisation consists of: an Editorial and Review Committee and a Management Committee.

The Editorial and Review Committee (Edit-C) appointed by the Executive Board of Aspher (EB), is responsible for all matters concerning the I-JPHE. The Edit-C is organised in such a way that as far as possible each of the larger European regions are represented, its duties being as follows:

- to stimulate and support the production of high quality papers,
- to promote visibility of and access to the I-JPHE,
- to review articles for the I-JPHE,
- to build a network of public health contacts in the respective regions, and
- to help raise additional funds e.g. for special editions.

Members of the Editorial and Review Committee:

Editor-in-Chief:

Carmen Sanchis, Valencia, Spain

Members:

Luka Kovacic, Zagreb, Croatia

Allan Krasnik, Copenhagen, Denmark

Hansheinz Kreuter, Magdeburg, Germany

Aislinn O'Dwyer, Liverpool, United Kingdom

The I-JPHE is managed by a Management Committee (MC) working under the supervision of the Editorial and Review Committee. The duties of the Management Committee (MC) are as follows:

- to maintain the I-JPHE website,
- to organise the review process and to keep a registry of reviewers,
- to submit an annual draft report to the Executive Board and the General Assembly of ASPHER.

Members of the Management Committee

Corinne Gaillard, ASPHER Office, Saint-Maurice, France

Thierry Louvet, ASPHER Office, Saint-Maurice, France

CONFERENCE PROGRAM



Dear Colleagues

We are delighted to welcome you all to Yerevan, Armenia, and the American University of Armenia. This Annual Meeting of ASPHER will be unusual for a number of reasons:

- *For the first time it is being held in one of the countries of the Newly Independent States*
- *In addition to the membership of ASPHER, we have invited to the conference participants from the schools of public health of the Eastern Mediterranean Region as well as Africa*
- *For the first time, we are holding a major public health conference of this size in Yerevan*

We hope that beyond its business and regular sessions, this Meeting will provide us an opportunity to

- *Share some common concerns in public health and the education of future generations of health professionals,*
- *Learn from each other's experiences, and*
- *Know each other better.*

The Organizing as well as the Scientific Committee will do their utmost to facilitate the Conference proceedings as well as help you with your individual needs.

We would also like to help you spend more time in discovering Armenia and make this visit a most positive and unusual experience.

An experience that you hopefully will repeat in the future.

A handwritten signature in black ink, which appears to read "Haroutune K. Armenian".

Haroutune K. Armenian, MD, DrPH
Dean, College of Health Sciences
President,
American University of Armenia

Keynote Speakers

DONALD A. HENDERSON, MD, MPH



D.A. Henderson is Professor of Public Health and Medicine at the University of Pittsburgh and Resident Fellow of the Center for Biosecurity of the University of Pittsburgh Medical Center. He is Dean Emeritus of the Johns Hopkins School of Public Health and a Founding Director (1998) of the Hopkins Center for Civilian Biodefense Strategies. From November 2001 through April 2003, he served as Director of the Office of Public Health Emergency Preparedness and, later, as Principal Science Advisor, in the Office of Secretary of the Department of Health and Human Services.

Dr. Henderson's previous positions include: Associate Director of the Office of Science and Technology Policy, Executive Office of the President (1990-93); Dean of the Faculty of the Johns Hopkins School of Public Health (1977-90); and Director of the World Health Organization's global smallpox eradication campaign (1966-77).

In 2002, he received the Presidential Medal of Freedom, the nation's highest civilian honor. He is the recipient also of the National Medal of Science; the National Academy of Sciences' Public Welfare Medal; and the Japan Prize, shared with two colleagues. He has received honorary degrees from 16 universities and special awards from 19 countries.

Dr. Henderson serves as an advisor to many organizations in the United States and abroad. His roles in this capacity include: Chairman of the Technical Advisory Group on Vaccines of the Pan American Health Organization; Chairman of the National Advisory Council on Public Health Emergency Preparedness; Chairman of the WHO ad hoc Orthopoxvirus Advisory Committee. He is a Member of the Institute of Medicine; a Fellow of the American Academy of Arts and Sciences; an Honorary Fellow of the National Academy of Medicine of Mexico; an Honorary Fellow of the Royal College of Physicians of London; an Honorary Member of the Royal Society of Medicine; and is a Fellow of a number of professional medical and public health societies.

Dr. Henderson is a member of the editorial board for the peer-reviewed journal, *Biosecurity and Bioterrorism: Biodefense Strategy, Practice and Science*. Additionally, he has authored more than 200 articles and scientific papers, 31 book chapters, and is coauthor of the renowned *Smallpox and Its Eradication* (Fenner F, Henderson DA, Arita I, Jezek A, and Ladnyi ID. 1988. Geneva: World Health Organization), the authoritative history of the disease and its ultimate demise.

Dr. Henderson, a Lakewood, Ohio native, graduated from Oberlin College, from the University of Rochester School of Medicine, and the Johns Hopkins School of Hygiene and Public Health. He served as medical resident at the Mary Imogene Bassett Hospital in Cooperstown, New York.

HUDA C. ZURAYK, MA, PhD



Dr. Huda Zurayk is presently the Dean of the Faculty of Health Sciences at the American University of Beirut, in Lebanon, a position she has held since September of 1998. Dr. Zurayk earned her undergraduate degree in Statistics from the American University of Beirut in 1965, received an MA in Statistics from Harvard University in 1966, and completed her PhD in Biostatistics from The Johns Hopkins University in 1974. Dr. Zurayk joined the American University of Beirut as Assistant Professor in 1974, progressing to Professor in 1985.

In 1987 she joined the Population Council Regional Office for West Asia and North Africa in Cairo, as Senior Representative and then as Senior Research Associate. During her eleven years tenure at the Population Council, Dr. Zurayk established the Regional Reproductive Health Working Group that continues today as a multi-disciplinary network of researchers throughout the Region examining issues critical to reproductive health.

Dr. Zurayk has participated in a number of advisory boards and professional organizations throughout the world. Most recently, she was a member of the International Scientific Advisory Board of the Africa Centre for Health and Population Studies in South Africa from 2002-2005. She was member of the Scientific and Ethical Review Group (1991-93) and of the Social Science Task Force (1994-99) of the Special Program of Research Development and Research Training in Human Reproduction of the World Health Organization, Geneva. She was also a member of the Reproductive Health Panel of the U.S. National Academy of Sciences from 1994 until 1995. She served two terms as an elected member of the Council of the International Union for the Scientific Study of Population from 1993 to 2001.

Andrija Stampar Award

Each year, during its Annual Conference, the Association of Schools of Public Health in the European Region (ASPHER) awards the prestigious Andrija Stampar Medal to a distinguished person for excellence in the field of Public Health. The medal itself is named after Doctor Andrija Stampar from Croatia.

"Doctor Andrija Stampar was born in the Croatian countryside 100 years ago. His parents were schoolteachers and moved around the country a lot. This gave him many opportunities to observe the daily life of the people.

He qualified in medicine in Graz during the period of the Habsburg Empire. There was no medical school in Croatia at that time. In the 1920s he worked in a senior position in the newly created Ministry of Health in Belgrade. Apparently at this time he was very outspoken about what needed to be done.

In the period 1927/8 he founded the School of Public Health in Zagreb, with a grant from the Rockefeller Foundation. From this base he began to develop the public health system for the whole of Yugoslavia. As a result of these successful activities he was invited by the King to take up the cabinet post of Minister of the Interior. He accepted subject to certain conditions, which the King did not accept. Subsequently he went to China as an official of the League of Nations, and set up a fledgling public health system under its auspices.

He spent the period of the Second World War in prison, but in 1945 was appointed as Professor of Social Medicine in Zagreb. He also served as Dean of the Medical School and as President of the Academy of Arts and Sciences of Croatia.

In 1946 he was president of the Interim Committee of WHO, charged with setting up its structures and constitution. It also drew up the famous definition of health. Professor Stampar was chairman of the first WHO General Assembly in 1948.

He died in 1958, tragically early, from a stroke."

Speech by Professor Richard Madeley, Aspher Annual Conference, Torino, Italy, October 10-14, 1998.



This year the recipient is George Soros. On 18 September 2005, ASPHER will award its 13th Stampar Medal to Mr. George Soros of Open Society Institute (OSI), in recognition of OSI's support to the development and improvement of public health training in Central and Eastern Europe and the former Soviet Union.

George Soros is chairman of the Open Society Institute and founder of a network of philanthropic organizations that are active in more than 50 countries. Based primarily in Central and Eastern Europe and the former Soviet Union - but also in Africa, Latin America, Asia, and the United States - these foundations are dedicated to building and maintaining the infrastructure and institutions of an open society. They work closely with OSI to develop and implement a range of programs focusing on civil society, education, media, public health, and human rights as well as social, legal, and economic reform.

Mr Michael Borowitz, Director of Open Society Institute's Public Health Programs, will accept the award on behalf of OSI's Public Health Programs.

Introduction

A strong public health infrastructure provides the capacity to prepare for and respond to emerging and long standing public health challenges. Such an infrastructure serves as the foundation for planning, delivering, and evaluating public health and requires a well-educated and well-trained professional public health workforce. Assuring a competent public health workforce is vital to managing the health of a population.

In light of recent emerging threats such as bio-terrorism, the development and expansion of public health training programs are now receiving renewed interest from governmental and non-governmental public health agencies. Yet, these programs themselves have a major and indispensable role in developing new insights and innovative solutions to public health training, including the introduction of new educational formats and modalities, contemporary technologies and managerial/organizational options. The process of globalization and accompanying scientific and technological changes requires the schools to design programs corresponding to global and Western standards of excellence, at the same time responding to more pressing country-specific, local needs, which is often logistically and methodologically burdensome process. Often the decisions are made and transformations are initiated by public health schools in limited resource environments. In this state of affairs, the expansion and support of amicable working network of public health programs both on regional and global level, which would allow sharing experiences and collaboratively finding best approaches to old and new public health education issues, appears to be a necessary (but not sufficient) prerequisite for successful development.

The 27th ASPHER Annual conference will address the issues of development perspectives of Public Health schools in European and Mediterranean regions, revealing possible barriers and catalysts to the process of development. For the first time, the ASPHER conference will formally involve several schools of public health and health management from WHO's Eastern Mediterranean Region, increasing the diversity of opinions, approaches, and methodologies and to expand the network of cooperating schools and faculty throughout the region. We hope that the conference will lead to better understanding of future trends and challenges in public health training globally, and will leave schools of public health with sound solutions and working approaches to these emerging challenges.

Conference themes

1. Creating sustainable partnerships
2. Core public health competencies: Linking knowledge to real world practice
3. Evidenced based practice: Strengthening the link between health research capacity and policy development
4. Flexible learning: Cutting-edge learning techniques and technologies
5. Public Health training and global problems: Responding to migration, urbanization, poverty, and multi-cultural strife

Pre-Conference Workshops

Workshop 1:	Health Systems in Transition – Lessons Learned, Opportunities Lost
Venue:	AUA Business Center, 9 Alex Manoogian
Faculty:	Allan Krasnik, Institute of Public Health, University of Copenhagen Varduhi Petrosyan, American University of Armenia
Date:	15 and 16 September [9am - 5pm each day]
Overview (Provisional):	<p>The Observatory's periodic reports on health systems in transition (HiT) are a rich, roughly comparable data source for comparing and understanding the evolution of health systems in transition. Valuable opportunities are lost when lessons learned are not shared and applied.</p> <p>This workshop will address the major elements of ongoing reform processes in European health care. It will start with a common orientation defining terminology and reviewing methodology for analyzing and comparing reforms. The workshop will provide a conceptual and practical approach to assess and analyze health systems in transition, highlighting recent examples from HiT reports and identifying emerging trends and key issues to resolve. Guest lecturers will present several case studies on national and regional reforms, and an active discussion by participants will follow. One of the case studies will present the changes of the Nordic tax financed and decentralized publicly provided health care services emphasizing the organization of services, public/private mix, and evidence base for quality management. A session with the representatives of the European Observatory will be devoted to the discussion of how these HiT reports can be integrated as a resource into public health teaching programs.</p>
Objectives:	<p>Workshop participants will</p> <ul style="list-style-type: none">• Develop a conceptual and analytic framework for comparing and contrasting health systems• Review and develop examples/case studies from the literature and personal experience• Identify themes, trends, and lessons learned by examining a multitude of national case studies and clarify how these lessons can serve as a basis for strategic planning and management of health care services• Guide the development of an analytic framework for a collaborative course utilizing the Health In Transition reports
Target Audience:	This workshop is intended for academicians and practitioners involved in health system design and assessment and/or health policy formulation.

Workshop 2:	Prevention of blindness: Strategies for European and EMRO Regions
Venue:	AUA Business Center, 9 Alex Manoogian
Faculty:	Astrid Fletcher, London School of Hygiene and Tropical Medicine Naira Khachatryan, American University of Armenia
Date:	15 September [1pm - 5pm]
Overview:	<p>Recent population based studies coordinated by the WHO estimated approximately 37 million people worldwide are blind. Every year, an additional 1-2 million persons go blind. The major causes of blindness and low vision vary widely from region to region, being largely determined by socio-economic development and the availability of primary health care and eye care services.</p> <p>Blindness still remains one of the major public health problems in the Eastern Mediterranean and Eastern European Regions. In both regions the blind population is increasing daily, mainly due to the backlog of untreated cataracts. Without intervention, this number will double within the next twenty years.</p>
Objectives:	<p>Workshop participants will</p> <ul style="list-style-type: none"> • Identify main barriers to cataract surgery and suggest strategies to eliminate them • Provide recommendations on improving quality of cataract care • Discuss and identify mechanisms of integration of primary eye care into the existing primary health care system • Discuss human resource development for eye care • Examine current advocacy activities in eye care and recommend new approaches • Suggest strategies on expanding partnership between international blindness prevention NGOs and local ophthalmic centers
Target Audience:	Ophthalmologists, ophthalmologists in training, eye care program managers, public health professionals interested in eye care, nurses

Workshop 3:	Toolbox of Assessment Methods for Competence Assessment
Venue:	AUA Business Center, 9 Alex Manoogian
Faculty:	Ara Tekian, University of Illinois at Chicago
Date:	16 September [9am – 1pm]
Overview:	Public Health schools are increasingly interested to review educational programs, revise and update the essential competencies for public health professionals, and reevaluate assessment methods. Accreditation bodies are scrutinizing public health programs and among many issues inspecting assessment methods. This workshop will examine the current methods of assessment, and offer a toolbox consisting of a variety of instruments that could be used to assess any competency.
Objectives:	Participants at the end of the workshop should be able to: <ul style="list-style-type: none">• Examine and evaluate current assessment methods• Explore new methods of assessment techniques• Understand the psychometric properties of these assessment methods• Select instruments which are appropriate to assess different public health competencies.
Target Audience:	Public health professionals, course directors, leaders, and decision-makers.

Detailed Program for the 2005 ASPHER Conference in Yerevan

Saturday, 17 September
AUA Business Center, 9 Alex Manoogian

09:00-12:00	ASPHER Executive board Restricted to ASPHER executive board members	Conference Hall
12:00-13:30	Lunch	Cafeteria
13:30-15:30	ASPHER General Assembly Restricted to delegates of ASPHER member schools	Conference Hall
15:30-16:00	Coffee break	Conference Hall
16:00-18:00	ASPHER General Assembly – continuation	Conference Hall
18:00-19:00	<i>Light fare reception at the Museum of Folk-Art of Armenia accompanied by a performance of Speghany Youth Choir Buses depart AUA Business center at 18:00</i>	

Saturday, 17 September
AUA (main building), 40 Marshal Bagramian

10:30-12:00	Workshop 1 OSI Regional Cooperation Workshop <i>(Exploring partnerships with schools of public health to address HIV/AIDS in partnership with OSI and the Global Fund to Fight AIDS, TB, Malaria (GFATM) in Africa, Eurasia, Europe and Middle East)</i> Participants: Academic program directors and deans of schools/faculties of public health, from countries of Africa, Middle East, and Central Asia Part 1, Session 1	Room 23A
12:00	<i>Transition to AUA Business Center, 9 Alex Manoogian</i>	

Saturday, 17 September
AUA Business Center, 9 Alex Manoogian

12:00-13:30	Lunch	Cafeteria
13:30-15:30	Workshop 1 Part 1, Session 2 Part 1, Session 3 OSI Regional Cooperation Workshop <i>(Exploring partnerships with schools of public health to address HIV/AIDS in partnership with OSI and the Global Fund to Fight AIDS, TB, Malaria (GFATM) in Africa, Eurasia, Europe and Middle East)</i> Chairs: Linas Sumskas, Kaunas University of Medicine, Lithuania	Room 501
16:00-17:30	Michael Borowitz, OSI Ara Tekian, American University of Armenia, Armenia	

09:00-10:30	Opening Ceremony ASPHER Annual Conference Official Welcome	Large auditorium
10:30-11:00	Stampar Award Ceremony	Large auditorium
11:00-11:30	Coffee break	Lobby
11:30-13:00	Parallel Communication Session A Public Health training and global problems: Responding to migration, urbanization, poverty, and multi-cultural strife Chair: Tatul Hakobyan, Ministry of Health, Armenia	Large auditorium
	The Social Context of Public Health: Professional Training Needs in Armenia Vincent O'Brien, St Martin's College, UK	
	Model Village for Health program (MVH) of Isra University: A base line Tufail Bhatti, Isra University, Pakistan	
	IT&C and Traditional Medicine across European and Asian Cultures (TMEA) Rosa Giuseppa Frazzica, CEFPAS, Italy	
	Positive Deviance as a basis for behavioral change in the management of obesity and compliance to the Mediterranean lifestyle Elliot Berry, Braun School of Public Health, Israel	
11:30-13:00	Parallel Workshop 2 Public Health Training in the Context of an Enlarging Europe –PHETICE Thierry Louvet, ASPHER, France	Small auditorium
11:30-13:00	Parallel Student forum Student research development	Room 23a
13:00-14:00	Lunch	Cafeteria
14:00-15:30	Parallel Communication Session B Core public health competencies: Linking knowledge to real world practice Chair: Ramune Kalediene, Kaunas University of Medicine, Lithuania	Large auditorium
	The ways for improving the quality of education of PH workforce Stojniew Sitko, Institute of Public Health, Poland	
	Maximizing the public health role of community nurses Selena Gray, University of the West of England, UK	
	A Minimum Health Indicator Set for PH-SEE Countries Ulrich Laaser, University of Bielefeld, Germany	
	Public Health Ophthalmology Course for Eye Care Professionals in Armenia Naira Khachatryan, American University of Armenia, Armenia	

14:00-15:30	Parallel Workshop 3 OSI-ASPHER Julien Goodman, ASPHER, France	Small auditorium
14:00-15:30	Parallel Student forum Student research development	Room 23a
15:30 -16:00	Coffee break	Lobby
16:00-17:30	Parallel Communication Session C Core public health competencies: Linking knowledge to real world practice Chair: Grace Sullivan, American University of Armenia, Armenia	Large auditorium
	European accreditation of educational programs for the competitiveness of the PH workforce Stojniew Sitko, Institute of Public Health, Poland	
	New Concept of the Public Health Program in Republic of Macedonia Dragan Gjorgjev, Republic Institute for Health Protection, Macedonia	
	Decentralization and Public Health Education in Croatia Aleksandar Dzakula, Andrija Stampar School of Public Health, Croatia	
	Sciento-metric analysis of the master thesis of MPH students Lora Georgieva, Medical University, Bulgaria	
16:00-17:30	Parallel Workshop 3 - continuation OSI-ASPHER Julien Goodman, ASPHER, France	Small auditorium
16:00-17:30	Parallel Student forum Sharing experience	Room 23a
17:30-18:00	Posters viewing	Entrance Hall
18:15-19:00	Concert by Komitas Quartet	Large auditorium
20:00-23:00	<i>Dinner at Ojakh restaurant, Abovyan city</i> <i>Buses depart AUA main building at 19:30 sharp</i>	

09:00-09:30	Conference lecture <i>New and Emerging Infections: Catalysts to Needed Change in Public Health</i> Donald A. Henderson, MD, MPH Dean Emeritus, Johns Hopkins Bloomberg School of Public Health Johns Hopkins University Distinguished Service Professor, Professor of Medicine and Public Health, University of Pittsburgh Center for Biosecurity, University of Pittsburgh Medical Center	Large auditorium
09:30-11:00	Parallel Communication Session D Evidenced based practice: Strengthening the link between health research capacity and policy development Chair: Ann Allen, Cardiff University, UK	Large auditorium
	Ethical Restrictions on International Recruitment of Health Professionals from Low-income Countries Ulrich Laaser, University of Bielefeld, Germany	
	Assessment of the feasibility of establishment of food fortification program in Republic of Macedonia Dance Gudeva Nikovska, School of Public Health, Macedonia	
	Tobacco control policy in Armenia: Translating evidence into practice Narine Movsisyan, American University of Armenia, Armenia	
	Birthing in the Arab region: how to translate research into policy? Tamar Kabakian-Khasholian, American University of Beirut, Lebanon	
09:30-11:00	Parallel Workshop 4 Cooperation in the field of public health training from a global perspective Stojgniew Sitko, Institute of Public Health, Poland	Small auditorium
09:30-11:00	Parallel Student forum Sharing experience	Room 23A
11:00-11:30	Coffee break	Lobby
11:30-13:00	Parallel Communication Session E Evidenced based practice: Strengthening the link between health research capacity and policy development Chair: Ann Allen, Cardiff University, UK	Large auditorium
	To Develop a Coherent Legislation on Prevention: The German Experience Ulrich Laaser, University of Bielefeld, Germany	
	Whose evidence, anyway? Rosa Giuseppa Frazzica, CEFPAS, Italy	
	Meeting the Challenge of Injection Drug Use and HIV Epidemic in Armenia Karine Markosyan, World Bank, Ministry of Health, Armenia	
	New projects in a health care services sector - learning and practicing project management. Stojgniew Sitko, Institute of Public Health, Poland	

11:30-13:00	<p>Parallel Workshop 5 Exchanging experience: How can schools of public health engage with the wider community, Martin McKee, London School of Hygiene and Tropical Medicine, UK</p>	Small auditorium
11:30-13:00	<p>Parallel Student forum Sharing experience</p>	Room 23A
13:00-14:00	Lunch	Cafeteria
14:00 -15:30	<p>Parallel Communication Session F Creating sustainable partnerships Chair: Lars Cernerud, Nordic School of Public Health, Sweden</p>	Large auditorium
<p>Continuous education in public health as a challenge for international collaboration Dorota Szosland, Nofer Institute, Poland</p> <p>International Collaborative Partnership in Health Management Education Mihran Nazaretyan, School of Health Care Management and Administration, Armenia</p> <p>Integration among Health Professionals in Sicily Rosa Giuseppa Frazzica, CEFPAS, Italy</p> <p>Building Public Health Association in the Transition Countries of South Eastern Europe: The Example of Albania Enver Roshi, University of Tirana, Albania</p> <p>The importance of sustainable partnerships for students. Esther Slits, Maastricht University, The Netherlands</p>		
14:00-15:30	<p>Parallel Workshop 6 PEER Review as a tool for continuous quality improvement in public health training, Ramune Kalediene, Kaunas University of Medicine, Lithuania</p>	Small auditorium
14:00-15:30	<p>Parallel Workshop 1 Part 2 Session 1 OSI Regional Cooperation Workshop <i>(Exploring partnerships with schools of public health to address HIV/AIDS in partnership with OSI and the Global Fund to Fight AIDS, TB, Malaria (GFATM) in Africa, Eurasia, Europe and the Middle East)</i> Chairs: Linas Sumskas, Kaunas University of Medicine, Lithuania Michael Borowitz, OSI Ara Tekian, American University of Armenia, Armenia</p>	Room 23A
15:30-16:00	Coffee break	Lobby

16:00 -17:30	<p>Parallel Communication Session G Creating sustainable partnerships Chair: Lars Cernerud, Nordic School of Public Health, Sweden</p> <hr/> <p>ASPHER: Damp Squib or the Powder's Keeper Jeffrey Levett, NSPH, Greece</p> <p>Development of professional Public Health education in Tajikistan Zumrat Maksudova, Tajik State Medical University, Tajikistan</p> <p>Quality Development of Public Health Teaching Programs in Croatia: Lessons Learnt Gordana Pavlekovic, Andrija Stampar School of Public Health, Croatia</p> <p>ERASMUS MUNDUS Application: a Masters Consortium Approach for High Quality Services to Third-Country Students and Scholars Fanny Heliot, Ecole Nationale de la Sant Publique, France</p> <p>European partnership: a solution for the challenge of the increasing dependence of ageing people Hlne Malterre, Ecole Nationale de la Sant Publique, France</p>	Large auditorium
16:00-17:30	<p>Parallel Workshop 7 ASPHER Membership Criteria and standards Rosa Giuseppa Frazzica, CEFPAS, Italy & Anders Foldspang, Univresity of Aarhus, Denmark</p>	Small auditorium
16:00-17:30	<p>Parallel Workshop 1 OSI Regional Cooperation Workshop <i>(Exploring partnerships with schools of public health to address HIV/AIDS in partnership with OSI and the Global Fund to Fight AIDS, TB, Malaria (GFATM) in Africa, Eurasia, Europe and the Middle East)</i> Chairs: Linas Sumskas, Kaunas University of Medicine, Lithuania Michael Borowitz, OSI Ara Tekian, American University of Armenia, Armenia</p> <p>Part 2 Session 2</p>	Room 23A
17:30-18:00	<p>Posters viewing</p>	Entrance Hall
20:00-23:00	<p><i>Conference Dinner at Nor Dzoraberd restaurant</i> <i>Busses depart hotels at 19:30 sharp</i></p>	

09:00-09:30	<p>Conference lecture <i>Reaching beyond boundaries in academic public health: the case of the American University of Beirut</i> Huda Zurayk, MA, PhD Dean, Faculty of Health Sciences, American University of Beirut</p>	Large auditorium
09:30-11:00	<p>Parallel Communication Session H Flexible learning: Cutting-edge learning techniques and technologies Chair: Elliot Berry, Braun School of Public Health, Israel</p> <hr/> <p>Innovation in Training Human Resources for Health through Quality Distance Learning Programmes Rosa Giuseppa Frazzica, CEFPAS, Italy</p> <p>Using on-line virtual classroom and video-conferencing systems as a tool for public health education and research at the Trnava University in Slovakia Marek Majdan, Trnava University, Slovakia</p> <p>Accreditation Systems Dashboard for Schools of Public Health Nadim Haddad, American University of Beirut, Lebanon</p> <p>Growing a public health workforce in Sandwell, UK John Middleton, Birmingham University, UK</p> <p>The challenge of Bologna: the European public health training in transition Roza Adany, University of Debrecen, Hungary</p>	Large auditorium
09:30-11:00	<p>Parallel Workshop 8 Strengthening health systems in developing countries: Human resources development via eLearning. Alena Petrakova, WHO, Switzerland, Tom Cook, University of Iowa, USA</p>	Small auditorium
09:30-11:00	<p>Parallel Student forum Plans for future collaboration</p>	Room 23a
11:00-11:30	<p>Coffee break</p>	Lobby
11.30 – 12.30	<p>Closing ceremony, Best poster award</p>	Large auditorium
12.30 – 14.00	<p>Lunch</p>	Cafeteria
14.00 –18.00	<p><i>Optional: Guided tour to Echmiadzin (Holy See of the Armenian Apostolic Church)</i></p>	

Posters

Posters viewing:
Sunday, 18 September 17:30-18:00
Monday, 19 September 17:30-18:00
AUA (main building), 40 Marshal Bagramian
Entrance Hall

Health-express	Ulrikke Bryde Nielsen Copenhagen University	Denmark
Expenditures For Health Care In Kazakhstan	Maksut Kulzhanov Kazakhstan School of Public Health	Kazakhstan
Capacity strengthening for health research in public health training to improve population health in Kazakhstan	Madina Takenova Kazakhstan School of Public Health	Kazakhstan
Baseline Quality of Life Survey for the Evaluation of Support to Mobile Medical Teams Program in Lori and Gegharkunik, Armenia 2004	Anush Sahakyan World Vision, Armenia	Armenia
Title: Midwives Supportive Role in Prevention of Postpartum Depression	Roshanak Zahraei Esfahan Medical University	Iran
Comparative Study on the effect of Occupation and Socio-economic Status of Mothers on their Children s health trend	Ahmad Bozorgzad Islamic Azad University	Iran
A Review of Quality Assurance in the German Health System: a Complex Transition Process	Ulrich Laaser University of Bielefeld	Germany
A Review of the evidence for long-term use of Nicotine Replacement Therapy (NRT)	Lisbet Schmolker Master of Public health	Denmark
Development of a useful evaluation method of short-term post-education courses for health professionals. Systematic efforts in health counseling a post-education course from The Clinical Unit of Health Promotion in Hospitals	Jutta Skau University of Copenhagen	Denmark
The experience of development of evidence-based clinical practice guidelines	Rafail Kipshakbayev Kazakhstan School of Public Health	Kazakhstan
Dental public health and oral hygiene among the youngest population in Macedonia incorporated in the teaching curriculum by the Ministry of Education	Jaroslav Karadzinski University of MetSst. Cyril and hodus-Skopje	Macedonia
The relation between research and policy on drugs how was and how could be	Constanta Mihaescu Pintia National Institute for Health Research and Development	Romania
Cardio protective Medication Use in Post Myocardial Infarction Patients at Nork-Marash Medical Center	Zaruhi Bakalyan American University of Armenia	Armenia

Posters viewing:
Sunday, 18 September 17:30-18:00
Monday, 19 September 17:30-18:00
AUA (main building), 40 Marshal Bagramian
Entrance Hall

Risk factors associated with the development of atopic dermatitis among children in Yerevan: a case-control study	Anush Sahakyan American University of Armenia	Armenia
A multidisciplinary team evaluates the potential effects of local programs on the health of the population through health impact assessment (HIA)	Rosa Giuseppa Frazzica CEFPAS	Italy
Towards Unity for Health	Rosa Giuseppa Frazzica CEFPAS	Italy
MANAHEALTH extension and promotion of European Public Health and Management Training Initiative	Dorota Szosland Nofer Institute	Poland
The Foundation of the Center-School of Public Health in Belgrade in 2005	Vesna Bjegovic University of Belgrade	Serbia
Six universities under one roof. SSPH+	Julie Page Universities Basel	Switzerland
The importance of sustainable partnerships	Annemarie Heuvel University Maastricht	The Netherlands
International collaboration as a successful approach in meeting challenges in Public Health	Vuko Antonijevic Institute of Public Health Pristina-Kosovska Mitrovica	Serbia
The effect of the student health education on their family knowledge and performance	Shayesteh Salehi Nursing and Midwifery School	Iran
Experience with utilizing e-learning in the implementation of the national DRG system	Antonin Malina Institut for Postgrad M. Education	Czech Republic
Two day training courses for the village ambulatory nurses	Lilit Kirakosyan American University of Armenia	Armenia
The organization of pediatric ophthalmic services in Armenia	Hasmik Yeghiazarian Karagyozyan Foundation	Armenia
New Courses on Drug Management to Meet Needs of Professionals in Armenia	Irina Kazaryan Drug Utilization Research Group	Armenia

Scientific Committee

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Chair: Haroutune Armenian, AUA President
Contact/Secretary: Varduhi Petrosyan, Lecturer, AUA, Armenia
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Mihran Nazaretyan, Director, School of Health Care Management and Administration, Armenia
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Liana Kasyan, MPH Student, AUA
Members: Irina Papiyeva, MPH Student, AUA
Liana Martirosyan, MPH Student, AUA

*Special thanks to Corinne Gaillard, Information Manager, ASPHER,
and AUA Administration and support staff.*

***For those staying in Armenia after conference, site-seeing tours will be organized (on September 21, 22, 23, and 24).
For details, please contact MENUA Tour Agency.***

MENUA

19 Sayat Nova, Ani Plaza Hotel Lobby
Yerevan, Armenia
Phone 527372 / FAX: (37 410) 583901
E-mail: info@menuatours.com

Tours of Armenia

ITINERARY

Day One 10:00 AM September 21st

Duration: 3-4 Hours

Pay tribute to the heroes of the Battle of Sardarabad! The Sardarabad Memorial and Museum ensemble was built in 1968 to mark the victory over Turkey in the Battle of Sardarabad in 1918, which led to the first independent Republic of Armenia in 1918.

Here you will visit the largest ethnographic museum in Armenia, rich with artifacts and memorabilia.

In the afternoon 1:00-1:30 PM From Yerevan

Duration: 4 Hours

This tour would be started by a visit to the village of Garni where you would be served with freshly baked Lavash in traditional Tonir with homemade yogurt and Armenian cheese. A very light lunch.

Garni - *The only pagan temple existent in Armenia, the 2nd century pagan temple of Garni was reconstructed from ruins. This pre-Christian structure, with its classical Hellenist lines, is situated in a picturesque mountain locale, offering a breathtaking panorama of the valley below. The structure of the temple with its columns and dimensions was created to please the gods and protect the people from their wrath. Garni temple was destroyed by an earthquake in 1679 and rebuilt during the Soviet era. The ruins include a bathhouse, where you can see remnants of beautiful mosaic work.*

Geghard-*This ancient monastery was carved out of solid rock. In ancient times this monastery was known as "the monastery of the seven churches", "the monastery of the forty altars" or Ayrivank (the monastery of the cave), confirming the presence of ancient caves dug into the rock. Geghartavank is the monastery of the spear. This last name derives from the relics, for many years conserved in the monastery and now in Edjmiatsin's museum, of the spear that was said to have wounded the chest of Christ on the cross.*

The exact date of Geghard's foundation is not known, but according to the inscriptions found locally dating from the 7th and 8th centuries, it is likely that it dates back to the early times when Christianity was recognized and declared the official state religion. The main church dates back to 1215. Inside the church's interior exists a natural spring, anciently worshipped and today carefully preserved. A visit to Geghard is truly a spiritual experience.

Back to Yerevan

Day Two 10:00 AM September 22nd

Duration: 7 Hours

Khor Virab- *Khor Virab is the site where St. Gregory, the Illuminator, was imprisoned by an Armenian king for preaching Christianity. You can climb down into the dark pit yourself and then treat yourself to the most spectacular view of the glorious Mt. Ararat*

*Visit the monastery of **Noravank**, a 13th century structure with beautiful stone crosses. This monastery is considered to be the pulpit of Suinik bishops. The main church of St. Karapet was built in 1227. The relieves on the entrance tympanum and the windows on the western facade are interesting from an architectural point of view. The focus of the southern section is the two-storied church of Prince Orbelian, completed by Momik (great sculptor) in 1339. Two console stairs on both sides of the entrance take you inside the church.*

Continue the tour to the Areni Winery and taste the bounty of Armenia's sun kissed grapes. Along the way you would be greeted by hospitable villagers under the apricot trees (in season). Enjoy a freshly-prepared picnic lunch in the grounds of Noravank.

Day Three 10:00 AM September 23rd

Duration: 7 Hours

Dilijan—*Located in the northern part of Armenia, this region is famous for its forests and health resorts, its spectacular scenery and cultural centers. You will drive through a lush forest to reach the **Haghartsin Monastery**, an 11th-13th century church situated deep in the woods, about 18 km from the town of Dilijan.*

Lake Sevan- *No trip to Armenia is ever complete without a visit to Lake Sevan, one of the largest and highest lakes in Eurasia at about 1900 meters above sea level.*

Here you will enjoy a wine and cheese reception lunch aboard a boat sailing in Lake Sevan

Day Four 10:00 AM September 24th

Duration: 5 Hours

Amberd — *Visit the family castle of the Pahlavooni Princes, one of the few castles in Armenia that has been preserved. Tour the church and fortress of Amberd, built on a rocky promontory in the 10th-13th centuries and situated near Mt. Aragats and the Byurakan Astrophysical Observatory. The domed church was built in 1206 and is one of the most unique churches of its type in Armenia.*

Beyond the fortress is a fortified three-story castle made of basalt, built as a military measure for blocking invaders' access. Fragments of the water supply system of the castle together with baths and a secret passageway to the canyon are preserved. You will also be able to observe the ruins of the wall and gates of Amberd.

Enjoy your lunch at Tatoents Qotug – It is an old private house with beautiful garden, tonir and maran which was built in 1837. During the lunch in Maran you will have a chance to enjoy village local cuisine which is simple and tasty at the same time.

STAMPAR MEDAL AWARD CEREMONY

**Stampar Medal Award Ceremony
Laudatio on George Soros held by
Aislinn O'Dwyer, University of Liverpool, England
United Kingdom**

XXVII ASPHER Annual Conference, American University of Armenia, Yerevan

Dear colleagues, distinguished guests, ladies and gentlemen

On behalf of the Governing Body and members of ASPHER it is a great honour to be able to present the Andrija Stampar medal for distinguished service to the cause of public health in Europe to George Soros, Founder and Chairman of the Open Society Institute and chairman of Soros Fund Management LLC.

George Soros was born in Budapest, Hungary on August 12, 1930. He survived the Nazi occupation of Budapest and left communist Hungary in 1947 for England, where he graduated from the London School of Economics (LSE). While a student at LSE, Soros became familiar with the work of the philosopher Karl Popper, who had a profound influence on his thinking and later on his professional and philanthropic activities. It was Popper that first developed the concepts of an "open society".

In 1956, Soros moved to the United States, where he began to accumulate a large fortune through an international investment fund he founded and managed. Today he is chairman of Soros Fund Management LLC.

George Soros has been active as a philanthropist since 1979, when he began providing funds to help black students attend the University of Cape Town in apartheid South Africa. Today he is chairman of the Open Society Institute (OSI) and the founder of a network of philanthropic organizations that are active in more than 60 countries. Based primarily in Central and Eastern Europe and the former Soviet Union – but also in Africa, Latin America, Asia and the United States – these foundations are dedicated to building and maintaining the infrastructure and institutions of an open society. They work closely with OSI to develop and implement a range of programs focusing on civil society, education, media, public health and human rights as well as social, legal and economic reform. In recent years, OSI and the Soros foundations network have spent more than \$400 million annually to support projects in these and other focus areas. In 1992, Soros founded Central European University, with its primary campus in Budapest.

I would like to say a few words about the Open Society Institute.

The Open Society Institute is a private operating and grantmaking foundation based in New York City, that is the center of the Soros foundations network. OSI and the network promote open society by seeking to shape government policy and supporting education, media, public health, human rights and women's rights as well as social, legal and economic reform.

The goal of OSI is to transform closed societies into open ones and to protect and expand the values of existing open societies. Open societies are characterized by the rule of law; respect for human rights, minorities and a diversity of opinions; democratically elected governments; market economies in which business and government are separate and thriving civil societies, all activities that are very close to the heart of people working in public health.

Investor and philanthropist George Soros began establishing foundations in Central and Eastern Europe before the collapse of communism.

The Soros foundations are autonomous institutions established in particular countries or regions to initiate or support open society activities. A local board of directors in consultation with Soros and OSI boards and advisors, determines the priorities and specific activities of each Soros foundation.

OSI's network programs address specific issues or areas-public health media and early childhood education, for example – on a network-wide basis. ASPHER members will be aware that it's through the joint ASPHER-OSI initiative that we are actually here in Yerevan today.

I would like to spend a few moments focusing on the work of the public health program.

In the 1990's the Open Society Institute focused on improving health care in Central and eastern Europe, primarily by providing training to thousands of health professionals who have been closed off from advances in their fields. By 2000 the network Public Health program had shifted the focus from improving individual health care to promoting the development of public health policies that increase health equity and access of vulnerable populations to health and social welfare services.

OSI has played a significant role in fighting TB and multi-drug resistance TB, both in Central and Eastern Europe and globally, by supporting programs that impact policy, mobilize additional resources for TB control and strengthen the Stop TB Partnership. In Russia, OSI has spent over \$100m on public health issues, including the MDR-TB treatment model in the country's prisons, HIV/AIDS treatment, mental disability advocacy and support for schools of public health.

In 2004 the Public Health Program established Public Health Watch, a global initiative to encourage public engagement in the development, implementation and evaluation of health policies. Public Health Watch began monitoring policies to reduce TB and TB/HIV co-infection in several countries most affected by the 2 diseases – Bangladesh, Brazil and Thailand to name a few.

Another major area of activity of the Program is around the work to address the persistent differences in health status between Roma and majority populations in targeted countries in Central and Eastern Europe. Six NGO's in Macedonia and Serbia provided Romani communities with information on health and health insurance, documented discriminatory practice in health sectors and presented findings to national human rights advocates.

The Tobacco Control Program supported projects in Armenia, Kazakhstan, Romania, Moldova and Ukraine in an effort to build the capacity of tobacco control advocates and NGO's with special emphasis on the economics of tobacco control.

To build the capacity of public health professional and institutions the PH program sponsored bilateral East-West partnerships between public health schools and faculties. The University of Debrecen School of public health in Hungary, offered fellowships at the Braun School of Public Health in Jerusalem and the College of Health Sciences here in the American University of Armenia.

In addition to supporting the network's foundations and initiatives, OSI makes funds available to a variety of organizations, especially in the fields of human rights and anticorruption. Many of these grantees form close partnerships with OSI and are considered an integral part of the OSI/Soros Network.

I will finish with a few words about Soros, the author and philosopher. Soros is the author of eight books, including *The Bubble of America Supremacy: Correcting the Misuse of American Power* (Public Affairs, January 2004); *George Soros on Globalisation* (2002); *The Crisis of Global Capitalism: Open Society Endangered* (1998); and *Open Society: Reforming Global Capitalism* (2000). His articles and essays on politics, society and economics regularly appear in major newspapers and magazines around the world.

George Soros is a man who has always taken a deep interest in world affairs and has spent many years now working for the public good as demonstrated by the activities of the OSI. For all of these reasons there can be no doubt that George Soros is a very worthy holder of the Andrija Stampar Medal and I have great pleasure in asking our President, Anders Foldspang to present it to him via Michael Borowitz, Head of the Public Health program, on your behalf.

27th ASPHER conference, Yerevan Armenia 18th September, 2005
Michael Borowitz accepting the Stampar Award on behalf of George Soros

It is a great honor to accept this prize on behalf of Mr. Soros. Mr. Soros would like to have been here, but due to present engagements he was not able today to be here and asked me to accept this prize on his behalf. One of the things that he asked me to convey was that although he accepts the prize, he feels that the entire network is deserving of the prize. The Soros Foundation is constructed as a network of individual country level foundations. The Public health initiative is a network program: everyone has been involved in the activity around strengthening schools of public health, particularly the national foundations that we are working with at an individual level. Therefore we are accepting the prize really on behalf of entire network.

I think this is a very good time for us to receive this prize and to reflect on Soros Foundation activities in public health. It is a turning point for the foundation. As Aislinn said in her introduction, traditionally we have worked largely in Eastern Europe and the Former Soviet Union. However, increasingly, our mission has grown and our activities in general are more global. Mr. Soros began his public health philanthropic activities in South Africa taking on the Apartheid Government. Actually there is a long tradition within the foundation of work in Africa. That engagement has increased and will increase in the future. I am very glad to see that we have been able to invite people from other parts of the region where we are increasingly active; particularly we have schools of public health here from South Africa, from Ghana, from Kenya, and also from Iran and Lebanon and Palestine. This is a great opportunity for turn to reflect on a global challenge in public health.

I think that it might be useful to discuss the Soros Foundation briefly and the Open Society Institute and its agenda in public health. The agenda for the foundation is much broader than public health. To some extent it is represented by the name of the foundation - The Open Society Institute. The Open Society is a concept that comes from Karl Popper. Reflecting on the state of the world during the period of second world war and the horizon of totalitarianism, Popper conceptualized what constitutes the strength of open societies, and what is needed to have an open society. Some of the critical characteristics he mentioned – and I think they are important to reflect on and to reflect what they mean for public health – are open discussion and the free expression of ideas. Another is a civil society, one that is outside of the government. The third is a mechanism of democratic accountability where governments can be held accountable through rule of law. The fourth is the participation of all members of society, particularly the most vulnerable members of society.

The Open Society Institute as a foundation works on those four broad areas. The strongest focus of the overall OSI foundation program is on strengthening civil society. Particularly, here in Armenia, the primary goal of the foundation is to work on the strengthening civil society and the second largest program would be the rule of law, called the “Justice Initiative”. There is another program that works on the free flow of

ideas called “The Information Program”. These are all of the central programs. Now I want to reflect on how all these elements fit together in relation to public health.

The Open Society agenda for public health encompasses two broad agendas. The first focuses on marginalized populations and the second on concepts of accountability in public health as a role of civil society.

Regarding marginalized populations: I think that we actually touch on many of the areas that address marginalized populations. I would say the largest program that we have is HIV/AIDS and these populations affected by the HIV epidemic, particularly in Eastern Europe and the Former Soviet Union. For the last 10 years, we have been the largest funder of HIV prevention among injection drug users. We introduced the harm reduction strategy for this region called the needle and syringe exchange program. Additionally we are working on trying to restructure the risk environment around injection drug users. We also have programs for other marginalized populations affected by the HIV/AIDS epidemic, particularly sex workers and men who have sex with men, through programs for human rights. In this way we work with all marginalized populations that are touched by this pandemic.

We are the largest funder in the area of mental disability. Our long standing interest in the Eastern Europe and FSU is where the institutionalization of mentally ill and mentally disabled remains. This is an ongoing problem that is not going to be resolved easily within the region. We will continue to provide significant funding in the area for this marginalized population.

Roma, as gypsies, remain a critical issue in Eastern Europe. They are socially excluded not only from health services, but from education, from employment, and from housing. One of the areas that we are particularly interested in is the joint initiative of the Soros Foundation and the World Bank to try to improve the social integration of this population.

Another important group of issues particularly in relation to schools of public health, are the concepts of accountability in health and in public health. Questions that we discussed yesterday with schools of public health from Southern Africa and the Middle East, i.e. who will advocate for public health, and for population health in order to hold government responsible in countries? There really is no one to argue for population health. So the role of schools of public health becomes critically important in advocating for the public’s health at the country level. Working with schools of public health at the country level: to create a civil society that will hold governments responsible for their commitments in the area of health.

When we talk about civil society many people think exclusively of non-governmental organizations; and although non-governmental organizations play an important role, I think civil society needs to be regarded more broadly. Civil society will include academic institutions such as schools of public health and medicine. Mechanisms of accountability in public health, because many of the issues in public health are technical. These are

complex epidemiological issues that need to be translated to civil society organizations and use that information to hold governments accountable.

Although the current program around capacity building of schools of public health is coming to the end, we will continue engagement with schools of public health and the ASPHER office, particularly around the issues that I have been discussing -around accountability and around marginalized populations. And let me begin with the role of accountability.

As I mentioned before, one of the questions that we need to figure out is who is going to advocate for population health. There are a lot of different organizations but they focus on fairly narrow issues for example on HIV/AIDS. One of the issues we have been discussing yesterday, particularly as it relates to Africa, is that this tremendous assistance coming into Africa for AIDS from President Bush's initiative for HIV/AIDS and from the Global Fund which focus on early disease-specific programs. But who is actually advocating overall for the health of the population and for a structure of the overall health system that will improve the equity within the health system? I believe that schools of public health have a critical integrating role in thinking about population health and advocating, at the country level, the need for workforce development assistance and for country specific health policies that actually address the overarching issues of population health.

The second area is serving the critical role of translating technical issues in public health for civil society advocates. Although South Africa is within the treatment action campaign, and successful, however it is critically important that public health issues which are technical be translated to civil society organizations so that they can efficiently advocate, and advocating for the right issues. It is important to have a science-based, public health platform and for that information to be effectively communicated both to the media and to the civil society organizations. These entities have the foremost role in serving a civil society thus capable of drawing maximum attention to public health issues. Schools of public health play a critical role in bringing together civil society organizations and advocacy organizations that are working in the area of public health, so that they have some place to meet and to discuss technical issues. The OSI Board is trying to maintain some type of perpetual public health monitoring role in relation to government and a number of schools of public health have the capacity to assume that function. It is critically important for someone other than the government to be watching what is happening at the country level. So, in the area of public health who is going to provide that critical monitoring role? Who is building commitment to broader issues of health?

The second broader area is to see greater engagement of schools of public health around marginalized populations such as injection drug users, sex workers, around HIV/AIDS, around mental health, around Roma. We spent a lot of time building capacity and now would like to see fruits of that labor payoff, particularly on engagement in some of these areas. We would like to open up a dialog about how schools of public health could play a more critical role in working in some of these problematic areas.

My own theme that I would like to express is around globalization. Aislinn O'Dwyer raised a point on issue: Mr. Soros has written several talks about the issue of globalization and the changing global situation. I think that public health issues are really at the heart of globalization: the SARS epidemic raises very interesting questions globally. I think that this is one of the reasons public health awareness increased its prominence within OSI...because of seeing public health as a venue for opening closed societies and for thinking about how public health can integrate societies. Infectious diseases raised this issue, and I think that HIV/AIDS is another example of a disease of global proportion, with global implications and global consequences.

What has particularly changed in relation to HIV/AIDS, tuberculosis and malaria is the creation of new global governance instruments like the Global Fund for AIDS, TB and malaria. This is a new global partnership between the public sector and private sector that involves civil society. It is critically important that these mechanisms in public health, which are increasing the resources in public health, work effectively at the country level. But one of the questions about these new global mechanisms, and there are several, is what is the mechanism of accountability at the country level? How do we make these mechanisms work at the country level and how do they hold people accountable? The accountability arrangements for these mechanisms are very unclear, and in general there are not really any mechanisms of accountability at the country level, so we are concerned not only with accountability mechanisms, and whether or not these mechanisms actually reach socially marginalized populations.

We are also concerned about the overall effect on public health. Many governments focus on one specific disease and do not address population health. Then, you are taking for example already scarce resources from immunization to deliver services for HIV/AIDS. This is particularly true for South African countries. It is critically important to institute mechanisms of accountability. We believe that schools of public health can play the critical role in both monitoring and accountability in this new global governance arrangement.

In conclusion, I think it is critical for us to engage schools of public health in Eastern Europe and the FSU. I think this dialogue will continue throughout this conference in further sessions. We would like to reflect on what it is that we are accomplishing, and what the likely implications might be for other regions where we are beginning to work. This dialogue throughout the meeting will guide us around issues related to global law.

Finally I would emphasize that our initiatives are now global, and invite you to think about mechanisms for global accountability in public health to ensure that the voice of our traditional target region of Eastern Europe and the FSU fits into this emerging global mechanism. Although a lot of this new focus is on the AIDS epidemic in Africa, it is important that voices be heard regarding the epidemic in Eastern Europe, of particular aspects of the epidemic, and how global mechanisms need to be realigned in response to this information.

I would like to thank you again for the prize. I know that Mr. Soros appreciates it very much, and apologizes for not coming to thank you personally for the honor.

CONFERENCE LECTURES

New and Emerging Infections: Catalysts for Change in Public Health

D.A.Henderson, MD, MPH

Dean Emeritus, Johns Hopkins School of Public Health
21st Century Professor of Medicine, University of Pittsburgh
September 2005

From the mid-point of the 20th century, the focus of interest in public health progressively shifted from concerns about the infectious diseases and sanitation to chronic diseases – primarily cancer and heart disease – and the exploration of alternative systems for health care. The reasons for this are understandable. During the 1950s to 1970s, many infectious diseases, at least in the industrialized world, declined sharply or even disappeared. The causes were several – new vaccines and antibiotics, improved nutrition and housing, better sanitation and health care. Optimism, at least in some quarters, was unbridled. In fact, Sir Macfarlane Burnet, the Australian Nobel Laureate stated: *“One can think of the middle of the 20th century as the end of one of the most important social revolutions in history, the virtual elimination of the infectious diseases as a significant factor in social life.”* Although we knew that progress in the developing countries was modest, at best, resources for research and education in the infectious diseases steadily eroded.

In 1981, however, a small dark cloud appeared on the horizon in the form of the first cases of AIDS and by April 1984, the responsible virus was identified. The U.S. Secretary of Health and Human Services proclaimed this to have been “the triumph of science over a dread disease” and predicted confidently that a vaccine would be available in two years. Time passed and the unwarranted hubris among researchers and politicians began to ebb. Now, some 20 years later, a world-wide pandemic is in progress; AIDS is the fourth leading cause of death world-wide; there is no vaccine in sight and the quest for a curative drug still continues.

Other microbial agents have appeared: SARS from Asia; transmissible spongiform encephalitis (“mad cow disease”) from England; H5N1 influenza from Asia; monkeypox from Africa. Indeed some 30 new or emergent agents have been identified during the past 25 years. Increasingly, we are coming to appreciate that there are countless microbial agents, known and unknown, constantly evolving and adapting themselves to new hosts and, more readily than ever, being transmitted across the world. At the same time, it has been recognized that there is a markedly increased risk of microbial agents being used as weapons of terrorism. The microbial threat was aptly characterized by Dr. Joshua Lederberg, formerly President of Rockefeller University and a Nobel Laureate, in solemnly pointing out that man’s only competitors for the dominion of the planet are the viruses and that the ultimate outcome of that competition is not foreordained.

Why is the threat becoming apparent at this time? Few, today, appreciate the profound and increasingly rapid societal changes that are taking place across the world. Four are of particular significance. The growth in urban populations is staggering. Fifty

years ago, there were only two cities with a population greater than 5 million persons – New York and London. Today, there are 20 with populations larger than 10 million and 6 that have more than 15 million. Many of these cities are in tropical and subtropical regions where crowding is most severe, malnutrition is common and sanitation is minimal – a fertile soil for a mutant organism to gain a foothold and to be transmitted. Second is the logarithmic growth in international travel – 18 million commercial flights each year carrying 1,600 million passengers, some coming from the most remote parts of the world. No town on earth is more than 36 hours from any other town, well less than the incubation period of most infectious diseases. Third is the fact that we are witnessing an unprecedented growth in hospitals and health care facilities everywhere. Although this could bode well for better health, many of these facilities have limited equipment and trained personnel; provisions for sterilization are often limited; and cross-contamination is not uncommon. Thus, many, unfortunately, serve as a focal point for transmission of blood-borne disease and antibiotic resistant organisms. Finally, foods of all types are moving across the globe in unprecedented quantities, sometimes carrying with them, microbes of many types. An internationalized food supply is not an unmitigated advantage. At the same time, food production and processing has been moved from small farms and animal herds to enormous farms, large herds of animals and food processed in factories of a size, hitherto unknown. With these developments has come the possibility of contamination and spread of disease across large areas and to large populations.

A further threat has emerged over the past decade – the possible use of microbes as biological weapons. This was a threat that was essentially ignored until the mid 1990s in the belief by many that it was so difficult to grow and disseminate highly virulent organisms that none would try to do so and, in any case, biological organisms had seldom been used by nation states in warfare. However, as rapid advances began to be made in biotechnology, the capacity and expertise for producing potential weapons became ever more widely available and potentially possible in laboratories around the world. A watershed event was the discovery in 1995 that a little-known religious cult in Japan had produced and endeavored to disseminate both anthrax organisms and botulinum toxin throughout Tokyo and were planning to acquire Ebola virus so as to be able to disseminate it in an aerosol spray. Meanwhile, the cult released sarin gas in the Tokyo subway inflicting many casualties.

An equally disturbing revelation was made in the 1990s by the former Deputy Director of a hitherto unknown USSR bioweapons program after he had defected. Prior to his revelations, it had been thought that, since 1973, as a result of the Biological Weapons Convention, all countries had ceased research and production of biological weapons. He brought the alarming news that the Soviet Union had had a biological weapons program, that employed some 60,000 persons at 50 laboratories. It was, in fact, as large as the Soviet nuclear weapons program. The weaponization and production of large quantities of smallpox virus were an important part of this effort. Subsequent to the Russian economic crisis, support to the laboratories sharply diminished and many scientists left to take positions elsewhere in Russia and the rest of the world, bearing with them, knowledge of biological weapons.

In our own country a 2000 review of programs needed to deal with disease outbreaks of any substantial size, especially those involving large numbers of patients, revealed that few municipalities, states or countries were at all well-prepared. The potential release of biological weapons was a real concern but the SARS outbreaks served to illustrate the fact that Mother Nature herself could potentially precipitate no less a major human infectious disease catastrophe even in this present era. If complacency prevailed briefly as the SARS threat receded, we now have the even more ominous challenge posed by H5N1 influenza and its potential for pandemic spread and casualties that could rival or exceed in number the 1918 outbreaks when tens of millions died world-wide.

Given the diverse possible array of agents that could conceivably result in large enough numbers of cases to threaten civil integrity, it is impossible to be fully prepared to deal with each. However, there are basic preparations that can be made that would be relevant to threats, whatever their origin. Of principal importance is the need to greatly heighten the level of public health and emergency preparedness and a special program with this in mind was initiated in the United States four years ago. This is a complex and long-term task and, as evidenced this month in New Orleans, it is clear that our own country has a very great deal yet to be done. The essence of such a program is based on the development of mechanisms for rapid detection of a problem and its immediate investigation and characterization by public health teams, diagnosis by experts and requisite laboratories, plans to respond with large scale deployment of vaccines or antibiotics and well-defined plans to provide medical care for much larger numbers of patients than are normally accommodated.

To effect an operable plan requires participation of a diverse array of different groups including health care workers, hospitals, voluntary organizations such as the Red Cross and Red Crescent, law enforcement to assure order, methods of transportation for patients and refugees, methods for essential communication among the principal participants and with the general public. Who should lead such an effort whose principal objective is the prevention and alleviation of human suffering? In an earlier era, the public health department was usually expected to take a predominant role in orchestrating the diverse organizations and talents necessary to meet the challenge. However, in our own country and I know in many others, public health departments have diminished in size and expertise; many now lack skills in epidemiology and management; and surveillance systems that might detect problems have languished.

Change is needed in the perception of and respect for public health. Today, an important opportunity is offered for public health to reaffirm its role and to take a lead in fostering the needed community and national programs for emergency preparedness measures for public health and medicine. Regrettably, Schools of Public Health, as a whole, have not been distinguished for their leadership in policy development, in research and in needed public advocacy. And this, I would note, is from the perspective of one who has spent 14 years as a Dean of a School of Public Health and, who, more recently, has been involved at the highest level of government in endeavoring to initiate national

and local programs of public health preparedness. It seems to me that there is not only a need but an important opportunity for a fuller mature development of Schools of Public Health that are professional schools; that work closely with those who are dealing with real world problems; that are truly dedicated to educating tomorrow's professional leaders in public health; that undertake research to bridge the now cavernous gaps between basic research and its application; and that define and actively advocate for needed public policy. The need is international.

A final caution is in order and, for this, I quote from a statement published two years ago by the U.S. Institute of Medicine – as you know, one of our National Academies of Science:

“Today’s world is truly a global village, characterized by growing concentrations of people in huge cities, increasing global commerce and travel...One can safely predict that infectious diseases will continue to emerge...Depending on present policies and actions, this situation could lead to a catastrophic storm of microbial threats.”

New and Emerging Infections: Catalysts for Change in Public Health

D.A. Henderson, MD, MPH

Center for Biosecurity, U. of Pittsburgh Medical Center
Dean Emeritus, Johns Hopkins School of Public Health

XXVII Aspher Annual Conference
Yerevan, Armenia
September 2005

- *Man's only competitors for the dominion of the planet are the viruses – and the ultimate outcome is not foreordained.*

Joshua Lederberg
Nobel Laureate, USA

The competitors are increasing

- New and emerging infections have been increasing in number
- The sources of the threat:
 - Natural mutation of microbes
 - Emergence of organisms from remote areas
 - Biological terrorism
- The threats are international

"Conquest" of the infectious diseases 1950s-70s

- Dramatic changes: 1950-1970
 - Vaccines
 - Antibiotics
 - Nutrition
 - Housing
 - Sanitation
- Decline or elimination of many diseases in the industrialized world
 - Smallpox, diphtheria, whooping cough, tetanus, polio, measles, *et alia*

- *"One can think of the middle of the 20th century as the end of one of the most important social revolutions in history, the virtual elimination of the infectious diseases as a significant factor in social life"*

Sir Macfarland Burnet
Nobel Laureate, Australia

A cloud on the horizon

- June, 1981 – first cases of AIDS diagnosed
- April, 1984 – HIV is identified
 - "the triumph of science over a dread disease"
 - "a vaccine will be available in 2 years"
- 2005 -a world-wide pandemic in progress
 - 4th leading cause of death world-wide
 - No vaccine
 - No curative drug

HIV is not the only surprise

- 1989 Conference on Emerging Infections
- An illustrative additional inventory
 - SARS – from Asia
 - Monkeypox – from Africa
 - TSE – “mad cow” disease – from UK
 - *H5N1 influenza* – from Asia
- More than 30 new agents in 25 years

Why now?

- Growth in urban populations
 - Population of cities
 - 1975 – 5 with more than 10,000,000
 - 2005 – 20 with more than 10,000,000
 - 6 with more than 15,000,000
 - By 2015
 - 5 cities with more than 20,000,000 persons
 - 55% of world's population in urban areas

Why now?

- Growth in urban populations
- International travel
 - Volume
 - 18 million commercial air flights yearly
 - 1.6 billion air passengers per year
 - Remote area destinations
 - All cities less than 36 hours from others

Why now?

- Growth in urban populations
- Travel
- Growth of hospitals in endemic areas
 - Major sites for disease distribution
 - Problem of blood borne diseases
 - Development of antibiotic resistance

Why now?

- Growth in urban populations
- Travel
- Growth of hospitals in endemic areas
- Food supply
 - Internationalized
 - Industrialized
 - Animal husbandry
 - Food processors

Intentional release of biological agents

- A threat, largely ignored until 1995
 - Too difficult to grow organisms
 - Technologically difficult to disseminate
 - Not used because of a moral barrier

What has changed?

- Advances in biotechnology
 - Numbers and sophistication of laboratories
 - Information access – internet
 - Trained microbiologists
 - Aerosolization devices
- Growth of independent terrorist groups

Watershed events Aum Shinrikyo -- Japan

- Religious cult released Sarin gas in Tokyo subway (1995)
 - Cult - previously unknown to intelligence
 - Thousands of members, well-funded
 - Tried to aerosolize anthrax and botulinum toxin throughout Tokyo at least 8 times
- *Concern – unknown, non-state sponsored organization, acting without concern for moral deterrents*

Watershed events USSR Bioweapons Program

- A secret program – unknown until 1989
- 1992 – Ken Alibek, Deputy Director of bioweapons program, deserts
- 1995 – Full scope of program apparent
 - 60,000+ persons in 50 different labs
- *Concern – Expertise and possibly specimens now dispersed world-wide. Still a secret program*

"On May 8, 1980, WHO announced that smallpox had been eradicated..Soon after, **smallpox was included in a list of biological weapons targeted for improvement in the 1981-85 Five -Year Plan...**

Where other governments saw a medical victory, the Kremlin perceived a military opportunity...the military command issued an order to maintain an annual stockpile of 20 tons (of smallpox virus)."

Alibek, 1998

A recurrent menace -- influenza

- Influenza – 1918 – H1N1
 - Case-fatality rate - about 2 %
 - Deaths -- U.S. 675,000
World >40,000,000
- Influenza – 2004/2005 – H5N1
 - ~100 cases/ 53 deaths

Responses to the threat

- Detection
 - Mechanisms for reporting "24/7"
 - Team for emergency investigation
- Diagnosis
 - Known and identified experts
 - Laboratory capability
- Response
 - Vaccines, antibiotics
 - Isolation and quarantine
 - Provision of medical care

Coping with the New Threats-- public health leadership is key

- Planning and preparation
 - Collaborative participation of many groups needed
 - Health care staff and hospitals
 - Voluntary organizations such as Red Cross/Red Crescent
 - Pharmaceutical and medical supply providers
 - Law enforcement agencies
 - Education and transportation departments
- Execution and the role of a command center
- Communication
 - Public
 - Local, national, international – political and professional

Special needs for the future

- Greatly strengthened network of international cooperation and communication
 - Cooperative international centers for epidemiology and laboratory diagnosis in all countries
 - A far more generously supported WHO effort to orchestrate the many national initiatives
- A focused research and development program

- "Today's world is truly a global village, characterized by growing concentrations of people in huge cities, increasing global commerce and travel...One can safely predict that infectious diseases will continue to emerge...Depending on present policies and actions, this situation could lead to a catastrophic storm of microbial threats."

*Institute of Medicine/ National Academy of Sciences
Microbial Threats to Health, 2003*

- *International collaboration and cooperation is not an option for dealing with infectious diseases. It is a necessity if mankind is to survive.*

Reaching Beyond Boundaries in Academic Public Health:
The case of the American University of Beirut
Huda Zurayk
Keynote presentation: 27th Annual Conference of ASPHER
American University of Armenia
September 20, 2005

I am happy to be participating in the 27th Annual Conference of the Association of Schools of Public Health in the European Region (ASPHER) in Yerevan, and to be addressing this august audience this morning. The Conference theme on development perspectives of public health schools is an issue at the heart of my current concerns as Dean of the Faculty of Health Sciences at the American University of Beirut, and the Conference inclusion of the Middle East and Africa regions together with its main concern for the European region brings our perspectives closer together. This is an opportunity for me to share with you some of my experiences in academic Public Health in the Middle East region, and to draw from these experiences lessons that would hopefully be relevant, useful, and interesting for you too in your various environments. At the outset, I would like to thank in particular Dr. Haroutune Armenian, President of the American University of Armenia, for this invitation. Dr. Armenian is a colleague and a friend who was a faculty member and who served as Dean of the Faculty of Health Sciences at the American University of Beirut, leaving a strong valuable mark on FHS that is well appreciated at the Faculty and the University to date.

The title of my presentation this morning is “Reaching Beyond Boundaries in Academic Public Health: The case of the American University of Beirut”. “Reaching beyond boundaries” is the theme we adopted for the 50th anniversary celebrations that we organized last year for our Faculty of Health Sciences, mainly a school of public health which was established at the American University of Beirut in 1954. [Slides 1, 2, and 3] For it is my experience that as we strive to bring about health and well being to the populations of the world wherever they may be, we encounter boundaries that engulf our work as individuals and groups, boundaries that present us with contours that we sometimes work within and that we sometimes must choose to reach beyond. Dealing with boundaries requires a delicate act of balancing and choosing, and to make choices, we need to have a clear vision of where we want to go and an understanding of what is involved in getting there.

In my presentation, I will speak of five situations in my life where I have observed or have been part of processes of dealing with boundaries. Although I am recounting a particular case drawing from my own professional life in academic public health in a developing region of the world, I believe the case has relevance to development perspectives of schools of public health that is the concern of this Conference.

Let me begin by introducing where I come from briefly. I am really lucky to have been born in Lebanon, a beautiful country on the Mediterranean sea [Slide 4] which has offered me a wonderful childhood and adolescence, and where I happily continue to live

today despite the turbulences the country has passed through and continues to experience. I am also lucky to have been born into a family with strong educational resources where the stage was set for me from early on to pursue a University education and a specialization. This was not the case for the majority of women in my country and in the Arab region at the time I was growing up, and it is still not the case today.

1. The first situation I would like to consider here is the situation of being a woman in my region of the world and the boundaries that that imposes on the potential for professional involvement and growth. Indeed, it has been a concern of mine to observe these boundaries as they are experienced and negotiated by women, not only in developing countries, but worldwide. I see the boundaries between family and work as an issue for women everywhere, even though they may be experienced differently in the different regions of the world. I believe that not enough support has been offered to women to help them harmonize their dual roles.

My region of the world is complex particularly where lives of women are concerned. I will therefore consider here what I see as the most important issue in women's lives, namely, the extent to which women have the valuable resource of education that opens up possibilities for their lives. For without education, choices are very limited and this, I believe, should not be allowed in our day and age. The international agenda for women in developing countries has included education for girls as an integral issue especially recently. But in actual fact, on the public health front, I have seen issues for our region such as family planning and female circumcision take priority and precedence on the

international scene. Setting priorities is difficult when resources are limited but to my mind nothing can replace education in opening up the boundaries that surround women's lives in developing countries with all the positive consequences that follow.

I will review data from our region on selected countries [Slides 5] beginning with Lebanon, Jordan and Syria, that are relatively smaller countries with mainly service-based economies, to Egypt, Morocco and the Sudan that are largely agricultural and have substantial rural populations, and finally to Bahrain, Kuwait and Saudi Arabia that have oil-based economies.

It is clear that for all these countries except for Lebanon, the great majority of adult women were illiterate in the 1960's and early 70's. Men everywhere fared better. This situation has changed drastically and we find that all countries shown here have made big leaps forward in terms of reducing illiteracy levels of adult females and males. Yet still in some countries like Egypt, Morocco and the Sudan, a majority of adult women remain illiterate to date. Taking a historical perspective presents a more positive profile of the current status of educational levels in our region especially for women. It is clear, however, that we have a long way to go in providing women with the education and with university education [Slide 6] that enables them to have choices in their lives.

I was extremely lucky to have had the opportunity of good secondary and University education, which exposed me to diversity and opened up boundaries of mind and space for me. Since I did not get married, I did not face the boundaries standing between the

home and work that the majority of women face in all countries of the world. These are constraining boundaries for women in our region where marriage is highly prevalent and fertility, though recently declining, still stands at three or more per woman for most of the region. Two other features of family life in our region add to women's housework and caring burden: first children tend to stay at home until they marry and second parents and/or parents-in-law either reside with or are a responsibility for women. Thus married women are faced with tight boundaries within which to plan their lives.

I see that everyday around me among the young women faculty at AUB and among wives of faculty, and they make difficult choices. Some choose to pursue careers and have a hard and stressful time in coping. Others decide to stay at home or take less demanding positions to balance between family and work, which is sometimes difficult and equally strenuous. I know that the situation is similar for women all over the world and I believe that the world has failed women in providing support for their dual role. To my mind these boundaries on women's lives should be an important public health concern. On the one hand, women offer the best care for families, which is certainly desirable and an advantage. On the other hand, women need the support systems to enable them to go beyond the boundaries they willingly impose on themselves in marriage and raising a family. Education and support systems are important to promote women's health and well-being, and also family health, and must become more of a priority public health issue worldwide.

2. I move to an entirely different dimension as I present the second situation, which is currently coming up to the forefront of my concerns as Dean of the Faculty of Health Sciences, and that is the situation of dealing with the boundaries **between public health practice and research in academic public health**. The constraints drawn around public health practice in academic public health are loosening, while there is still a definite emphasis given to public health research. Balancing between research and practice may not be as much of an issue for professionals in academic public health in the European region. In Lebanon, in the Middle East region, and in developing countries generally, it certainly is. I observe this balancing act continuously at FHS where faculty members carefully negotiate the boundaries imposed on their practice activities in choosing careers in academic public health. The reason they challenge these boundaries is because they are public health experts in a situation of scarce human resources and they are called upon by their governments and by civil society organizations to contribute directly through programmatic involvement to improving public health in their countries and region. For a committed professional this is hard to resist. I would like to illustrate this situation by taking the extreme case of a University in the middle of civil war.

The civil war occurred in Lebanon between 1975 and 1992 and left a serious mark on the country [Slide 7]. We were there a School of Public Health- and Dr. Armenian was the Dean of the Faculty of Health Sciences for a crucial part of that period- we were there within a warring city and as much as we struggled to survive as a teaching institution, we could not also stay away from direct involvement in the public health problems of the city [Slide 8]. Of course, we as faculty tried to publish as much from these experiences as

possible but our involvement on a daily basis eroded the time available for reflection and writing. It took seventeen years for the civil war to end in 1992, leaving huge problems behind.

I left Lebanon in 1987 after experiencing 12 years of civil war (and actually one year after Dr. Armenian left for the US) to work with the regional office of the Population Council in Cairo, and remained there until 1998 when I returned to AUB as Dean of the Faculty of Health Sciences. After an absence of over ten years, I found the Faculty still largely committed and engaged in reconstruction efforts resulting from the war situation. Aiming to strengthen the academic programs at FHS, I had to negotiate with the faculty a return to the boundaries of academic work giving research activities and particularly writing and publication their due time. These were hard negotiations with a young and committed faculty who see part of their role as contributing to improving public health in such a needy situation. It is a hard boundary to negotiate for several reasons:

1. I do appreciate that faculty cannot easily extract themselves from the position of a highly demanded expert, in a situation of such scarce resources.
2. Public Health practice activities are often consultancies that bring in additional income to faculty members who are struggling with an ever-increasing cost of living.
3. It must be recognized also that it is often hard to foresee the impact that research activities, as an alternative development strategy, may have on actual programs and policies, particularly when the mechanisms that support the translation of research findings into public health improvements are weak.

I must emphasize that it is not the involvement of faculty in development projects that is the problem, for having faculty involved in public health practice is certainly a desirable process for a school of public health graduating public health practitioners with an MPH degree. However, in our part of the world involvement often means carrying the heavy burden of the work since in most situations there are no qualified counterparts to work with, and sustainability of such programs becomes also a major worry.

At FHS, we are now working at many levels to alleviate this difficult process of boundary balancing between research and practice. At the University level, we are leading the way in advocating for more engagement of the University with the community it is serving, and for more recognition of community service and professional practice in promotion criteria. We are taking up the challenge of developing modified promotion criteria that take practice activity into account in addition to teaching, research, and service to the University and community. It is a big challenge to develop measurable performance indicators for practice activities, but we need such indicators to be able to pass the modified promotion criteria for FHS through the various University boards, and we recognize that there is likely to be some resistance in this process. On the other hand, we are also trying to fund raise and put a cost to practice activities, so we can recruit “practice” faculty on soft funds who would have the main responsibility of implementation of projects and of working towards their sustainability. However, both funding and human resources are not easily available in our region. Thus expanding our involvement in practice activities is proving a particularly challenging boundary for us to negotiate. Dealing with it, however, is pressing on us as we seek accreditation for our

graduate public health program from the US Council on Education for Public Health (CEPH), where integrating practice with teaching and research is a main requirement.

3. I move to my **third situation for this morning, where I shall consider the boundaries imposed on us by our disciplinary specializations**. Moving beyond the boundaries of disciplines, through interdisciplinary collaborations, is a process that is increasingly being supported especially in academic public health. However, in my opinion that support is not yet strong enough.

I have a rich experience to recount in this respect from my association with the Population Council program in the Middle East region. Following obtaining the PhD degree in Biostatistics from the Johns Hopkins School of Hygiene and Public Health, I returned to Lebanon in 1974 a very quantitatively oriented professional. On my return, I was invited by the Population Council program in the region to participate in its activities, including serving on research committees and attending workshops that included sociologists, anthropologists and other social scientists. What a shock it was for me to hear particularly the anthropologists speak about their research over a few cases and hear what seemed like soft descriptions of results. With time, however, and also especially after being involved in a truly interdisciplinary study, the Giza women's reproductive morbidity study, while living in Egypt between 1987 and 1998, that my perspective totally changed to an appreciation of the diverse methodologies that can be applied to understanding public health problems.

I collaborated on this study with a leading medical anthropologist and a prominent Obs Gyn physician from Egypt. The study also included participation of other social science, medical, and public health researchers. The experience of this study provided me with very positive perspectives to interdisciplinary collaboration between public health, medical, and social science disciplines, perspectives that I have been able to put to good use in my current position as Dean of FHS. For while concerned with developing the classical public health disciplines of epidemiology and biostatistics, health behavior and education, health management and policy, and environmental health, I am at the same time building the social science disciplines at FHS. I have been recruiting sociologists and anthropologists to provide our students with an appreciation of the socio-economic and cultural context of public health, so important for our region. On the other hand, I am also rebuilding strong bridges with the Faculty of Medicine at AUB both to benefit from this sister specialization in our teaching and research programs, and also perhaps to help bring a more holistic approach to the teaching of Medicine at AUB.

So I am whole-heartedly in support of going beyond disciplinary boundaries. However, I find that interdisciplinary collaborations still face constraints that are not easily overcome in academic public health. First, building an interdisciplinary team and undertaking interdisciplinary research is time and effort consuming, and this is often not considered an investment worth making. Second, interdisciplinary collaboration may sometimes require compromises to be made in research methodology, which may not be readily acceptable. For example, in the Giza Study since we undertook medical examinations, which are very expensive, we had to restrict our sample to 500 women. To us the insights

we got from the medical component of the study are worth any shortcomings imposed on generalizability of results. However, the issue of representativeness of our sample was always brought up as a shortcoming whenever we presented our findings anywhere in the world. Finally, those seriously engaged in interdisciplinary collaboration, may find that their ability to contribute to their own discipline has diminished. I am no longer the mathematical statistician that I was, and the anthropologist on our team is not considered theoretical enough, and the Obs Gyn physician is considered “soft” by some of his medical colleagues. Since the three of us had attained professor rank and professional status in our countries and the region before conducting the Giza study, we were not worried. In fact, we were able to get the message across quite effectively. However, that might not be the case for a young professional beginning work in academic public health. Such a young professional would have to negotiate carefully the boundaries between disciplinary validity, which receives primary recognition in promotion considerations, and interdisciplinary collaboration. I believe that everywhere in the world support and academic recognition for the value of interdisciplinary collaboration should be enhanced. Our educational, research and practice programs need to fully face interdisciplinary challenges for a better preparation of our students to address the complex public health problems and realities they will face in their work.

4. The fourth situation I would like to bring here this morning is a new and ongoing experience that I will only recount briefly and will not elaborate on, as I feel that more time is needed for reflection and for drawing lessons learnt. We have recently embarked at FHS on a research program, supported as part of a grant by the Wellcome Trust

Foundation, and the aim of the program is to design and implement intervention studies in impoverished communities on the outskirts of Beirut directed at improving dimensions of health for adolescents, for reproductive age women and for older adults in these communities. Moving beyond the boundaries of classical research designs to incorporate a more participatory research approach has been both fascinating and trying, especially as we are funded by a foundation used to work within the boundaries of research designs imposed by the medical sciences. We are seeking community participation at every stage and are developing quasi-experimental intervention research designs that are more amenable to community implementation. I am sure there will be many lessons learnt from this experience of taking up the challenge of community-based intervention studies.

5. Finally I come to my **last situation of concern, which involves a University trying to go beyond its geographical boundaries**, as is the case for the American University of Beirut and that is part of its continuous history [Slide 9]. We at the Faculty of Health Sciences have been carefully considering our two goals of offering excellent education and relevant education: relevant primarily for contributing to developing the workforce in Lebanon and the Middle East region. We recognize that these goals call upon us to reach beyond the boundaries of Lebanon in attracting students from the region, and also in building networks with public health professionals and institutions from the region and internationally. We are thus dynamically moving outside of our geographical and cultural boundaries to satisfy our primary mission of preparing qualified public health professionals, and of contributing to the development of public health in the region. We willingly cross geographical and cultural boundaries for a partnership approach which

recognizes that these boundaries have meaning and that global does not negate the local and the regional.

Within this effort comes my participation in this ASPHER Conference to share experiences, to learn from the rich experiences available here, and to develop linkages and networks for the future. I believe that such exchange and networking make us all better Schools of Public Health, and enable us to collaborate in meeting the huge challenge of contributing to improved health and well-being in our societies. It is important to recognize, however, that successful networking is a time consuming process and that it is best to choose strategically the most efficient, productive and meaningful networks to invest in. At FHS, we have chosen to invest in regional research networks, with international contribution, around particular research interests such as reproductive health, childbirth, tobacco control, environmental issues and others. These networks are dynamic and flexible and have greatly contributed to enhancing the research environment, including research training for our students, to increasing research productivity and to opening up opportunities for engagement with policy.

These are networks that support the mission of the University which is to bring excellent education and quality services to the peoples of Lebanon and the region, so that, as the words engraved in stone at the main entrance of the university read, so that they may have life and have it more abundantly [Slides 10 & 11].

Thank you.

Slide 1- History AUB
1866 Syrian Protestant College
1920 American University of Beirut

Faculty of Arts & Sciences	1866
Faculty of Medical Sciences	
Faculty of Medicine	1867
School of Pharmacy	1871 (until 1979)
School of Nursing	1905
School of Dentistry	1910 (until 1940)
School of Public Health	1954
Faculty of Engineering and Architecture	1951
Faculty of Agriculture and Food Sciences	1952
School of Business	2001 (out from FAS)

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Slide 3- FHS Departments and Academic programs
Enrollment: fall 2004-2005

Department	Undergraduate		Graduate	
	BS	MS	MPH	TOTAL Graduate
Medical Laboratory Technology	102			
Environmental Health	107	12		12
Epidemiology & Population Health		13	17	30
Health Behavior & Education			28	28
Health Management & Policy			54	54
(General MPH)			5	5
TOTAL	209	25	104	129
Grand Total	338			

**Slide 2- Public Health at
AUB**

1954 School of Public Health

(Faculty of Medical Sciences)

1978 Faculty of Health Sciences

1978 Faculty of Medicine

- Public Health
- Nursing
- Allied Sciences

- Medicine

1982 Faculty of Health Sciences

1982 Faculty of Medicine

- Public Health
- Allied Sciences

- Medicine
- Nursing

**Slide 5- Illiteracy rates for Adult Women and Men
in Selected Arab Countries**

Country	Illiteracy rate (15+) in %			
	1960-1973		2000-2004	
	Women	Men	Women	Men
Lebanon	42 ¹	21 ¹	18 ²	7 ²
Jordan	85	50	15	5
Syria	88	53	26	9
Egypt	88	60	56	33
Morocco	94	78	62	37
Sudan	81 ³	49 ³	50	31
Bahrain	82	64	17	7
Kuwait	90	79	19	15
Saudi Arabia	99	95	31	13

UNESCO, Statistical Yearbooks, 1976 & 2005

1. For Lebanon 10+; 2. UN Statistical Yearbook, 2003; 3. For 1980



Slide 7- War Impact 1975-1990

Lebanon 3.6 million

Estimates:

- | | |
|----------------------|---------|
| • Killed | 150,000 |
| • Injured | 200,000 |
| • Seriously disabled | 50,000 |
| • Displaced | 500,000 |
-
- Psychological trauma
bombing, assault, torture, kidnapping
 - Infrastructural damage
physical economy
 - Migration

UNDP. 1998. National Human Development Report: Youth & Development.

Slide 6- Illiteracy Rates and Gross Enrollment Rate (GER) in Tertiary Education for Youth in Selected Arab Countries

Country	Illiteracy rate in % (15-24)		GER –Tertiary education in % (18-20)	
	2000-2004 ¹		1998-2001 ²	
	Women	Men	Women	Men
Lebanon	7 ³	5 ³	47.6	41.8
Jordan	1	1	31.3	30.7
Syria	7	3	-	-
Egypt	33	21	-	-
Morocco	39	23	9.2	11.4
Sudan	31	18	6.5	7.1
Bahrain	1	1	27.8	15.0
Kuwait	6	8	31.6	12.2
Saudi Arabia	6	2	26.5	17.7

1. UNESCO Institute for Statistics, 2005; 2. UNESCO, EFA Global Monitoring Report, 2005;
3. Human Development Report, 2001



Slide 8-FHS Activities in Endemic War Time

- Emergency and Epidemiological Surveillance
- War Situation Research
- Disease Control Activities
- Evaluation of Services
- Institutional Development

Armenian HK. & Acra A. 1998. "From the missionaries to the endemic war: public health action and research at the American University of Beirut". *Journal of Public Health Policy*, 9(2): 261-272



COMMUNICATION SESSION A

THE SOCIAL CONTEXT OF PUBLIC HEALTH: PROFESSIONAL TRAINING NEEDS IN ARMENIA

Vincent O'Brien, vincentobrien@mac.com
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St martin's College

Purpose

To explore possible education and training responses to the public health challenges facing Armenia in the post Soviet period.

Introduction

Following the collapse of the Soviet Union newly independent Armenia has faced serious economic and infrastructural problems. A deepening economic and energy crisis along with dramatic changes in political and social conditions in the early 1990's led to rapid deterioration in the quality of life and health of the population. With increasing levels of poverty, a failing social security system and under resourced health care services, public health services are ill equipped to deal with health challenges of the 21st Century.

In the Post Soviet era, high rates of unemployment have contributed to significant migration within Armenia and emigration of more affluent groups to Europe and America in search of a better life. This combination of a falling birth rate and migration of key economic groups left Armenia with an ageing population and a deficit of high-level skills and knowledge in important areas of the economy. At the same time as smoking and alcohol related problems were on the increase, activities such as public sport, tourism, entertainment that help to strengthen community networks were neglected in the face of a deepening economic crisis. The economic and political changes along with a rapid transition to an unregulated free market economy, has radically altered the public health needs of the population and the role of public health services.

Following privatization of medical services in 1997, access to health care became more difficult for many poorer groups in the population. A general decline in access to health care is reflected in the drop in number of visits to doctors from 9.8 per capita in 1987 to 1.9 in 2002.

State funding of medical services in Armenia is one of the lowest in the world and fluctuates between 0.8 to 1.3% of GDP in 1997-2002. Per capita expenditure on health is about 10 USD a year. Health care resources are inadequately and unevenly distributed with hospital and medical services receiving around 88% of available funding while preventive services receive less than 6%. Public health services have not been updated since Soviet times and remain concentrated in sanitary-epidemiologic stations that continue to focus on infectious disease and environmental problems related to water quality, waste management, food supply etc. Whilst these issues are of importance there is an urgent need for public health services to become more effective at working with communities, promoting health and engaging in multi agency work around community development and regeneration if they are to make any realistic impact on contemporary public health challenges.

Public health training in Armenia still follows the traditional Soviet model in the medical universities and continues to focus almost entirely on epidemiologic issues, food, water, and occupational safety. There is an urgent need to broaden the curriculum, to learn from the experiences of other countries and to develop a public health system which combines health

protection with new strategies in health development and community regeneration designed to improve the health and well being of the Armenian people.

Methods and materials

Review of policy documents, academic literature and official statistics on public health in post soviet countries especially Armenia.

Results

There is a need for public health training incorporate knowledge and skills that will enable practitioners to:

- use modern community based more social approaches, which help to increase community participation in public health
- work in partnership with environmental, economic, and social services as well as NGO's and private agencies linked to the public health agenda.
- become more focused on primary prevention, promoting healthy lifestyles
- gain skills in working with and through educational, cultural, and business partnerships to help regenerate communities and improve the health of the population.
- communicate effectively with individuals and communities, using face to face and the mass media strategies
- develop skills in problem solving; decision making and evaluating public health data and interventions.

Discussion and conclusion

The changes in the social and economic conditions in Armenia following the collapse of the soviet union have had a direct impact on the health of the population. The public health challenges facing Armenia today are a consequence of social and cultural change. If public health services are to be effective in improving the health of the people they must engage in activities that seek to reform and improve social, cultural and economic factors influencing public health. There is an urgent need for trainers to develop more socially coherent and relevant programmes to equip specialists with the essential skills and knowledge to work effectively in the new conditions facing Armenia.

Keywords: Social Health Context

Innovation and Creativity in Public Health Education

Vincent O'Brien

Kyrgyzstan: Engaging Communities



Public Health Curriculum Development in Kyrgyzstan 2002-2004



- Project Achievements
- 19 new courses within two new undergraduate programmes in public health
 - Preventive Medicine
 - Public Health Nursing
- Masters in Public Health
- Dissemination events and products (Forum, web site and DVD)
- Ongoing research and teaching collaboration



Kyrgyzstan



The Impact of the Collapse of the Soviet Union

Table 2. Health indicators, 1990-1997

Indicators	1990	1991	1992	1993	1994	1995	1996	1997
Female life expectancy at birth ^a	73.0	72.7	72.2	71.1	69.9	69.9	71.0	71.2
Male life expectancy at birth ^a	64.4	64.6	64.2	62.5	61.1	61.3	62.5	62.5
Infant mortality rate per 1000 live births ^a	30.2	29.7	31.6	32.9	29.6	27.7	26.6	28.6
Maternal mortality per 100 000 live births ^a	62.9	55.6	49.9	44.5	42.7	44.3	31.5	62.7
Abortions per 1000 live births ^a	41.6	37.7	34.2	31.9	28.5	23.1	22.4	21.2
SDR ischaemic heart disease 0-64 per 100 000 males ^a	103	104	109	135	158	152	153	136
SDR cerebrovascular diseases per 10 000 ^a	60.7	67.7	71.1	79.8	96.0	103.9	91.1	85.8
Syphilis incidence per 100 000 population ^a	1.9	2.1	2.8	4.4	23	74	153	151
Tuberculosis incidence per 100 000, all forms ^a	52.9	56.9	57.9	54.5	61.4	75.4	90.1	114

Source: ^a WHO Regional Office for Europe health for all database; ^b UNICEF TransMONEE database 3.0.

Key Problems



Public Health Foundations



Adapted from Seedhouse, D (1986) *Health: The Foundations for Achievement* Chichester John Wiley

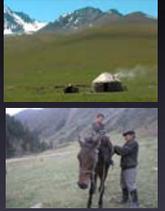
Lifestyle and Culture

QuickTime™ and a H.263 decompressor are needed to see this picture.

Susaanmyr Valley Kyrgyzstan

Research for Change

- Participatory Research
- Collaborative Analysis
- Photo Exhibits
- Participatory Video



Student Video

-What are you doing here?
Just here?

MODEL VILLAGE FOR HEALTH PROGRAMME (MVH) OF ISRA UNIVERSITY: A BASE LINE

Tufail Ahmed Bhatti, dr_tufailbhattia@yahoo.com
Siraj Mohummad Pandhani
Isra University

Purpose

The purpose of study was to determine possible health related problems in village Haji Ismail Chand, identify priorities, and make recommendation to take initiatives for improving the health status of Model Village.

Introduction

In 2000 the Isra University assigned the important task of Model Village for Health (MVH) to the Public health department to be implemented between 2000 and 2003. The aims of the MVH were to access the better services to the population with in selected area, increase the effectiveness and the existing health care network, and build institutional capacity to achieve the above objectives and plan to the strategy for future interventions. MVH is establishing primary health care (PHC) programs, focused on maternal and child health care, serving people in the catchment area of selected health facility. Services were improved by training and supporting community health workers, strengthening referral and enhancing the capacity to handle medical emergencies at the peripheral level.

Methods and materials

A descriptive (cross-sectional Study) was done, in Village Haji Ismail Chand is near Isra University, Hala Road Hyderabad. The village population were 500 heads in 60 houses. These houses are built as slums. The people generally low income group. In this well -defined target population every house was selected just as done in "census". The questionnaire was filled from every house.

Results

We obtained information about the household members. All persons who shared needs with the respondent were defined as a household. We had information of 542 household members, from 58 households. The young population was about 44% of less than 15 years of age. The literacy level in MVH was 36% of the people can read at least read and 15% have a matric certification. Males were better qualified than females. Regarding water supply 90% were using handpumps, 71% of the population don't know the nearest government health facility, 53.4% of village population covered by lady health workers, and only 47% were knowing the name of LHW of in village. In village Haji Ismail Chand (MVH) were using Pit hole (56%) type of Toilet facility which were observed very sever damaged situation. In last 5 years of death records total 23 deaths had been observed, majority were due to old age, only 2 deaths were below 1 year observed. No death during pregnancy or within 42 days of delivery in the households. The disease information gathered, this can be arranged according to the population groupings used in the section pre-school children, school, general population. According to disease priority ranking malaria, T.B, Diabetic mellitus, hypertension were on the top list.

Discussion and conclusion

The selected area of village which we called the MVH should become model when priority wise many intervention small programs will be implemented to improve the health, social and economical conditions of the local peoples. In conclusion, MVH should improve the sanitation

epically waste disposal management, toilet facility, education of the children and health education of every body in the village.

Keywords: Model Village for Health, Isra University, Primary Health Care

MODEL VILLAGE FOR HEALTH(MVH) OF ISRA UNIVERSITY: A BASE LINE AND INTERVENTION

Presented by:

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Research Medical Centre, LUMHS Jamshoro
Sindh, Pakistan

1. Background:

- ❏ In 2000 the Isra University assigned the important task of Model Village for Health (MVH) to the Community Medicine Department to be implemented between 2000 and 2001.
- ❏ The aims of the MVH are to improve the health status of population with in selected area, increase the effectiveness of the existing health care network;
- ❏ and build institutional capacity to achieve the above objectives and plan the strategy for future interventions.

- ❏ Access to better services is being improved by training and supporting creating linkages with community health workers, increasing female paramedical staff, strengthening referral and enhancing the capacity to handle medical emergencies at the peripheral level.

- ❏ Quality is being improved through in-service training of the field staff, upgrading peripheral health facilities, increasing availability of integrating services and increasing management and supervision.
- ❏ Utilization is being improved by encouraging community participation and health education

- ❏ MVH is establishing primary health care (PHC) programs, focused on maternal and child health care, serving people in the catchments area of selected health facility.

- ❏ This survey was conducted to assess demographic and village health profile in which the model village for health is being implemented at the time of providing the inputs.
- ❏ Another survey will be conducted at the end of the project to measure the change in this area after the provision of inputs.

2. Aim of Survey:

- ❏ The aim of survey is to determine possible health related problems in village Haji Ismail Chand.
- ❏ Identify priorities,
- ❏ Make recommendations to take initiatives for improving the health status of Model Village.

3- Objectives: -

- ❏ To determine the demographic situation such as Age, Sex and Martial status and education level of people in village Haji Ismail Chand.
- ❏ To determine the water, sanitation and deaths during the last 5 years in village Haji Ismail Chand.
- ❏ To identify the people's perceptions regarding Utilization of health facilities and diseases priorities in general population, pre-school children, school children and maternal morbidity in village.
- ❏ To finalize recommendations / suggestions of the base line survey for intervention in Model Village for health.

Health Facility:

- ❏ Isra Welfare Hospital was chosen as health facility for "Model village for health" in district Hyderabad; this facility has Surgical, Medical, Gynae & Obs service. Moreover it is located near the selected village.

Site of Study:

- ❏ Village Haji Ismail Chand is near Isra University, Hala road Hyderabad. The village population is approximately 500 heads residing in 60 houses.
- ❏ These houses are built as slums (Katchi Abadies). The people generally belong to low income group. The main sources of income are agriculture, cattle farming, small business and daily wages labor-work.

Sample Selection:-

- ❏ In this well-defined target population village Haji Ismail Chand, every house was selected just as is done in "census" performed at village.
- ❏ The questionnaire was completed once from the entire household in the village, so that each household in the village got equal chance to be surveyed.
- ❏ Household means persons residing in the same compound and share common Kitchen, Head of the household was expected to answer the questions.

Selection and training of interviewers:

- ❏ The Community Medicine department of Isra University selected male students from M-1 batch (1997-1998). These students were learning the community medicine subject for last 3 years and had good communication skills.
- ❏ They received one day training prior to conducting the survey, during the workshop the aims of the Model Village for Health and survey were stressed,

the interviewers were familiarized with questionnaires and they practically administering the questionnaire among each other, before going to the field site.

Date Management

- Data collection took place on 2nd of February 2001. The field editor duty was performed by Dr. Tufail Ahmed Bhatti (Lecturer in Community Medicine Department) who was present in the field at all-times during data collection.
- When the interviewers completed the forms the editor checked them for completeness and consistency.
- Questions were included in the questionnaire to check for errors of data collection. The data were analyzed manually by students in the groups then data were double entered in MS – Word and Excel Program.

Results:

- We obtained information about the household members.
- All persons who shared needs with the respondent were defined as a household.
- These data are based on information about household members provided by our respondent (who was generally the head of the household).
- We have information on 542 household members, from 58 households.
- This is a Young population; about 44 % of the population is less than 15 years of age.
- The literacy level in Model Village of Haji Ismail Chand is fair 36% of the people can at least read, and 15 % have a matric or higher certification. Males are better qualified than females.

MARITAL STATUS OF STUDY POPULATION OVER 15 YEARS OF AGE, VILLAGE HAJI ISMAIL CHAND FEBRUARY 2001.

Category of Marital Status	Numbers	%
Married	138	40.2
Not married	191	55.6
Divorced	1	0.29
Separated	1	0.29
Widowed	12	3.7
Total	343	

TABLE:
EDUCATION STATUS OF STUDY POPULATION AGED 6 – 70 YEARS OF BY SEX
VILLAGE HAJI ISMAIL CHAND FEBRUARY 2001.

Education Status	Male		Female		(Total)
	Numbers	%	Numbers	%	
Illiterate	107	40.5	108	48	215
Can read	4	1.5	9	4	13
Can read & write	11	4.1	11	4.8	22
Primary education	77	29.1	66	29.3	143
Metric	48	18.1	10	4.4	58
Intermediate	6	2.2	0	0	6
Graduate	10	3.7	1	0.4	11
Can read Quran only	0	0	19	8.4	19
Don't know	1	0.37	1	0.37	2
Total	264		255		489

House Hold Information

The socio-economic status is outlined in this survey by asking the respondent the availability or non-availability of type of house, durable goods, presence and number of Cattle.

TABLE
MEANS OF WATER SUPPLY IN VILLAGE HAJI ISMAIL CHAND, FEBRUARY 2001.

Means of water supply	Numbers	%
Hand Pump	53	91.40
Well	0	0
Outside the House	2	3.45
Public tap	0	0
Tanker	0	0
Vendor	0	0
Others	4	5.16

Type of house in Village Haji Ismail Chand:

Type of House	Numbers	%
Pucca	34	58.62
Semi Pucca	18	31.03
Katcha	4	6.90
Jhonpri	2	3.45

N = 58

Table :
PLACE OF KITCHEN IN THE HOUSE OF
VILLAGE HAJI ISMAIL CHAND, FEBRUARY 2001

Place of Kitchen	Numbers	%
Kitchen inside (living room)	1	1.72
Kitchen Outside Living room	55	94.83
Others	2	3.45

TYPE OF TOILET FACILITY IN
VILLAGE HAJI ISMAIL CHAND, FEBRUARY 2001.

Toilet Facility	Numbers	%
Bucket	1	1.72
Flush	16	27.59
Pit	33	56.89
Others	5	8.62
No Facility	3	5.17

Toilet Facilities in Haji Ismail Chand Village

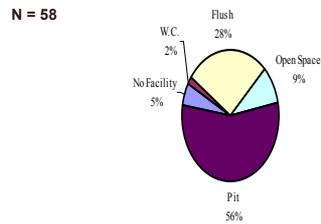
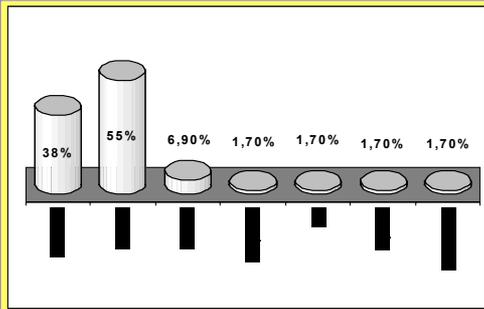


Table #
DEATH STATUS OF STUDY POPULATION
DURING LASTS 5 YEARS.

Age at Death	Male	Female	Total
0 – 1 years	00	02	02
1 – 5 years	00	00	00
6 – 10 years	00	00	00
21 – 60 years	08	04	12
61 and above	05	04	09
TOTAL	13	10	23

☺ No any death of female during pregnancy or within 42 days of delivery in the household during last 5 years.

TYPE OF HEALTH FACILITY UTILIZATION BY THE POPULATION IN LAST ILLNESS, VILLAGE HAJI ISMAIL CHAND



- Seventy percent (70.77%) of the population don't know the nearest Government Health Facility in this area, village Haji Ismail Chand, February 2001.
- Fifty-three percent (53.4%) Of population covered (ever visit) by lady health workers, village Haji Ismail Chand, February 2001
- Forty Six percentage (46.5%) of covered population knowing the name LHW of Village Haji Ismail Chand February 2001

LHW LAST VISIT TO THE COVERED POPULATION VILLAGE HAJI ISMAIL CHAND, FEBRUARY 2001.

Performance of LHW	%
Last month	50%
Within 3 Months	1.7 %
Within 6 Months	3.4 %
Last Year	1.7 %
Never	31 %
Not remember	12 %

N = 58.

WORK LHW DID IN THE LAST VISIT VILLAGE HAJI ISMAIL CHAND FEBRUARY 2001.

ACTIVITIES OF LHW	%
Collect information	19
Registration	22.4
Weigh the child	00
Advice on Family Planning and Weaning	13.8
Given ORS	8.6
Ante natal care	00
Gave Polio vaccination	13.8
Did nothing	22.4

N = 58

Disease Priorities:

- The disease information gathered in the survey asking the respondent their opinion for the most important disease problems in the village Haji Ismail Chand.
- Ranking the major causes of morbidity as reported from household persons is a simple means of summarizing the information on disease from the base line survey.
- This can be arranged according to the population groupings used in the section i.e. pre-school children, school age children, General Population etc.

General Population Group

Disease Priority Ranking	Health Problem
1	Malaria
2	Tuberculosis
3	Diabetes mellitus
4	Hypertension
5	Fever
6	Asthma
7	Skin infection

Population Group (pre-school children) 0 – 3 years

Disease Priority Ranking	Health Problem
1	Malaria, Diarrhea
2	Acute Respiratory Infection , Measles and Malnutrition
3	Skin Infection
4	Eye Infection
5	Intestinal Worms

Population Group (school age 5 – 14 years)

Disease Ranking	Health Problem
1	Malaria
2	Anemia
3	Intestinal Worms
4	Skin infection
5	Others (T.B, Diarrhea)

Population Group (Maternal Morbidity)

Disease Ranking	Health Problem
1	Anemia
2	Causes associated with pregnancies
3	Infection
4	Others (T.B, Diabetes, B.P, Jaundice)

RECOMMENDATION:

- For improving the social status of village Haji Ismail Chand we need to improve the sanitation especially waste disposal management and establish the toilet facility of their houses, this will be fulfilled by improving drainage system (implemented by community participatory method).
- This base line survey shows that LHW of Government sector is not performing their job. So the village needs new Women Health Worker (WHW) appointed by Isra University, which will perform the same job and improve the health status of mother and child.
- Four major diseases have come up to our attention ranking through people's perception. Therefore we will develop the intervening projects such as.

- Malaria Control Program (Spray of whole area, fill the water stagnant pits, collect M.P Slides) etc.
- Dot (Direct Observational Therapy) project for Tuberculosis.
- Health Education and Nutrition Education for Diabetics mellitus and Hypertension related disease
- Train all paramedical staff of welfare hospital in "Community Participation"

IT&C AND TRADITIONAL MEDICINE ACROSS EUROPEAN AND ASIAN CULTURES (TMEA)

Rosa Giuseppa Frazzica

Di Mattia Lino; Noto Salvatore, Sole Fabio
CEFPAS

Purpose

To promote inter-cultural knowledge, understanding, respect and peace by sharing illness-healing related practices and beliefs, through ethno-anthropological field studies, the implementation of a Virtual Platform and a Thematic Network on traditional popular medicine in the European and Asian countries.

Introduction

The increasing mobility of populations from Asian and European Countries makes it important for health professionals worldwide to understand the culture of migrants in order to provide them with more effective care and services.

Methods and materials

Different methods have been used for the various components of the project; its activities have been grouped into six phases:

1. A preparatory step to plan its implementation.
2. A documentary investigation on written, published or on otherwise available information and material referred to popular medicine in each country involved in the project.
3. Field studies: series of ethno-anthropological studies on traditional medicine aiming at exploring how people of different Euro-Asian cultures and social groups interpret the causes of 5 common symptoms/illnesses, (headache, fever, diarrhoea, joint pains, spontaneous abortion), the type of treatment they believe in, and resort to when ill, their perception of efficacy, possible side-effects, and costs. The studies involve 5 target groups (population, traditional healers, PHC Doctors, gynaecologists/midwives, traditional birth attendants) and uses qualitative-quantitative research tools (semi-structured questionnaires and focus-group discussions).
4. Traditional Medicine across Euro-Asian Cultures on the web: creation of a virtual platform and a thematic network to share/exchange information obtained.
5. Monitoring and Evaluation activities.
6. Multiplier effect through dissemination and training.

Results

1. The two International meetings held (2003-Caltanissetta and 2004-Bangkok), the many virtual discussions and the continuous exchange of information through e-mails by the six Partners Teams, have brought about mutual knowledge, respect, understanding and co-operation.
2. Exchange of results of documentary investigation through e-mail discussions and through the project website.
3. Creation of 5 data gathering tools related to the 5 different target groups. They are composed of a common English format, translated into the 6 local languages of the project partners, adapted to the different contexts and pre-tested.
4. Creation of a database, in Excel format, that allows the data entry and the data grouping of the complex quantitative and qualitative information gathered from the field studies performed in the six partners countries. The database is composed of 28 electronic sheets connected by hyper-textual links and supported by pull-down menus facilitating the data entry.

5. The field studies have brought very interesting results. Each country has carried out at least 60 interviews to the general population, 10 to PHC Doctors, 5 each to Traditional Healers, to Gynaecologists/Obstetricians, and to Traditional Birth Attendants.
6. Creation of a common virtual platform in English and six web-sites, one for each partner, in the six local languages. These are linked among themselves and they are all connected to the common platform.

The scripting language used for developing the TMEA common platform refers to the Active Server Pages (ASP) technology. The ITC architecture was built by using one of the most advanced Content Management Systems, which is a software driven by a database that simplifies and automates the construction of Web pages.

The main idea is to facilitate the administration of the TMEA platform and to involve each partner in editing their own Web areas, with each becoming responsible for the publication and updating of their own inputs and outputs.

Discussion and conclusion

The project has achieved its main goal. Important knowledge has been gained and shared on the topic. Health personnel worldwide will have the opportunity to better understand patients from different cultural backgrounds, improve diagnosis and offer more efficient and effective clinical and human quality of care. The virtual platform will also provide concrete and qualified information for populations of all continents on traditional medicine.

Keywords: Traditional medicine, migration, virtual platform





TMEA

Traditional Medicine Across European and Asian Cultures

Authors: Frazzica P; Di Mattia L; Noto S, Sole F

1



CEFPAS

Centre for Training and Research in Public Health



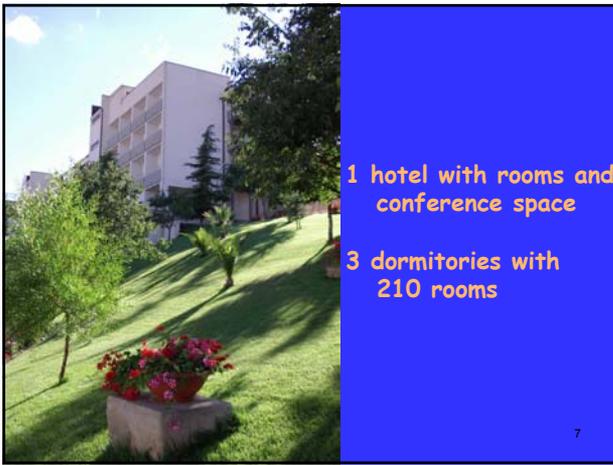
- A Sicilian Regional Government Institution
- An organisation similar to Local Health Organisations
- It started its activities in 1996

3




- 16 buildings for 26.000 sqm of covered surface:
- 11 buildings for training
- 1 gymnasium for sports & rehabilitation

6



1 hotel with rooms and conference space
3 dormitories with 210 rooms



The Auditorium



CEFPAS, has invested heavily on e-Learning activities



Purpose

To promote inter-cultural knowledge, understanding, respect and peace by sharing illness-healing related practices and belief through ethno-anthropological field studies, the implementation of a Virtual Platform and a Thematic Network on traditional popular medicine in European and Asian Countries.



IT&C and Traditional Medicine across European and Asian Cultures



13

14

Countries

- Italy
- Greece
- India
- Nepal
- Philippines
- Thailand



15

Introduction

- Increasing mobility of populations from Asian and European countries
- Understanding patients' different cultural backgrounds for better health services and care



16

Project main components

1. A series of ethno-anthropological studies on traditional medicine in the involved countries
2. A virtual platform and a thematic network to share/exchange information



17

1st Project Component

It studies:

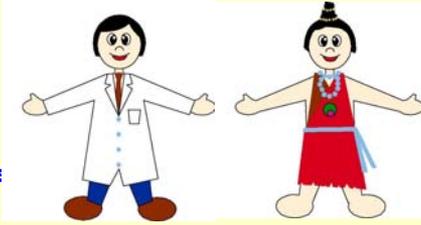
- How people of different Euro-Asian cultures and social groups interpret the causes of specific symptoms/illnesses
- The type of treatment they believe in
- The perceived efficacy
- Possible side effects
- Cost



18

Symptoms/illnesses selected

- Diarrhoea
- Fever
- Headache
- Joint pains
- Spontaneous



19

Targets

The field studies involve:

- Population
- Traditional healers
- Traditional birth attendants
- PHC Doctors
- Gynaecologists/midwives



Material and methods

The project utilizes:

- Quali-quantitative research instruments
- Ethno-anthropological comparative methods



21

2nd Project Component

It aims at:

- Storing collected field data
- Providing multi-lingual information



22

Results...

- Organisation of two international meetings (Caltanissetta-Bangkok);
- Exchange of information and results of documentary investigation through e-mail discussions;



23

Results...

Development, testing and validation of the data gathering tools related to the 5 different target groups.



24

Results...

Each partner has interviewed:

- 60 general population
- 10 PHC Doctors
- 5 TH
- 5 Obstetricians
- 5 TBAs



25

Results...

Creation of:

- a virtual platform and
- a TMEA e-group were created.



26

Results...

The database, in Excel format, allows the entry and the data grouping of the complex quali-quantitative information from the field studies in each Country.



27

The scripting language used for the development of the TMEA common platform refers to the Active Server Pages (ASP) technology.



28

The ITC architecture was built using one of the most advanced "Content Manager System", a software driven by a database that simplifies and automates the construction of Web Pages.



29

Discussion and Conclusions

- The virtual platform will provide concrete and qualified health information for populations of all countries
- Professionals worldwide will be able to better understand patients from different cultural backgrounds



30

Discussion and Conclusions

- Make better diagnosis
- Offer more efficient/effective clinical and human quality of care



31



32



Thank you !

**POSITIVE DEVIANCE AS A BASIS FOR BEHAVIORAL CHANGE IN THE
MANAGEMENT OF OBESITY AND COMPLIANCE TO THE MEDITERRANEAN
LIFESTYLE**

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Hebrew University Hadassah Medical School

Purpose

Positive Deviance (PD) is a relatively new way of looking at health problems that require social or behavioral changes. The core idea is that in every community there are a few “deviant” people whose uncommon practices or behaviors enable them to succeed, or find better solutions to pervasive common problems that their neighbors with whom they share the same resource base and surroundings.

Discussion and conclusion

The technique has been used extensively in combating malnutrition in Vietnam and in countries in transition for this trouble but also in relation to other problems as diverse as girl trafficking and HIV/AIDS education. Thus, it is possible to find solutions that have already been found to work in the appropriate context, thereby avoiding a top down approach in favour of a proven community solution. The PD process involves the following: Define the problem, Determine the “Deviants”, Discover their “solutions” that are applicable to the rest of the community, Design appropriate interventions, Do them and monitor the results. This powerful technique may have obvious applications in many other public health challenges such as in combating obesity by concentrating on the lean members of the society or improving diabetic care by finding out how the successful patients manage their disease. Lifestyle management has much to learn from positive deviance.

For more details please see: <http://www.positivedeviance.org>

Keywords: Positive-deviance, lifestyle change

Positive Deviance and the battle against "Globesity"

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ASPHER,
 Yerevan, Armenia, September, 2005

The Joseph H. and Belle R. Braun
 Hebrew University-Hadassah School of
 Public Health and Community Medicine



בית הספר לבריאות הציבור ורפואה קהילתית
 של האוניברסיטה העברית-הדסה
 ע"ש יוסף ובלה בראון

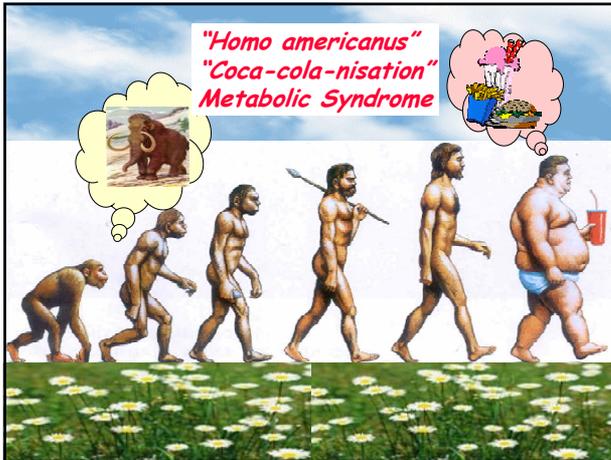


The Catastrophic Failures of Public Health
Lancet Editorial March 6th 2004, 363: 745

"People are getting fatter & less physically active, and are therefore prone to killer chronic illnesses, such as cardiovascular disease, stroke, cancer and diabetes....

"But what are public-health physicians and government policy makers DOING about this state of affairs? There is no coordinated strategy, and there is a very poor information base on effectiveness, let alone cost-effectiveness, of interventions and health promotion efforts that are at best piecemeal, at worst non-existent..

"Our public-health leaders must replace prevarication with imagination"



The Physiology of Weight Regulation: 1st Law of Thermodynamics

Energy input **Energy output**

Food **Exercise**
 Basal metabolism
 Thermogenesis

Control factors
 Genetics
 Metabolic Efficiency

INPUT **OUTPUT**

1 "cake" /day = 50 kcal = 18,250 kcal/yr = **+ 2.5 kg/yr**

What is needed to lose weight??

10 min walking/d = 50 kcal = 18,250 kcal/yr = **- 2.5 kg/ yr**

VS

- Eat Less - ALL DIETS WORK!!
- Exercise More
- Keep to the routine ~ Compliance
- Sense of Humor
- = Change in Life Style

Obesity **Heart Disease, Diabetes**
Joints
Economic burden
Morbidity

BMI **Eating Habits**
Body Mass Index **Exercise**
 $Wt \text{ Kg} / [\text{Height M}]^2$ **Education**
 e.g. $85 / [1.75]^2$ **Socio-Economic Status**

Normal 20-25
 Overweight 25.1-29.9
 Obese > 30 Kg/M²

+ +++++

Adult Obesity (BMI>30) in Israel, 2000: international comparisons: WHO Monica 1987-92, Obes Res 1999



Year	Age / n	At risk + Obese	Country
1999	12-7 / 33000	13%	Finland
1997	10 / 700	14%	Holland
1995	10 / 2960	15%	Germany
2004	19-12 / 3802	15.4%	Israel (Jews)
1998	10-9 / 6288	16%	Yugoslavia
2000	11-7 / 3345	16%	Czech Rep
2000	10-7 / 1582	18%	France
2001	10 / 6700	18%	Sweden
2004	12-19 / 1061	21.5%	Israel (Arabs)
2000	13-6 / 970	30%	Spain
2000	10-6 / 1226	31%	Greece
2001	9 / 41149	36%	Italy
2002	12 - 19	46%	USA

Childhood Obesity:
% above the percentile corresponding to adult BMI > 25 (n > 650)

What goes wrong in ISRAEL after ages 12-19??

BMI kg/m ²	25-29 Overweight	≥30 Obese
Boys	12.7%	7.7%
Girls	12.9%	4.1%
Men	46%	20%
Women	33%	26%

National Health and Nutrition Survey (MABAT)

Heart Disease : the early signs

Effectiveness of 5 school interventions of ≥1 year in the prevention of childhood obesity (1993-2003)

study	Yr	#	Age	Nutr Educ	Behav Mod	Exercise	Parent Involve	School Food	Effective
Luepker 1996	3	4019	8.7	X		X		X	No
Caballero 2003	3	1704	7.6	X	X	X	X	X	No
Sallis 1993	2	305	9			X			No
Donnelly 1996	2	338	9	X		X		X	No
Sahota 2001	1	636	7-11	X	X	X		X	No
Gortmaker 1999	2	1295	12	X	X	X			Girls only
Sallis 2003	2	1109				X	X	X	Boys only
Muller 2001	1	297	5-7	X	X	X	X		Yes

Bautista-Castaño et al. Eur J Epidemiol 19: 717, 2004

The Power of Positive Deviance

Solutions before our very eyes!!

The Premise:

In every community there are certain individuals whose **uncommon practices/behaviors** enable them to find **better solutions** to problems than their neighbors who have access to the **same resources**

Marsh et al. BMJ 329, 1177, 2004

Positive Deviance (PD) Approach

Identifying Solutions to Community Problems *Within* the Community - Today

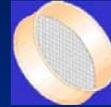


The Key Question?

What enables some members of the community (the "Positive Deviants") to find these better solutions?

The First Steps...

PD Inquiry (PDI) findings are passed through a conceptual "accessibility sieve"



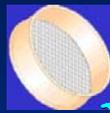
PD Behaviors
Behaviors
Behaviors
Accessible to All

Only those behaviors/strategies accessible to all are kept

The rest are "TBU," True but Useless (i.e. not accessible to all) & are discarded

Malnutrition in Vietnam

PD Inquiry (PDI)
How are some children well – nourished?????



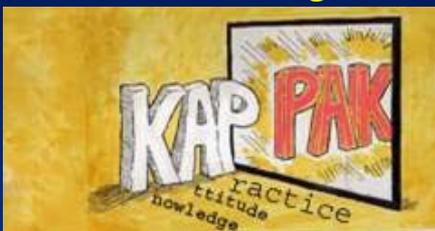
PD Behaviors
Behaviors
Behaviors
Accessible to All

Gathering vegetables	
"Stealing"	"TBU"
Money from outside	"TBU"
All family thin....	"TBU"
Breast feeding etc	

Project aim	Setting	PD Behaviors
Child Malnutrition	Vietnam 1999 - 2000	<ul style="list-style-type: none"> Eating Fruits & Veggies, Shrimp snails, Breast milk, beans, peanuts Boiling Drinking water 5-6 meals/d active feeding Mosquito bed net Immunization Daily bath Early care seeking for illness

Food Nutr Bull 2002, 23 suppl 4, 36

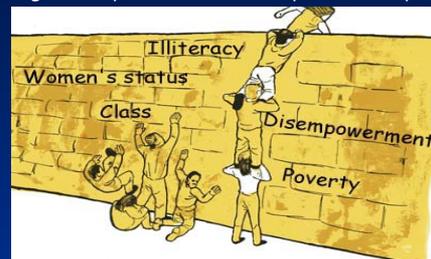
PD Focus on Practice Rather than Knowledge



"It's easier to **ACT** your way into a new way of THINKING, than to THINK your way into a new way of ACTING"

PD Enables us to Act TODAY

Although most problems have complex, underlying causes . . .



Positive Deviants enables finding successful solutions **TODAY** before all the underlying causes are addressed!

The road to Positive Deviance

Design & Do

Discover

Determine Deviants

Define Problem

Community valid

Solution already
WORKS!!!

"Traditional" Instruments of change

Level	Theory
Individual	Stages of Change
	Health Belief
	Consumer Information Processing
Inter-personal	Reasoned action / Behavior
	Information – Motivation - Behavior
Community	Social Learning: Individual/ Behavior/ Environment
	Organization
	Organizational Change
	Diffusion of Innovation

Glance, 1998 with additions - N.Daoud

TRADITIONAL vs POSITIVE DEVIANCE PROBLEM SOLVING APPROACH

TRADITIONAL

Deficit Based:
"What's WRONG here?"

Analysis of underlying
causes of **PROBLEM**

Externally Driven (by
"experts" or external
authority)

Top-down, Outside-in

POSITIVE DEVIANCE

Asset Based:
"What's RIGHT here?"

Analysis of demonstrably
successful **SOLUTIONS**

Internally Driven (by
"people like us", same
culture & resources)

Bottom-up, Inside-out

Current Applications of Positive Deviance

Program context	Countries
Childhood development & Malnutrition	> 40 countries throughout the world
HIV/AIDS risk reduction	Myanmar, Indonesia, Viet Nam
Antenatal care, Maternal & Newborn Care, Breastfeeding	Egypt, Pakistan Viet Nam
Female Genital Cutting	Egypt
Girl Trafficking	Indonesia, Nepal
Education Issues	Argentina, US (NSDC)

The origins of Positive Deviance

Wray JD,

Can we learn from successful mothers?

J Trop Pediatr Environ Child Health, 1972,18:27

Wishik SM, Van der Vynckt S,

The use of nutritional "Positive Deviants" to identify approaches for modification of dietary practices

Am J Public Health 1976, 66:38

Antanovsky
"Salutogenesis"

From PD
To TD
=Think Differently !!!
Just do it.....

Q: How could we apply Positive Deviance to the following Public Health problems....???:

- Childhood Obesity
- Violence in Schools
- Better Diabetic control
- Road Traffic Accidents
- Smoking / alcohol cessation
- Regular physical activity
- Immigrant workers' conditions
- Health of Lower socio-economic classes
- Successful Aging
- Etc, etc

www.positivedeviance.org

What Can Be Done to Beat Obesity through PD?



Possible Interventions - must be FUN

- Increase Leisure Activity* - Use of Pedometers: 10,000 steps. **NO STIGMA**
- TV and computer hours - INTERNET education
- How to eat fast food - food choices & cooking
- Building & Maintaining Sports facilities - SCHOOLS
- Incentives to improve Weight & Fitness - tickets to ball games for boys, for girls ???
- "Social engineering" - walk ways, bicycle paths, stairs..
- Monitoring & Evaluation: Positive deviance approach



*Voltaire : "le mieux est l'ennemi du bien"
The best is the enemy of the good"

To encourage activity>> Olympic sportsmen...(Hillel Raskin).



Solving the Problem

- 1 No Single Cause
- 2 No single or quick Solution
- 3 Multi-disciplinary approach
- 4 Long Term Planning

Funding

Industry
HMOs
NGOs

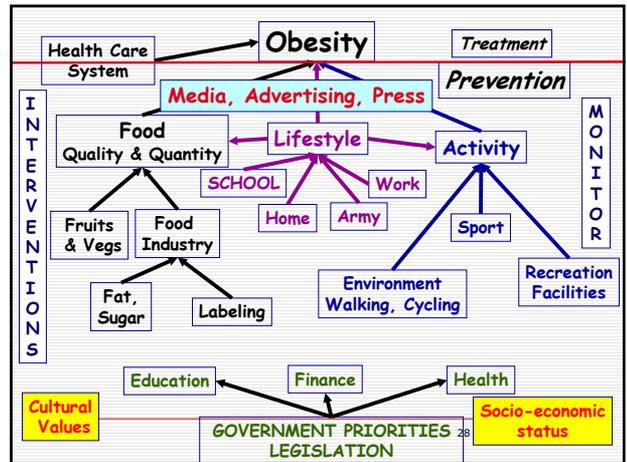
Top Down

Ministry
Local Authority
Health Cities Network
Schools
Family Community



Bottom Up

Socio-Economic Status



THE FIGHT AGAINST OBESITY

- ✓ Food is Fun - incl cooking
- ✓ Nothing is "Forbidden"
- ✓ "Moderation in all things including Moderation"
- ✓ **ACTIVITY** is THE most neglected change



- ✓ K'I'S'S
- ✓ Keep
- ✓ It
- ✓ Short &
- ✓ Simple

"More important what comes out of your mouth than what goes in...."



"According to the labour is the reward"

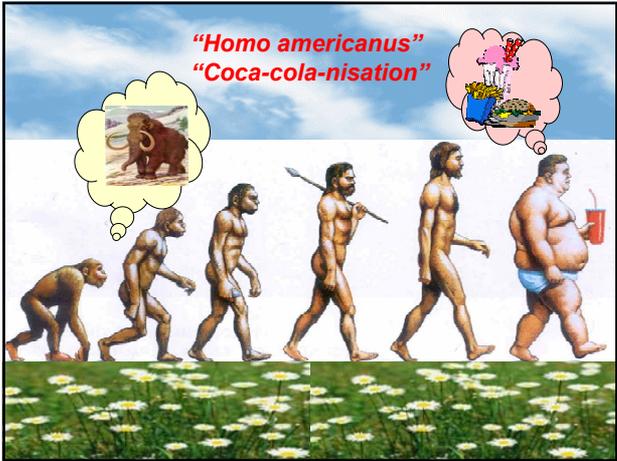
Ethics of the Fathers
V, 26



TASK force on Childhood Obesity

- Education & Health Ministries
- Community members
- Parents
- Students themselves
- Families
- Neighbors
- Health professionals
- Communication Advertising experts - INTERNET
- Outside creative thinkers
- "Not more of the same" and "Not People talking to themselves"
- TOP DOWN &
- BOTTOM UP approaches

We know WHAT to do up BUT We do not know HOW to



The Physiology of Weight Regulation: 1st Law of Thermodynamics

Energy input **Energy output**

Food **Control factors Genetics** **Basal metabolism Exercise TEF**

Metabolic Efficiency

What goes wrong after ages 12-19????

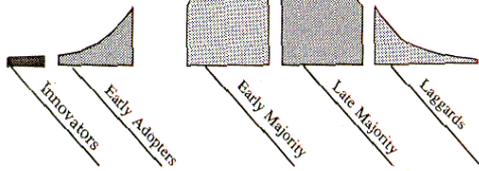
BMI kg/m ²	25-29 Overweight	≥30 Obese
Boys	12.7%	7.7%
Girls	12.9%	4.1%
Men	46%	20%
Women	33%	26%

Project aim	Setting	PD Behaviors
Improve household maternal & new born care	Pakistan 2001	<ul style="list-style-type: none"> ➢ Saving funds & obtaining transport for emergencies ➢ Tetanus vaccination ➢ Clean delivery conditions attendant's hands & blade ➢ Receiving blanket, leaving cord stump undressed ➢ Exclusive breast feeding ➢ Danger sign recognition with prompt care seeking

Food Nutr Bull 2002 suppl 4, 23: 109

PD & The Diffusion of Innovation Life-Cycle

Community participates in discovery of innovation



Thereby jumping the "early adopters/early majority" chasm

Geoffrey A Moore. *Crossing the Chasm.*

PD: Crossing The "Knowledge/Behavior Change Gap"



Project aim PD Behaviors

Reduce girl trafficking

Setting: Indonesia 2004

- ✓ Fear of losing contact with daughter, of disease,
- ✓ Shame from sex work or violating religion
- ✓ Planting multiple crops (beyond coffee)
- ✓ Reducing expenses so daughter stays in village
- ✓ Establishing daughter in small local business
- ✓ Explaining risks of entertainment industry work
- ✓ Identifying & Avoiding neighborhood "brokers"
- ✓ Monitoring daughter's friends
- ✓ Reiterating family values, daughter reports home
- ✓ Investigating out-of-village jobs

Project aim Setting PD Behaviors

Reduce Female Genital Mutilation

Egypt 2004

- ❖ Open discussion between uncircumcised and circumcised women (sharing the "secret")
- ❖ Discussion of the emotional & psychological trauma experienced
- ❖ Discussion with parents (breaking the "taboo")
- ❖ Discussion with Religious leaders

Projects Setting Results RESULTS

Projects	Setting	Results	RESULTS
Integrated Nutrition projects	Vietnam	<ul style="list-style-type: none"> ❖ Younger malnourished (WAZ <-2) children had less deterioration in Δ [weight for age] Z score -0.05 vs -0.20, $p=0.02$; and Δ [height for age] Z score -0.10 vs -0.23, $p=0.01$. 	
Prospective, randomized evaluation of PD integrated nutrition project: monthly weight for 1 st 7 months and at 12 months n= 240	Phu Tho Province 1999-2000	<ul style="list-style-type: none"> ❖ Intervention diet more energy/d 827 vs 718 Cal/d, $p<0.05$ ❖ & food 410 vs 340 g/d, $p<0.01$ ❖ More likely to meet daily Requirements 49% vs 35%, $p<0.01$ ❖ Less respiratory infections adj OR 0.5, $p=0.001$ 	

Social Net-working ????

The "Inverse Care Law"

People with the greatest need tend to have poorer access to quality services.



**"The rich stay healthy,
the sick stay poor."**

U2
'God Part II'

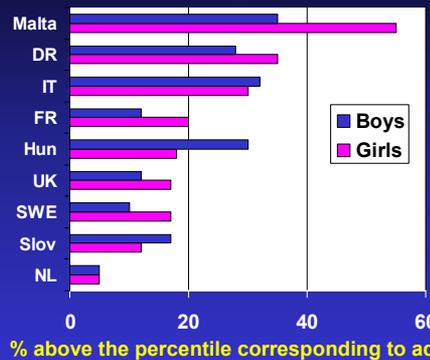
"The rich stay healthy..."

- Higher status people live longer & healthier lives
- Causal effect of economic status on health
 - Access to more & better food
 - Access to medical care
 - Access to education, including health-related knowledge
- **Policy implication:**
- **Improving economic conditions will improve health**

...the sick stay poor."

- Healthier people learn, work, & earn more
- Causal effects of health on economic status
 - Higher labor productivity
 - Higher incentive to obtain education/skills
 - Higher incentive to save
 - "Demographic dividend"
 - Improved health/mortality lowers fertility rates
 - "Quality vs. quantity".... (somewhat controversial)
- **Policy implication:**
- **Improving health will improve economic conditions**
- *Ignoring economic benefits of health interventions undervalues those interventions*

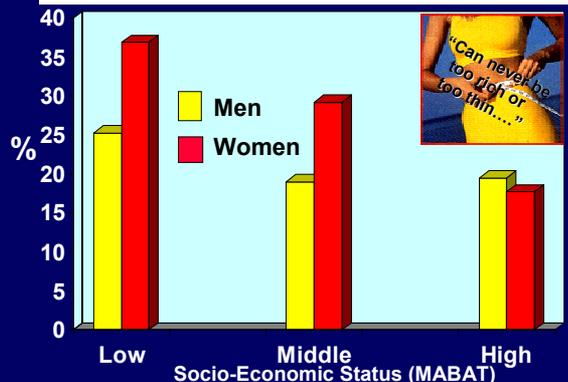
% Overweight & Obese 10 year olds in selected European Countries (IOTF)



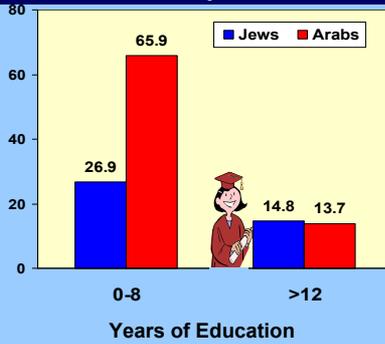
Year	Age / n	At risk + Obese	Country
1999	12-7 / 33000	13%	Finland
1997	10 / 700	14%	Holland
1995	10 / 2960	15%	Germany
2004	19-12 / 3802	15.4%	Israel (Jews)
1998	10-9 / 6288	16%	Yugoslavia
2000	11-7 / 3345	16%	Czech Rep.
2000	10-7 / 1582	18%	France
2001	10 / 6700	18%	Sweden
2004	12-19 / 1061	21.5%	Israel (Arabs)
2000	13-6 / 970	30%	Spain
2000	10-6 / 1226	31%	Greece
2001	9 / 41149	36%	Italy

Childhood Obesity:
% above the percentile corresponding to adult BMI > 25 (n > 650)

Age-adjusted Prevalence of Obesity (%) Increases With Lower Socio-economic Status

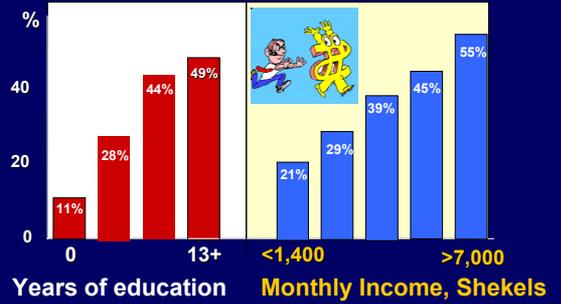


Obesity (BMI>30) in Women is Greater Among the Less Educated and in the Arab Population



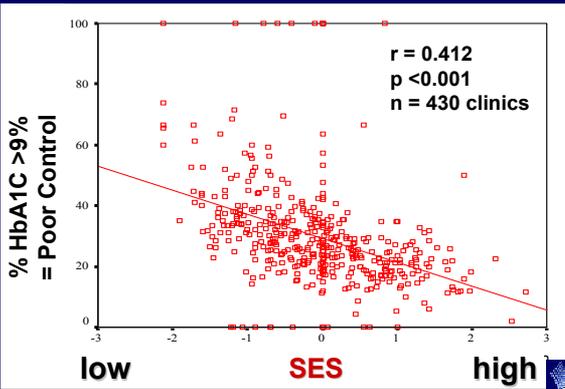
First National Health and Nutrition Survey (MABAT), 1999-2000

Exercise in The Over 60s Increases With Income & Education



Shemesh & Rasooli, 1999

Low SES Associated with POORER Diabetic Control in Clinics



MOTIVATING CHILDREN

- Role of Parents (57% TV/15% exercise together)
 - Role of School Interventions
 - Role of Media
 - Advertising
 - Films
 - Role models: Sportsmen, Pop & TV stars ??!
 - COMMUNICATION Skills
 - From Children - get to Parents: 4X4 → 2X2
- "Educate the child while he is young &, when he is old, he will not stray"...(Psalms)
- "Give me a child till he is seven and he'll be mine till he goes to heaven..."

COMMUNICATION SESSION B

THE WAYS FOR IMPROVING THE QUALITY OF EDUCATION OF PH WORKFORCE

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Katarzyna Czabanowska, MSc.
Institute of Public Health, Fac. of Health Protection,
Medical College, Jagiellonian University

Purpose

The main purpose of this presentation is an analysis of the most important factors influencing the quality of training of PH professionals using the input-process-output system model of educational institutions such as SPH.

Introduction

Nowadays the process of change and dynamic development of Public Health (PH) sector results in the emergence of new challenges for PH professionals. This comes along with the current EU policy directed towards enhancing quality in the higher education sector (Copenhagen Declaration, Nov., 2002). This also reflects the perceived needs of different key stakeholders: universities, employers, students and graduates. According to the Lisbon Strategy (March, 2000) special emphasis is to be put on vocational training: access to education, lifelong learning and mutual recognition of diplomas and certificates acquired in different European educational settings.

Methods and materials

There is a number of different approaches towards the QI of education. Using the system model of organization one may argue that all three: the quality of input elements, quality of processes inside the organization and the quality of output are strongly interconnected and influence the total effect of a final product on the market. This approach applied to the educational institution reveals some specific elements of analysis. Recruitment of students and staff members, ways of absorption on the educational market and new developments are examples of input areas, whereas the educational method, practice and organization (technology) are the main component of a process. Graduates' success on the labour market, the ways of career development, feedback from the graduates might be enumerated as the examples of output elements. The qualitative analysis of three different QI tools developed by ASPHER in a few cases of SPH has been carried out using this approach.

Results

The three quality assessment methods, currently practiced or planned to be implemented by ASPHER, namely PEER Review, SAQ (Self Assessment Questionnaire) and Accreditation have different values what concerns their influence on input, process and output quality of education in Schools of Public Health.

Discussion and conclusion

Each of three presented methods seems to have the sound influence on the quality of education of PH workforce, however, they differ with respect to the scope and area of main concentration. They are complementary to some extent and because of that need to be developed in future in an interrelative way. They are also important and specific brand products of ASPHER which have to be properly marketed.

Keywords: education, accreditation, assessment

The ways for improving the quality of education of PH workforce

*Stojniew J. Sitko PhD
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Institute of Public Health, Fac. Health Protection,
Medical College, Jagiellonian University, Krakow, Poland*

Goal:

To present the QA ASPHER philosophy – the attempt to the **triple** European project devoted to the development of the quality improvement process based on the **PEER** Review, **SAQ** (self-assessment questionnaire) and **ACC**reditation

Motto

→ *Nowadays there is a great challenge for the higher education establishments forcing them to **actively react to changes on the job market**, indirectly engaging them in the employment policy*

Quality improvement

1. Identification of the **gap** in performance
2. **Comparison** of the results
3. **Benchmarking**
4. Identification of „**best practice**”
5. **Continous** evaluation and improvement process **outcome oriented**

Quality *Accountability*

- Showing value of programs for the purpose of e.g. *accreditation*
- Allows **judgements** about performance

Research

- Educational studies
- Evaluation studies
- Comparative studies

One of the ASPHER
basic objectives is:

Improvement of Quality of Education

ASPHER „TRIPLE” approach to Quality Improvement



“Accreditation Framework” Accreditation Task Force, S.Sitko et al.,
v.4, November 2002. www.aspher.org/C_projects/Accreditation

since 1993

PEER

Public Health European Education Review

- an ASPHER „product”:
- a tool of external,
- supportive,
- quality evaluation
- over 20 SPHs reviewed

*Criteria in: QI and ACCR of Training Programs in PH („BlueBook”),
ASPHER - Foundation Merieux, Lyon, June 2001
- see ASPHER web site*



Euro-ACCReditation

- initiated by APHER
- EUPHA partnership, WHO-Europe support
- European Accr. of PH Education
- Elaboration of standards and procedures
- *Accreditation Procedure Document* – draft ready
- PH-ACCR LdV Project succeeded

Partners:

ASPHER, EUPHA, Maastricht (NL), Copenhagen (DK),
Rennes (F), Scheffield (UK), Sofia (BG), Krakow (PL),



What is SAQ?

- a **prototype web-based self-assessment tool** - LdV pilot project called „*Improving Employability of Public Health Graduates*“ (IPH Jagiellonian University, Maastricht University, SchARR)
- Evaluated and monitored by external experts (nominated for the best LdV project award in Europe)



Innovative approach - SAQ

1. Measures the Q of **output** of education
2. Allows **monitoring** showing the dynamism of the rapidly evolving PH
3. **Promotes partnerships** between academic institutions, employer organizations, graduates/alumni organizations and policy makers
4. Tool/methodology has a potential for **transfer** to other areas and disciplines

An **SAQ** enlargement LdV project is currently in preparation

Conclusions

- Quality improvement process is a “**must**” of each School of Public Health on its way to efficiency
- There is a need to develop and establish a QI system for Public Health education in **Europe**.
- PEER ACCR and SAQ are **ASPHER** supported steps towards this goal in Europe

References

- PEER: www.aspher.org
- SAQ: www.healthgraduates.info
- ACCR: www.aspher.org

MAXIMISING THE PUBLIC HEALTH ROLE OF COMMUNITY NURSES

Selena Gray, selena.gray@uwe.ac.uk
Glenys Hook Neil Brocklehurst
University of the West of England

Purpose

To highlight the changing roles of community nurses in the UK and its impact on their contribution to the public health workforce and to stimulate debate in this area maximised merits further exploration and debate.

Introduction

Many parts of the world have expressed concern about capacity in public health systems, highlighted in the responses to the SARS epidemic (1). As well as those in clear public health leadership roles at strategic level, a large number of practitioners make an important contribution to the public health workforce, although they may not be identified directly as such.

In the UK, changes in the registration process for nurses, under the umbrella of the Nursing and Midwifery Council has led to the establishment of a register with 3 parts; nursing; midwifery and specialist community public health nurses (1). This latter group will include those who work with both individuals and a population, and could include health visitors (ie family nurses who work in the community with a focus usually on young children), occupational health nurses, school nurses and those who work on infection control within the community.

Methods and materials

Community public health provision is focussed on social groups such as families and communities, and operates in a variety of settings, including homes, schools, workplaces and local area. The standards for this part of the register have now been extended beyond the previous competencies used for community healthcare and nursing to include the 10 key public health standards used in the UK to define public health practice; grouped into four domains:

- Search for health needs
- Stimulation of awareness of health needs
- Influence on policies affecting health
- Facilitation of health enhancing activities.

These changes represent a potentially radical change to traditional roles and offer an opportunity to develop and enhance public health skills amongst the community nursing workforce. We will describe how one UK University is using these changes to develop this group further.

Results

In response the University of the West of England is undertaking a variety of steps:

- Changes in curriculum for the existing courses are planned to provide further integration with the existing Master's level provision
- A programme of local learning sets has been run with existing community nurses and environmental health officers.
- Consideration is being given to extend existing provision for school and occupational health nurses and public health nurses to ensure a strong public health element to the work.

Discussion and conclusion

The role of contribution of community nurses to the public health workforce and how this can be maximised merits further exploration and debate.

Keywords: Community public health nurses

Maximising the public health role of community nurses

Selena Gray, Professor of Public Health UWE
Glenys Hook, Senior Lecturer, Health and Social Care UWE
Neil Brocklehurst, Independent Consultant in Public Health Practice



Context

- Concern about capacity in public health systems
- Highlighted in the responses to the SARS epidemic
- Public health workforce requires strategic leaders and hands on practitioners



UK Nursing Registration

- UK Nursing Midwifery Council changes to the Register in 2004
- A new 3 part register:
 - Nursing
 - Midwifery
 - Specialist community public health nursing (migration of existing staff)



Specialist community public health nursing (NMC)

“aims to reduce health inequalities by working with individuals, families and communities promoting health, preventing ill health and in the protection of health. The emphasis is on partnership working that cuts across disciplinary, professional, and organisational boundaries that impact on organised social and political policy to influence the determinants of health and promote the health of whole populations.”



Who is included?

- those who work with both individuals and a population and could include:
 - health visitors
 - occupational health nurses
 - school nurses
 - community infection control nurses



New standards of proficiency

- 4 domains of Health Visiting:
- Search for health needs
 - Stimulation of awareness of health needs
 - Influence on policies affecting health
 - Facilitation of health enhancing activities
 - 10 key areas of public health practice now mapped into the 4 domains



Opportunities

- Explicit link to public health skills and partnership working with other agencies
- Radical change to traditional roles
- Opportunity to develop and enhance public health skills amongst the community nursing workforce.
- Provides a career framework



Programme

- 52 week course
- 50% in practice based settings- both specific to discipline and public health
- Recommended 2 years minimum of nursing training



UWE response:

- Changes in curriculum
- Widening practice placements on existing courses for health visitors and school nurses
- Further integration with the existing MSc in Public Health provision
- Local learning sets run with existing community nurses and environmental health officers.



Local learning sets

- Health visitors (family nurses), school nurses, health promotion staff and environmental health officers
- All have geographical focus
- Working together to identify community problems and to address them in partnership
- Demonstrate lack of understanding of roles



Examples of family centred public health role

- Group for postnatal depression; focus on mothers; massage, support infants; reduces one to one visits
- Pre-school literacy development- one to one; play talk; family talk
- Older peoples groups; addressing isolation; accident prevention; exercises
- Improving local environment; litter & parks



Conclusion

- Community nurses are an important part of the public health workforce
- Recent changes to the register in the UK provide an opportunity to enhance this role
- How this can be maximised merits further exploration and debate.

A MINIMUM HEALTH INDICATOR SET FOR PH-SEE COUNTRIES

Ulrich Laaser, ulrich.laaser@uni-bielefeld.de
On behalf of the PH-SEE Collaboration Group
Centre School of Public Health, Belgrade

Purpose

The Stability Pact includes a programme for the development and reconstruction of training and research in public health in South Eastern region of Europe (PH-SEE). One of the identified priorities of national public health development is the definition of a Minimum Indicator Set for all countries of SEE and some of their neighbour countries.

Introduction

Methods and materials

Methods: A Task Force of the PH-SEE Network has proposed a Minimum Indicator Set on the basis of the list of 224 indicators of the World Health Organization (WHO) Health for All (HFA) 21 strategy. The indicators selected follow the selection criteria as defined by expert groups of WHO and the European Commission. A meta-database describing the indicators was established.

Results

A list of 30 indicators was finally agreed at the 3rd PH-SEE Conference, Tirana, Albania, in May 2002. All indicators are included in the WHO HFA DataBase indicator set.

Discussion and conclusion

Conclusion

After principal agreement of the expert group on the list of indicators, further practical steps were done, among which building a logistic network for realizing the Minimum Indicator Set. This includes a pilot phase, a revision of the Minimum Indicator Set, data collection and data analysis. Further steps should include the transfer of the project into a continuous surveillance and monitoring system.

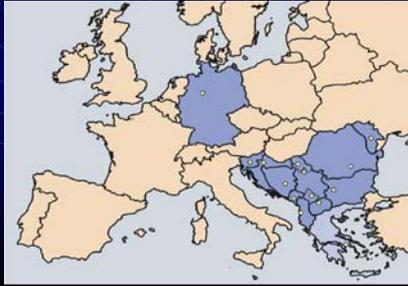
Keywords: Health surveillance, health indicator, health planning



STABILITY PACT FOR SOUTH EASTERN EUROPE

Public Health Collaboration in South Eastern Europe (PH-SEE)

Programmes for Training and Research in Public Health



04.10.2005

1

Final Report on the PH-SEE Minimum Health Indicator Set (MHIS)

Working group: Doris Bardehle, Germany
Genc Burazeri, Albania
Doncho Donev, Macedonia
Lijana Kragelj-Zaletel, Slovenia
Ulrich Laaser, Germany

04.10.2005

Minimum Indicator Set

2

Objectives of the MHIS

- To use health indicators for health reporting (Indicator-based health reporting)
- To compare the data between the countries of South Eastern Europe and with EU countries
- To develop benchmarking criteria
- To create a circle of health targets, health indicators and health reporting
- To include the MHIS into the PH curriculum

04.10.2005

Minimum Indicator Set

3

Selection of Indicators (2nd)

- The main source of indicators is the list of the 224 indicators of the WHO Health 21 strategy (HFA21).

Structure:

Demography / Social Economy	03
Mortality-based Indicators (+5)	16
Morbidity / Hospital Discharges (+1)	03
Environment / life style (-4)	00
Health Care Resources (-2)	04
Health Care Utilization / Costs (-1)	02
Maternal and Child Health (-1)	02
Together	30

04.10.2005

Minimum Indicator Set

4

Rules and Metadatabase

- All indicators have to represent a determinant of health or to satisfy different stakeholders (primary, secondary)
- To limit the MHIS to approx. 30 indicators
- The database is completed by a metadatabase
 - definition of indicator
 - the source of data
 - description of method of data collection
 - description of measurement of data
 - assessment of quality & limitations
 - why this indicator was preferred.

04.10.2005

Minimum Indicator Set

5

List of indicators eliminated from the 1st version of PH-SEE MHIS

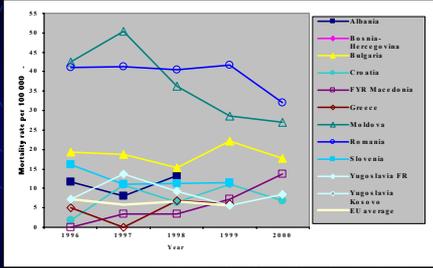
- *DMFT-12 index*
- *Population % connected to water supply*
- *Population % with access to hygienic sewage disposal*
- *%000 PHC units*
- *%000 nurses*
- *% infants vaccinated against tetanus*
- *% vaccinated against pertussis*
- *% vaccinated against measles*

04.10.2005

Minimum Indicator Set

6

Figure 7: Data for MHIS PH-SEE indicator 05 - Maternal deaths, all causes per 100 000 livebirths, 1996 – 2000 (Main data source: WHO Health for All Database 2002)

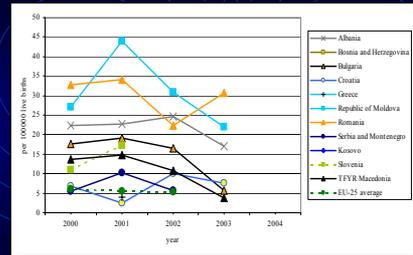


04.10.2005

Minimum Indicator Set

7

Maternal deaths, all causes per 100 000 livebirths, 2000– 2003

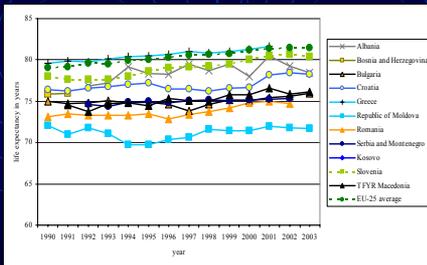


04.10.2005

Minimum Indicator Set

8

Indicator 5: Life expectancy at birth, in years, female, SEE-countries, 1990-2003

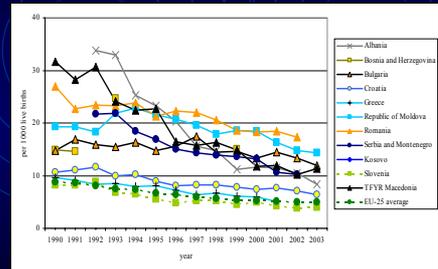


04.10.2005

Minimum Indicator Set

9

Indicator 6: Infant deaths per 1,000 live births, SEE-countries, 1990-2003

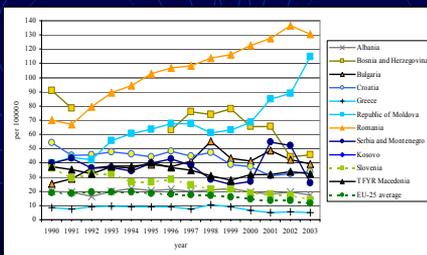


04.10.2005

Minimum Indicator Set

10

Indicator 20: Tuberculosis incidence per 100,000, SEE-countries, 1990-2003



04.10.2005

Minimum Indicator Set

11

Results of the analysis of indicators (+)

- The deterioration of health status has been stopped
- Life expectancy is increasing
- Infant mortality is decreasing
- The number of hospital beds and the length of stay decreased

04.10.2005

Minimum Indicator Set

12

Results of the analysis of indicators (-)

- **The incidence is too high in some countries**
- **The Min-Max ranges have been increasing from 2000-2003**

04.10.2005

Minimum Indicator Set

13

04.10.2005

Minimum Indicator Set

14

Historical Background

The PH-SEE identified the development of a MIS as priority goal in Febr. 2001

The MHIS was accepted in May 2002 in Tirana

The data collection and metadatabase were prepared and continued during the Summer

School in Ljubljana, July 2002

The Final Report was prepared by Lijana Zaletel-Kragelj during her stay in Bielefeld at the end of 2002.

The Final Report for the period 1996-2000 was presented and modified at the 4th Coordination Meeting of PH-SEE in Sinaia, Romania April 12-15, 2003.

The second edition for the period 2000-2003 has been published 2005.

04.10.2005

Minimum Indicator Set

15

Selection Criteria for Health Indicators (2)

- relevant (regarding priorities)
- valid (regarding determinants of health)
- measurable (in quantitative or qualitative terms)
- sensitive (to change and differences)
- comparable (interterritorial)
- repeatable (for time series)
- affordable (in terms of relative costs)
- useful (for intervention)

04.10.2005

Minimum Indicator Set

16

List of indicators for the 2nd version of PH-SEE MHIS (1)

- No 1 % of population aged 65+ years
- No 2 Life births per 1,000 population
- No 3 Unemployment rate in %, 15-64yrs
- No 4 Life expectancy at birth, in years, males
- No 5 Life expectancy at birth, in years, females
- No 6 Infant deaths per 1,000 live births
- No 7 Perinatal deaths per 1,000 births
- No 8 Maternal deaths, all causes, per 100,000 live births
- No 9 Maternal deaths, abortion, per 100,000 live births

04.10.2005

Minimum Indicator Set

17

List of indicators for the 2nd version of PH-SEE MHIS (2)

- No 10 SDR, all causes, all ages, per 100,000 males
- No 11 SDR, all causes, all ages, per 100,000 females
- No 12 SDR, circulatory system diseases, all ages, per 100,000 males
- No 13 SDR, circulatory system diseases, all ages, per 100,000 females
- No 14 SDR, malignant neoplasms, all ages, per 100,000 males
- No 15 SDR, malignant neoplasms, all ages, per 100,000 females
- No 16 SDR, external causes, all ages, per 100,000 males
- No 17 SDR, external causes, all ages, per 100,000 females
- No 18 SDR, infectious & paras. dis., all ages, per 100,000 males
- No 19 SDR, infectious & paras. dis., all ages, per 100,000 females

04.10.2005

Minimum Indicator Set

18

List of indicators for the 2nd version of PH-SEE MHIS (3)

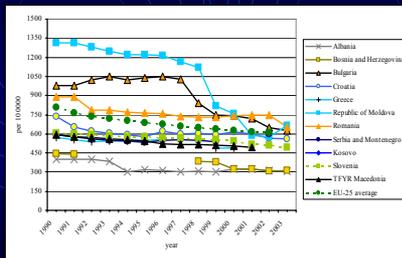
- No 20 Tuberculosis incidence (all forms), per 100,000 population
- No 21 Incidence of measles, per 100,000 population
- No 22 Incidence of diphtheria per 100,000 population
- No 23 No of hospital beds per 100,000 population
- No 24 No of physicians per 100,000 population
- No 25 No of general practitioners per 100,000 population
- No 26 No of dentists per 100,000 population
- No 27 Average length of stay, all hospitals
- No 28 Total health expenditure as % of GDP
- No 29 % of infants vaccinated against diphtheria
- No 30 % of infants vaccinated against poliomyelitis

Table 53: Data for MHIS PH-SEE indicator 25 - Total health expenditure as percent of GNP (Gross Domestic Product), 1996 – 2000 (Main data source: WHO Health for All Data-base 2002¹).

Country	1996	1997	1998	1999	2000
Albania	-	-	-	-	-
Bosnia-Herzegovina	-	-	-	-	-
Bulgaria	-	-	-	-	-
Croatia	-	-	-	-	-
FYR Macedonia	-	-	-	5.00	4.50
Greece	8.80	8.70	8.50	9.30	8.70
Moldova	6.90	6.00	4.30	2.90	3.00
Romania	2.80	2.60	2.60	-	-
Slovenia	3.80	3.70	3.70	4.20	4.00 ²
Yugoslavia 19 ³	8.00	8.10	7.50	6.90	7.50
Kosovo	-	-	-	-	-
EU average	8.58	8.44	8.40	8.52	-
MIN PH-SEE	2.80	2.60	2.60	2.90	3.00
MAX PH-SEE	8.80	8.70	8.50	9.30	8.70

¹ - If not stated otherwise, the data sources for present table is WHO/HU-All-2002
² - The data source of data additionally provided by PH-SEE countries
 Slovenia: Institute of Public Health of Republic of Slovenia
³ - No data on additional data available till the end of production of the report
 - Data with known

Indicator 23: Hospital beds per 100,000, SEE-countries, 1990-2003



PUBLIC HEALTH OPHTHALMOLOGY COURSE FOR EYE CARE PROFESSIONALS IN ARMENIA

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Introduction

The causes of blindness are embedded in each community and a public health perspective is required to measure the extent of blinding diseases, to characterise the unique risk factors that each disease poses and to develop effective and practical approaches to prevention and treatment.

In March 2005 the Garo Meghriyan Eye Institute for Preventive Ophthalmology (GMEIPO) of the American University of Armenia delivered a two-week course Introduction to Public Health Ophthalmology (PHO). Jinishian Memorial Fund sponsored the course.

Aims and Learning Outcomes of the Course

The course was designed for ophthalmologists in training, practising ophthalmologists, optometrists and ophthalmic nurses with a career interest in public health programs in eye care.

- Aim: the primary objective of this course was to equip students to develop a community eye care program.
- In order to achieve the Aim of the course the following Learning were chosen. By the end of the course the student should be able to:
 - (i) Describe the basic epidemiology of the major blinding eye diseases
 - (ii) Distinguish the various types of studies designed to assess community eye health needs
 - (iii) Interpret the results of eye surveys
 - (iv) Understand the basic issues surrounding program planning, resource mobilisation, management and evaluation of local comprehensive eye care programmes
 - (v) Conduct a Community Eye Care Needs Assessment
 - (vi) Critically Appraise and select appropriate control strategies for the major blinding eye diseases
 - (vii) Develop presentation skills to sell the programme

Description of the Course

- This course was designed as a mixed-type course incorporating aspects of discipline-based, experiential, competency based and problem solving course designs.
- Throughout the course a variety of teaching methods were employed including:
 - (i) Lectures, usually not more than 40 minutes long, which incorporated exercises built into the presentation.
 - (ii) Group work (brainstorming, open discussions, and rounds)
 - (iii) Experiential learning methods such as project work were enhanced by time for self-reflection and evaluation. Reflection was also incorporated into the other aspects of the course.

The first five days of the course were spent covering the theoretical background to community eye health, orienting students to a public health understanding of the major blinding diseases and their epidemiology, and equipping them to do a needs assessment. During the second week the student were though the various aspects of programme design, such as planning, budgeting, management and evaluation of eye care programs.

The assessment of the course was based on the individual work, including participation, results of the quiz, and presentation; and group work. Students were asked to work in groups of 2-3 people to design and write up an eye care program for a province of Armenia, not exceeding 2,500 words.

Results

Overall, 6 participants- 3 regional ophthalmologists and 3 ophthalmic nurses from Gegharkunik and Tavush marzes of Armenia were involved. All participants actively participated in the course. They were divided into two groups. Each group selected a topic of interest and worked on it throughout the course. By the end of the course the first group outlined an Eye health education campaign, the second group- an Outreach program for Geghrkunik marz of Armenia. They presented their programs during the last day of the course and were provided feedback from their peers and the course organisers.

All participants completed the course and were given the certificates of completion.

Conclusion/Recommendations

The participants positively evaluated the course and teaching, providing the following recommendations:

- To incorporate the course into the clinical residency program for ophthalmologists
- To deliver the PHO course on a regular basis as a refresher course for regional ophthalmologists

Public Health Ophthalmology Course for Eye Care Professionals in Armenia

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DrPH Candidate, LSHTM
Lecturer of Preventive Ophthalmology,
College of Health Sciences, AUA

Background

There are 291 ophthalmologists in Armenia, 82% work in Yerevan, and 18% in the rural areas.

- Only 25% of ophthalmologists are surgeons; others are mainly doing refraction and outpatient treatment.

Background (cont)

The Yerevan State Medical University and National Institute of Health deliver the ophthalmic education.

- YSMU is a governmental academic institution under the supervision of the Ministry of Education and Science.
- NIH is also a governmental institution under the Ministry of Health. NIH has exclusive right to deliver Continuing Medical Education.

Background (cont)

Ophthalmic courses and programs:

- 2 week course for medical students, YSMU
- 2 week course for family physicians, YSMU
- 3 year clinical residency, YSMU and NIH
- 7-week refresher courses, NIH

The clinical aspects of ophthalmology are of the main focus of those courses

Background (cont)

A public health perspective is required to measure the extent of blinding diseases, to characterize the unique risk factors that each disease poses and to develop effective and practical approaches to prevention and treatment.

A two-week course “Introduction to Public Health Ophthalmology” was designed by the Garo Meghriyan Eye Institute for Preventive Ophthalmology.

Conducted in March 2005

Aim

To equip students to develop a community eye care program.

Audience

- Ophthalmologists in training, practising ophthalmologists, optometrists and ophthalmic nurses with a career interest in public health programs in eye care.
- Practitioners will be sent by their health district and participation in this course will constitute part of their Continuing Professional Development requirement.
- Students will enrol to prepare them to develop eye programmes in their district or to work in existing eye programs.

Learning Needs of Students

The students will be expected to have prior experience with:

- Clinical knowledge of the main blinding diseases and of their treatment
- Principles of prevention of the main blinding diseases (including early diagnosis and screening)
- Basics of hygiene, epidemiology and public health

Learning Outcomes

By the end of the course the student should be able to:

- (i) Describe the basic epidemiology of the major blinding eye diseases
- (ii) Distinguish the various types of studies designed to assess community eye health needs
- (iii) Interpret the results of eye surveys

Learning Outcomes (cont)

- (iv) Understand the basic issues surrounding program planning, resource mobilisation, management and evaluation of local comprehensive eye care programmes
- (v) Conduct a Community Eye Care Needs Assessment
- (vi) Critically Appraise and select appropriate control strategies for the major blinding eye diseases

Description of the Course

This course was designed as a mixed-type course incorporating aspects of discipline-based, experiential, competency based and problem solving course designs.

Description of the Course (cont)

The course is problem-centred rather than subject-centred, it focus on the problem of designing a programme rather than learning discipline of public health. This helps the course be directly applicable to students' future practice.

Description of the Course (cont)

Throughout the course a variety of teaching methods were employed including:

- (i) Lectures, usually not more than 40 minutes long, which incorporated exercises built into the presentation.
- (ii) Group work (brainstorming, open discussions, and rounds)
- (iii) Experiential learning methods such as project work followed by self-reflection and evaluation.

Description of the Course (cont)

The first five days of the course were spent covering the theoretical background to community eye health, orienting students to a public health understanding of the major blinding diseases and their epidemiology, and equipping them to do a needs assessment.

During the second week the student were thought the various aspects of programme design, such as planning, budgeting, management and evaluation of eye care programs.

Description of the Course (cont)

The assessment of the course was based on

-individual work, including participation

-results of the quiz

-presentation

-group work. Students were asked to work in groups of 2-3 people to outline an eye care program for a province of Armenia, not exceeding 2,500 words.

Results

Overall, 6 participants- 3 regional ophthalmologists and 3 ophthalmic nurses from Gegharkunik and Tavush marzes of Armenia were involved.

All participants were divided into two groups. Each group selected a topic of interest and worked on it throughout the course.

Results (cont)

By the end of the course the groups outlined and presented

- Eye health education campaign
- Outreach program for Geghrkunik marz of Armenia.

All participants completed the course and were given the certificates of completion.

Conclusion/Recommendations

The participants positively evaluated the course and teaching, providing the following recommendations:

- To incorporate the course into the clinical residency program for ophthalmologists
- To deliver the PHO course on a regular basis as a refresher course for regional ophthalmologists

Course supported by
Jinashian Memorial Fund

Materials used:

- PHO course at Dana Center at JHU;
- MSc in Community Eye Health at LSHTM;
- Teaching for Health Professionals Course at LSHTM



COMMUNICATION SESSION C

EUROPEAN ACCREDITATION OF EDUCATIONAL PROGRAMS FOR THE COMPETITIVENESS OF THE PH WORKFORCE

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Katarzyna Czabanowska, MSc., Christian Chauvign, PhD, Aase Gudmann, LL.M, Tom Kuiper, MPH, Allan Krasnik, PhD, MD, Thierry Louvet, Sc Po, Andre Meijer, PhD, Lidia Georgieva, PhD, MD, Ewa Nowak, MSc, Anna Szetela, MSc, Mark Thompson, MBA, Paul Ward, PhD.
Institute of Public Health, Fac. Health Protection, Medical College, Jagiellonian University

Purpose

Presentation of the approach to organize the Accreditation of Public Health (PH) educational programs due to the cooperation of six European Schools of Public Health (SPH) together with ASPHER and EUPHA. This cooperation is set in order to elaborate and establish the processes and institution aimed at improving the quality of PH education across Europe and – as a result - to increase the competitiveness of PH professional workforce on the European labour market.

Introduction

WHO in its Training and Research in Public Health Dialogue Series no 2 focuses on defining strategies to achieve competencies in Public Health. It was felt that it was necessary to set standards for public health training by specifying competence requirements for different types and levels of Public Health professionals that exist in various countries. Approaches to quality assessment of PH education and entry into the labour markets for PH professionals varies in different countries of Europe. Presently only different national organizations (if these exist in a given country) provide licensing, certification or/and accreditation of educational programs, which is not comparable across European countries. Moreover, those national-level procedures do not properly cater for discipline specific assessment, especially for Public Health educational programs. It is worth mentioning here that the more established disciplines such as engineering, business administration or medicine (physicians and nurses; especially at post-graduate level) have already made efforts for agreeing on common standards/criteria for the accreditation of their educational programs.

Methods and materials

Process and ways of implementation of the Accreditation of PH educational programs, the latter - in the form of EAAPHE - European Agency for Accreditation of PH education have been elaborated. This was described in the form of an EU project proposal where the 6 SPHs - members of ASPHER - cooperated together with ASPHER and EUPHA with support of WHO Europe.

Results

A detailed plan of action was elaborated concerning the establishment of the European Accreditation System for PH Education as well as agreement among the partners about the way to co-operate. This System is to be achieved due to the following main activities: (1) Stakeholders interests analysis, Project Observatory building on major stakeholders representatives for advice and consultation on the project (2) Mapping and analysis of quality assessment and accreditation systems especially in Public Health education, (3) Establishment of quality assessment Expert Team in Public Health education, (4) Accreditation System draft Document preparation and approval ; interim and final conferences organization, (5) Development and launch of the European Agency for Accreditation of Public Health Education (EAAPHE) and , (6) Ongoing (multilevel) evaluation of the project products, (7) Pilot accreditation of first educational programs in Public Health, (8) Valorization and dissemination, (9) Management of the project.

Discussion and conclusion

The presented approach is the materialization of the ideas launched by ASPHER and elaborated during several debates initiated by this Association. The project sets the framework of process towards the establishment the European Agency for Accreditation of Public Health Education and for the start of accreditation of PH educational programs in Europe.

Keywords: accreditation, quality of education, process

European accreditation of educational programs for the competitiveness of the PH workforce

Stojniew J. Sitko (PL), Katarzyna Czabanowska (PL), Christian Chauvigné (F), Aase Gudmann (DK), Tom Kuiper (NL), Allan Krasnik (DK), Thierry Louvet (F), Andre Meijer (NL), Lidia Georgieva (BG), Ewa Nowak (PL), Anna Szetela (PL), Mark Thompson (F), Paul Ward (GB)

Goal of the presentation

- Show the approach to organize the European Accreditation of PH educational programs due to the cooperation of 6 European SPHs ASPHER and EUPHA
- present the frame of LdV PH-ACCR Project

One of the ASPHER basic objectives is:

Improvement of Quality of Education

ASPHER *Triple* approach



from: "Accreditation Framework" Accreditation Task Force, S.Sitko et al., v.4, November 2002. www.aspher.org/C_projects/Accreditation

Leonardo da Vinci grant

Accreditation of Public Health Training Programs in Europe PH-ACCR

Some data about the Project

- **8 partners**
- **succeeded** in July/August 05 as one of the best evaluated projects
- **2 yrs** starting from Oct/Nov. 05
- total **budget** of about 400k€
- EAAPHE and pilot **Accreditation** – from Dec. 2006 on

Participating SPHs

1. University of **Copenhagen** (UoC) - DK,
2. Europ. Public Health Association (**EUPHA**) - NL
3. Ecole Nationale de Sante Publique (**ENSP**) - Rennes, F
4. Assoc.Schools of Publ.Health Europ.Region (**ASPHER**)- F
5. **Maastricht** University (MU) - NL
6. Jagiellonian University (JU) - **Krakow**, PL (coordinator)
7. Medical University of **Sofia** (MUoS) - BG
8. **SCHARR** (Sch) - GB
in cooperation with EASP - Granada, ES
with support of WHO Europe

Aim of the Project

- Elaborate and establish the **rules, processes and institution** (EAAPHE) aimed at improving the quality of PH education across Europe
- as a result → to increase the **competitiveness** of PH professional workforce on the European labour market.



„Work Packages” of the Project

- (1) **Stakeholders** interests analysis, **Project Observatory** building on major stakeholders representatives for advice and consultation on the project
- (2) **Mapping** and analysis of **quality assessment and accreditation systems** especially in Public Health education,
- (3) Establishment of quality assessment **Expert Team** in Public Health education,

„Work Packages” of the Project

- (4) **Accreditation System** draft **Document** preparation and approval ; interim and final **conferences** organization,
- (5) Development and launch of the **European Agency for Accreditation of Public Health Education** (EAAPHE) and ,
- (6) Ongoing (multilevel) **evaluation** of the project products ,

„Work Packages” of the Project

- (7) Pilot **accreditation** of first educational programs in Public Health,
- (8) **Valorization** and **dissemination**,
- (9) **Management** of the project

WAY BEHIND US



Long preparatory way

- PEER review(s) (since 1993)
- „Blue Book” (2001)
- multiple DDm, GA, EB discussions and decisions
- Accreditation Task Force „Framework...”(2002)
- EMPH and its component:
- Accreditation Procedure Document (2005)
- many persons involved

**Thank you all
who have been invlved
and supportive !**

1st meeting Kraków (PL) fall 2004



T.Louvet S.J.Sitko K.Czabanowska L.Mladenova

2nd meeting – StMaurice (F) January 2005



M.Thompson T.Kuiper S.J.Sitko

Final meeting – Kraków (PL) end of January 2005



S.J.Sitko A.Meijer P.Ward A.Krasnik
Ch.Chauvigne A.Gudman K.Czabanowska
E.Nowak



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*Thank you for your
attention*

NEW CONCEPT OF THE PUBLIC HEALTH PROGRAM IN REPUBLIC OF MACEDONIA

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Fimka Tozija
Republic Institute for Health Protection

Purpose

The new functions of the Public Health program annually adopted and symbolically funded by the Government should be based upon the basic public health functions of the institutes for health protection defined with the domestic legislation as well as with the international trends and standards.

The aim of the project is to propose a model for modernization of these functions. The introduction of a new Public Health program is harmonized with the ongoing process of health care reforms in the country.

Introduction

The competencies of the current network of National and regional public health institutes have been extended with the Law for Local Self-Government, for the territory covered by them. This is in accordance with the DECISION No 1786/2002/EC of the European Parliament and of the Council (of 25 September 2002), concretely with the activities envisaged with the Program of Community Action in the field of public health (2003-2008), for the action at the local community level as well as defining health priorities and health strategies.

Methods and materials

As basic documents and approach in the process of designing the new modern public health functions the authors used the list of Essential Public Health functions which will be included in the basis of action of all departments of the institutes: Monitoring, Evaluation and Analysis of Health Status Public Health Surveillance, Research, and Control of Risks and Threats to Public, Health Promotion, Social Participation in Health Development of Policies and Institutional Capacity for Planning and Management in Public Health Strengthening of Institutional Capacity for Regulation and Enforcement in Public Evaluation and Promotion of Equitable Access to Necessary Health Services Human Resource Development and Training in Public Health Ensuring the Quality of Personal and Population-based Health Services Research in Public Health Reducing the Impact of Emergencies and Disasters on Health.

Results

The main sectors in the institutes should add some more public health oriented activities in the business plan. The new functions of the Sector for Social medicine includes: Health policy formulation – Strategies and strategic document development; Establishment of Health Statistical-information Center; Publishing of modern Health Statistical Yearbook in accordance with the EU standards; Defining health standards and indicators in accordance with the WHO Strategy Health for all by the 21 Century – HFA database; Information-Reports on health status of different vulnerable groups; Preparation of Programs for promotion of the high priority public health problems with intra and inter sector approach and with the main objective to mobilize the population; Conduct Life style survey and develop modern application software. Public health management training for public health workers of the regional institutes for health protection, local level as well as other forms of continuous health education.

The new – enhanced functions in the Epidemiology should be: Health policy – Preparing the strategic documents and strategies for communicable diseases control and management, Strategy for surveillance and control of the outbreaks and establishing the fast – Alert response system; Analysis and information for prevention and eradication of the intra-hospital infections; Training and education for epidemiologists and other health workers on the local level.

Sector for Environmental Health should put more emphasize on the Creation of the EH policy- Preparing the strategic documents and Strategies (NEHAP, CEHAPE, Food and Nutrition Action Plan, etc.); New and modern environmental health risk assessment and prioritizing of public health problems related to Environmental Health; Publishing the new form of Annual Report of the Environmental Health status in the country; Training in the field for Environmental Health risk assessment for the health workers and other interested parties on national and local level.

Discussion and conclusion

The introduction of a new Public Health program is harmonized with the ongoing process of health care reforms in the country as well as transferring of some basic health and public health functions from national to local level. Government and international agencies should provide sufficient funds for program implementation.

Keywords: public health; functions

DECENTRALIZATION AND PUBLIC HEALTH EDUCATION IN CROATIA

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Luka Voncina Ognjen Brborovic Selma Sogoric
Andrija Stampar School of Public Health

Purpose

Analyse organisation, relations and functions of decentralized health care system in Croatia and define critical issues for public health education, particularly in field of health care management and planning.

Introduction

Croatia has a 30-year experience of decentralization in health care. However, none of the reforms succeeded in achieving the system in which local authorities could carry out long-term and successful management. Many problems appeared during 1990-ies when ownership was transferred to local governments. One of the key problems was local government without capability for integral management of the entrusted health care.

Methods and materials

We analysed official data of the Croatian Institute of Public Health, National Bureau of Statistics, Croatian Institute for Health Insurance, published studies, official documents and unpublished documents of "Healthy county project".

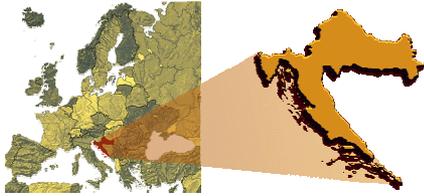
Results

Croatia has highly decentralized health care system. Limitations for successful decentralization are capability of local authorities for health management available to local authorities. Development of population and public health programs is not tightly linked with state control and financing, and it is field with most evident lack of satisfactory professional and political leadership. In existing system local authorities do own health providers, but on the level of management there are only a few people really in charge of health issues. A system is thus created where a group of 5-8 politicians and clerks, without appropriate education, are responsible for activities of 500 to 1000 health professionals employed by providers on local level. Hospital and Primary Health Centre managers also are without systematic education in public health and health care management. Andrija Stampar School of Public Health launched few new programs and courses in public health and health care management education. The educational Healthy Counties program, /developed in cooperation with CDC-Atlanta, US; has built county capacity to assess public health needs in a participatory manner, to plan for health and assure provision of the type and quality of services better tailored to local health needs. Postgraduate course "Leadership and management in health services" was designed as university program for public health professionals, hospital managers, decision makers and other professionals in health care system. Public health residency program and Master of public health are under reform. Aim of the proposed changes is to educate professionals capable to introduce changes in health care system in Croatia

Discussion and conclusion

Croatian model of decentralization model has decentralized activities in many services, but should be improved to become effective. People in charge lacked adequate training and managing skills. In other words, despite legislation framework, there was no force that would be able to integrate the system on the local level. University, public health's, and programs of continues professional education should me more coordinated and further developed to assure necessary and relevant knowledge for public health and professionals involved in health care management.

Keywords: decentralization, education, Croatia



DECENTRALIZATION AND PUBLIC HEALTH EDUCATION IN CROATIA

Aleksandar Džakula
Luka Vončina
Ognjen Brborović
Selma Šogorić

The aim of this presentation is to define critical issues for public health education, particularly in the field of health care management and planning

04/10/2005

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Zagreb, Croatia

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Croatia naturally decentralized



Population: - 4,437,460
Geography: - unique geographical shape
- 66 permanently inhabited islands
History: - until 1990 self-managing health care system
Administration: - 21 local units (counties).

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Decentralization in Croatia

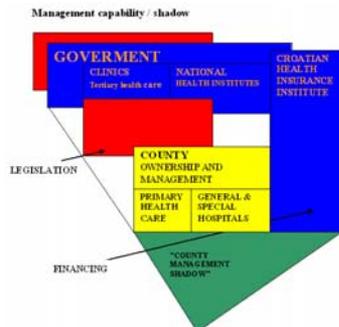
1980's **Socialism** (self-managing, decentralization)
1990-1993 **Centralization** (war, crisis...)
1993-2000 **Reform** (re-decentralization)
2000 -... **New activities**
(i.e. partially decentralized financing, "Healthy counties project".....)

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Decentralization and Management

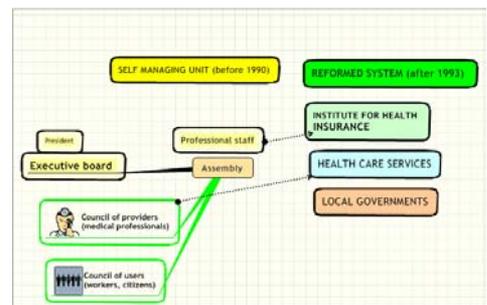


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Critical changes in health care management

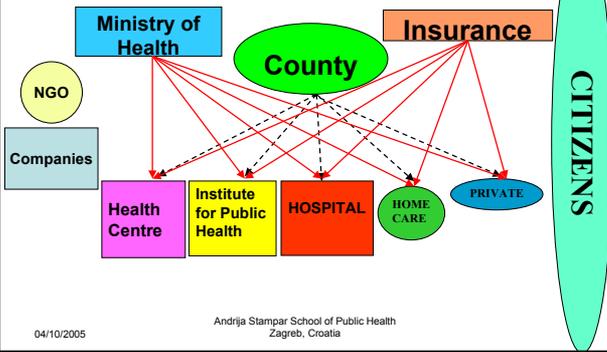


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Educational challenges and specific knowledge needs for Public Health



Existing programs in PH and health management education

Postgraduate courses

Master in PH

Leadership and Management in Health Services
(2002)

Healthy Counties project

- collaboration with CDC, Atlanta (2002)

Management in Health Care

- 4 year university program (2005)

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Findings

People in charge of management lack adequate training.

Universities, Ministry of Health and Public Health professional community do not have defined necessary competencies for professionals involved in health care management

There is no coordination between education and practice

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Conclusions

The precondition for implementing decentralisation is the empowerment of local politicians and professionals for management and decision-making (decentralisation should not be merely a political decision)

Not enough educated managers (local politicians and professionals) can slow down the development, block the changes and eventually decrease quality of health care

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Lessons Learnt

There is no success if **health care system** and **education in public health** are not well coordinated partners

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SCIENTO-METRIC ANALYSIS OF THE MASTER THESIS OF MPH STUDENTS

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Albena Kerekovska
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Purpose

The analysis aims at studying major fields (key words) of master theses, methods used, final results and conclusions made.

Conclusion

The results of the study will help the Programme Council in the selection and approval of the topics of master theses, their tutoring, as well as the improvement of quality of master theses and their closer orientation towards the needs of public health practice.

Introduction

An objective of the Faculty of Public Health at the Medical University - Varna is the overall training in the Master Programme of Public Health, including the development of final master theses to be oriented towards the real world practice.

Methods and materials

Biblio-metric methods for analysis of the master theses of all graduates of the programme are used.

Results

The analysis of the key words used shows that most frequently master theses focus on healthcare reform, quality of healthcare and prevention. The fields of research are varied, which corresponds to the students' background and work position. The adequateness of the methods used is analyzed. The most frequently used methods by the students are documentary method, sociological method (questionnaires), economical analysis, historical methods, and anthropometric methods. The conclusions and recommendations made, as well as their correspondence to master theses objectives are analyzed.

Conclusion

The results of the study will help the Programme Council in the selection and approval of the topics of master theses, their tutoring, as well as the improvement of quality of master theses and their closer orientation towards the needs of public health practice.

Keywords: Sciento-metric analysis, MPH thesis

COMMUNICATION SESSION D

ETHICAL RESTRICTIONS ON INTERNATIONAL RECRUITMENT OF HEALTH PROFESSIONALS FROM LOW-INCOME COUNTRIES

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on behalf of the WFPHA Policy Committee
World Federation of Public Health Organisations (WFPHA)

Purpose

The General Assembly of the World Federation of Public Health Associations following a proposal of the American Public Health Association adopted in its session of May 16, 2005 in Geneva a Resolution on “Ethical restrictions on international recruitment of health professionals from low-income countries”. The WFPHA recommends health worker employers in developed countries, including public and private hospitals, long-term care facilities, and outpatient facilities, voluntarily adopt a code of ethics to judiciously manage the employment of health professionals (including unlicensed caregivers) from abroad. Governments should take an active lead by clearly requiring all public health services to adopt the code of ethics.

Results

Governments can encourage compliance in the private sector by contracting only with health care delivery organizations that have signed and are abiding by the code, and by discouraging the movement of recruited individuals from the private sector (to which they may have been actively recruited) to the public sector. Governments should be encouraged to also ask health care employers to report regularly on their recruitment practices.

Low income countries that lose significant numbers of health professionals to migration shall commit to improving the working conditions for health workers, in order to mitigate the factors that push them to emigrate. This can involve adequate and regular payment, professional development opportunities, sabbatical time, career pathways, opportunity for research etc. WHO and other relevant international organizations are requested to help develop models of best practice. Public Health Associations should help to strengthen the involvement of public health professionals.

Discussion and conclusion

Further steps and problems of operationalisation will be discussed as of September 2005
Keywords: International recruitment, low-income countries, Public Health Associations

ETHICAL RESTRICTIONS ON INTERNATIONAL RECRUITMENT OF HEALTH PROFESSIONALS FROM LOW-INCOME COUNTRIES

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http://www.wfpfa.org/pg_about_policy.htm

September 17, 2005

THE BURDEN OF DISEASE AND HEALTH EXPENDITURES

- In 1990, nearly 90% of the worldwide burden of disease occurred in developing regions, where only 10% of healthcare funds were spent.
- In terms of overall worldwide BoD, Sub-Saharan Africa and India had the largest proportions (21.4% and 20.9%, respectively) but very small proportions (0.7% and 1.0%) of health expenditure.
- Established market economies accounted for 7.2% of burden but 87.3% of health expenditure, whereas formerly socialist economies of Europe accounted for only 4.5% of burden and 2.9% of health expenditure"

THE DISPROPORTIONATE DISTRIBUTION OF HEALTH PROFESSIONALS

- The developed countries having 33% of the world's population contain 74% of the world's physicians and 89% of the world's migrating physicians.
- The vast majority of 14000 nurses moving across national boundaries each year are headed for Europe, North America and the developed Western Pacific.
- Africa needs about 1 million more physicians, nurses and midwives and other health professionals to achieve the Millenium Development Goals (Chen et al., Lancet 2004).

RESOLUTION (57.19) OF THE WORLD HEALTH ASSEMBLY 2004

Urging member states to

“develop strategies to mitigate the adverse effects of migration of health personnel and minimize its negative impact on health systems”

US PHYSICIANS FOR HUMAN RIGHTS

request

That low-income countries be compensated for the loss of health professionals to rich countries and that rich countries should adopt national ethical recruitment codes

(Friedman 2004)

SPECIFIC RECOMMENDATIONS

- 1) Gov to Gov agreements (or WHO like FCTC)
- 2) Reciprocal strategies e.g.:
Offering exchange and scholarships
Continuing education in home country
Remunerating investments
- 3) No active recruitment s. Gov to Gov
- 4) Equal conditions for all employees
- 5) Monitoring of movements of professionals
- 6) Improve working conditions in sending c.
WHO et al.: Best practice models (payment, career, sabbatical time)
- 7) Destination countries to provide their own workforce in sufficient numbers

ELIMINATED PROPOSITIONS

Health care employers may consider unsolicited applications directly from an individual in a developing country only if that individual is making an application on their own behalf and is not using a third party, such as a recruitment agency

ETHICAL DILEMMA

Individual freedom versus social obligation?

Returning investment into up-bringing and education of health professionals in the context of their family and society!

CONCLUDING STATEMENT

Therefore:

WFPHA recommends that health worker employers in developed countries, including public and private hospitals, long-term care facilities, and outpatient facilities, voluntarily adopt a code of ethics to judiciously manage the employment of health professionals (including unlicensed caregivers) from abroad. Governments should take an active lead by clearly requiring all public health services to adopt the code of ethics.

CONCLUDING STATEMENT

Governments can encourage compliance in the private sector by contracting only with health care delivery organizations that have signed and are abiding by the code, and by discouraging the movement of recruited individuals from the private sector (to which they may have been actively recruited) to the public sector. Governments should be encouraged to also ask health care employers to report regularly on their recruitment practices.

ASSESSMENT OF THE FEASIBILITY OF ESTABLISHMENT OF FOOD FORTIFICATION PROGRAM IN REPUBLIC OF MACEDONIA

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Fimka Tozija, Dragan Gjorgjev
School of Public Health, Republic of Macedonia

Purpose

The purpose of this paper is to explore the hypothesis that given existing network of institutions, manpower and industrial facilities it is feasible to establish food fortification program in RM. The main goal is to provide recommendations for policy decision makers for subsequent implementation and reduction of diseases and conditions attributable to micronutrient deficiencies.

Introduction

Full harmful extent and impact of micronutrient malnutrition have been recognized only recently. Good nutrition practices separately, or in combination with educational programs for raising awareness of the population are considered insufficient to prevent diseases and conditions that can be attributed to vitamin and mineral deficiencies, even in developed countries with affluent health care. Public health responsibility has been pointed as major factor in ensuring all people to get adequate vitamin/mineral daily intake.

Food fortification is described by USA CDC as “among the major achievements of public health in 20th century”, underlining that diseases such as goiter, rickets and pellagra in USA are almost eliminated as a result of instrumental measures. WB publication “Enriching Lives” ... has documented that micronutrient deficiencies “could waste as much as 5% of GDP, yet, addressing them comprehensively, using an array of cost-effective solutions could cost less than 0.3% of GDP”. Proven as cost-effective, food fortification is persuasive and becoming more realistic and accessible option for developing countries.

Methods and materials

The proposal employed appropriate methodology as to evaluate the possible impact of food fortification on micronutrient deficiencies; to develop a plan able to create an environment conducive to the fortification of foods by the food industry as well as to develop a strategy/working partnership among all stakeholders in the food fortification project (Government, food industry, NGOs and donor agencies, academe, laboratories and fortificant suppliers).

Discussion and conclusion

In RM, as in other countries in transition, societal and political changes are contributing to deterioration in health status for a relatively large portion of the population, especially in certain risk categories. Of note, however, is the adverse impact of the 2001 conflict on overall health indicators caused by reduced health care delivery, fragmented health information flow and severely restricted preventive services.

Multiple Indicator Cluster survey with Micronutrient Component (UNICEF, 1999) showed that 7% of the children (6-59 months) had height-for-age < -2Z score. Significantly higher proportion (9%) of low height-for-age was observed in rural children. Low height-for-age was particularly elevated in Roma (32%) followed by Albanian (11%); others showed prevalence < 5%. Large proportion of the children had mild retinol deficiency (30%), with higher rates in urban areas.

Low haemoglobin was present in 27% of the children. Severe iron deficiency was observed in 14% of the cases (more common in rural areas); mild in 37%. There are still cases of rickets in RM.

In collaboration with WHO, MoH has issued the Food and Nutrition Action Plan, adopted by the Government. Food fortification has been emphasized as an essential preventive measure for micronutrient's deficiencies. Establishment of appropriate policy and cooperation among the sectors in the Government and with the food industry on this issue has been also underlined. Recently, the MoH has started a project for fluoridation of the milk - a measure for public health oriented prevention of caries as one of the major public health problems in the country.

There is no official Registry for the prevalence of birth defects in the country and this is a major area to be further explored, in order to provide reference for fortification with folic acid.

Keywords: feasibility, micronutrient deficiencies, food fortification

TOBACCO CONTROL POLICY IN ARMENIA: TRANSLATING EVIDENCE INTO PRACTICE

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American University of Armenia

Purpose

In December 2003, the Open Society Institute funded a consortium known as the Armenian Public Health Alliance (American University of Armenia, Armenian Public Health Association, Armenian Public Health Union) to implement a multi-year program designed to build knowledge and capacity among key stakeholders toward advocacy and implement of evidence-based tobacco control policies in Armenia.

Introduction

Built upon the scientific evidence that only comprehensive tobacco control programs are effective, a multifaceted program was implemented to employ strategies proven be effective in other countries: building a public coalition, partnering with media, and supporting policy and decision makers with evidence-based information. Given budget constrictions, the most cost-effective strategies were chosen to satisfy the principle of multifaceted intervention.

Methods and materials

Following review of existing literature on contemporary approaches in tobacco control and a situational analysis which identified the positions of stakeholders, an assessment of opportunities and challenges was conducted. Appropriate messages and materials were developed and disseminated through a variety of formats (print materials, individual meetings, public meetings, etc.)

Results

During the first year of the project, a national tobacco control coalition of NGOs was established. Its work led to increased coverage of tobacco control issues and access to policy makers. As a result, Armenia adopted the Framework Convention on Tobacco Control, making it one of the first 40 countries to do so. In parallel a national tobacco control law was adopted which brought Armenian laws closer to alignment with the FCTC.

Discussion and conclusion

The formation of the coalition and ensuing process highlighted several lessons: 1) Elected officials and civil servants are unpredictable, both in their positions on issues and on the timing of discussions: flexibility is critical; 2) Having an ally in the policymaking body who is a recognized leader is an asset; 3) Media in Armenia are most effective when provided with written press-releases, as they lack analytical and investigative skills; 4) Open, transparent, and democratic management is critical to building a coalition among disparate NGOs interested in tobacco control but with different decision-making styles and different priorities; and 5) Governmental bodies are only now beginning to recognize the importance of public support.

Key to success in tobacco control is the thoughtful adaptation of methods and materials to the specific characteristics of the country. A cadre of appropriately trained public health cadre professionals, supported by professional and community organizations, is essential.

Keywords: tobacco control; evidence-based interventions; policy development

XXVII ASPHER CONFERENCE

Tobacco control policy in Armenia: Translating Evidence into Practice

Narine Movsisyan, MD, MPH

ArmPHA Tobacco Control Policy Project Director

Yerevan, Armenia

19 September, 2005



AMERICAN UNIVERSITY OF ARMENIA
COLLEGE OF HEALTH SCIENCES

1

Country Information

- Population 3,061,000
- Urban 64%
- Age <15 22.2%
- Age 65+ 10.1%
- Life exp 65.0/72.0 (m/f)
- Total health expenditure 5.8% of GDP (2002)

Source: World Almanac 2005



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2

Smoking in Armenia



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SMOKING BURDEN

- Male smoking rate 67.5%
- Female smoking rate* 3.1%
- Smoking attributable mortality 22%
- Yrs of life lost due to smoking** 17

*Health and Demographic Survey 2000

**Mortality caused by smoking in developing countries. Peto, R, Lopez, A



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4

ArmPHA Tobacco Control Policy Project
(funded by OSI)

Armenian Public Health Alliance

- American University of Armenia
- Armenian Public Health Association
- Armenian Public Health Union



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5

Preliminary assessment



- Review of literature
- Stakeholders identification
- Assessment of opportunities and challenges

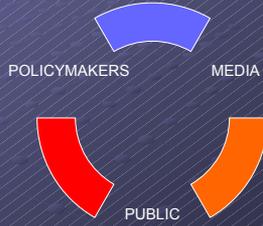


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6

INTERVENTION

- Assisting/ supporting policymakers
- Partnering with media
- Building public coalition



Achievements

- The Coalition for Tobacco-free Armenia established June 12
- Armenia ratifies the FCTC, becoming one of the first 40 countries October 12
- Parliamentary hearings held on tobacco control issues November 17
- National Law on tobacco control adopted December 24



ArmPHA InfoPack



Building public support



Parliamentary Hearings



World No Tobacco Day 2004



LESSONS LEARNED

- #1
Elected officials and civil servants are unpredictable, both on positions and the timing of discussions; flexibility is critical
- #2
Having an ally in the policymaking body (a “champion”) is an asset



LESSONS LEARNED

- #3
Media work best when provided with written press-releases; it lacks analytical, investigative skills
- #4
Democratic and transparent management is critical to building a coalition of NGOs



Challenges in implementation



- Low public awareness of the law
- No administrative & financial mechanisms to enforce the law
- Insufficient means to monitor the process
- Industry counteraction
- Lack of political will to enforce



ACKNOWLEDGEMENTS

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for his guidance and kind encouragement
To the Alliance tobacco control team members
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Hovhannes Margaryants
Zaruhi Darbinyan
Ashot Davidyants
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To the WHO national counterpart
Alexander Bazarchyan,
for his support and cooperation



ACKNOWLEDGEMENTS

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for generously supporting our efforts to minimize smoking burden in Armenia through
 - funding ,
 - technical assistance, and
 - opportunities for the professional development.
- Thank you for your attention!



BIRTHING IN THE ARAB REGION: HOW TO TRANSLATE RESEARCH INTO POLICY?

Tamar Kabakian-Khasholian, tamar.kabakian@aub.edu.lb

Faysal El-Kak

American University of Beirut

Purpose

The Choices and Challenges in Changing Childbirth research network is a regional collaboration aiming to cumulate scientific evidence of childbirth practices in the Arab region and to identify areas amenable for change, in order to render maternity care safer for women and their newborn children. It is a regional research program involving researchers from Egypt, Lebanon, Palestine and Syria.

This program, working through a consolidated network of researchers in the Arab region, provides elucidation of one of the most important rites of passages in women's lives in a region with high fertility rates. The research is also important as childbirth in the region is salient concerning the implications of shifts from traditional to western biomedical health care systems for an event still highly embedded in traditional understandings and practices. Moreover, the variation in terms of practices and health care systems in our region offers researchers the opportunity to increase knowledge about a variety of intervention practices, with the potential of extrapolating findings to similar situations beyond the region.

Introduction

Our research has provided evidence on the variation in the process of maternity care in the region and on the discrepancy between routinely followed practices and best practices identified by the literature. The constellation of the studies conducted pinpoint to problems in the quality of maternity services provided in the region and the lack of women's involvement in the overall process of care. Currently, a number of intervention studies targeting behavioral change among providers and/or women as well as studies evaluating the effectiveness of practices with unknown outcomes are being conducted in these four countries.

Results

One major challenge facing the network is in using the research program as a window of opportunities to change childbirth practices and policies in the region. This is tackled by a) selecting areas for research that are amenable to intervention and most likely to influence practices; b) conducting quality research (some of the first randomized controlled trials in the region) in order to create regionally relevant evidence in high standards; c) assigning a major importance for dissemination and networking activities at a regional level, to form a better understanding of the diversity of stakeholders and to suggest policy solutions identified by research. The latter is done by finding the right communication channels and most effective vehicles for each group of stakeholders.

Discussion and conclusion

A vast number of barriers are faced in this process such as the dominant culture among women of great trust in physicians, lack of accountability of physicians, dominance of fragmented care and private sector, lack of interest of policy makers in clinical effectiveness and research evidence, and a social environment not conducive to policy change in general. In this regard, our network is actively seeking to mobilize agents of change by networking and collaborating with women's groups, media, professional associations and governmental bodies.

Keywords: childbirth; policy change; Arab countries.



Birthing in the Arab Region: How to Translate Research into Policy

Tamar Kabakian-Khasholian, Faysal El Kak, Rawan Shayboub

Choices and Challenges in Changing Childbirth Research Program
Centre for Research on Population and Health
Faculty of Health Sciences
American University of Beirut



Maternal health in Arab countries



- Decline in maternal mortality
- Increase in facility-based births
- Increase in levels of skilled attendants at delivery
- Studies from developing countries concentrate on high-risk pregnancies and emergency obstetric care or on traditional practices and home births.



Choices and Challenges in Changing Childbirth Research Program



- Choices and Challenges in Changing Childbirth regional program in Lebanon, Egypt, Palestine and Syria. Funded by the Wellcome Trust since 2001.
- Based on earlier research conducted by the B-WELL (Bettering women's experiences of labor and delivery) group at FHS, AUB and the Regional Reproductive Health Working Group.
- Aims:
 - 1) To create scientific evidence on childbirth practices in the region
 - 2) To understand and further assess how maternity care can be made safer and more satisfactory



Normal childbirth is over-medicalized in the Arab region



- Facility practices for normal delivery are not standardized and large gaps exist between actual practices and scientific evidence
- Women are discontent of normal delivery practices but not vocal and not involved in decision making process
- Uncritical adoption of ineffective or even harmful practices poses risks to the health of mother and infant.



Impacting policy and practice....



Recognized barriers:

- A culture of great trust in physicians
- Lack of accountability of health systems
- Dominance of fragmented care
- Lack of interest of policy makers in clinical effectiveness and research evidence
- An environment not conducive to policy change

The following discusses the challenges facing the network and the strategies adopted in using the research program as a window of opportunity to change childbirth practices and policies in the region.



Challenges



- **Reproductive Health agendas**
 - Promotion of family planning
 - Reduction of maternal mortality
 - Universal uptake of prenatal care
- **Organization and delivery of health care**
 - Differences in health care systems between Arab countries
 - High workload & understaffing in hospitals
 - Contribution of physician's convenience factor in shaping routines
 - Inappropriateness of physical structures
 - Lack of medical training in evidence-based care for normal physiological childbirth
 - Lack or inappropriate application of standard protocols & guidelines
- **Women's involvement**

Adopted Strategies

- Choice and quality of research**
 - Conducting quality research and building a hierarchy of evidence in the region
 - Selecting issues most amenable for change and sustainable in its context
 - Expected implications on practice and policy presented within the proposal
- Multidisciplinary team**
 - Involvement of clinicians:
 - Providing an opportunity of change to the center through the research conducted on their premises
 - Using their own channels to access health care centers with a wide influence on obstetric practice in the country and/or to involve prominent obstetricians in research activities.



Disciplines Involved



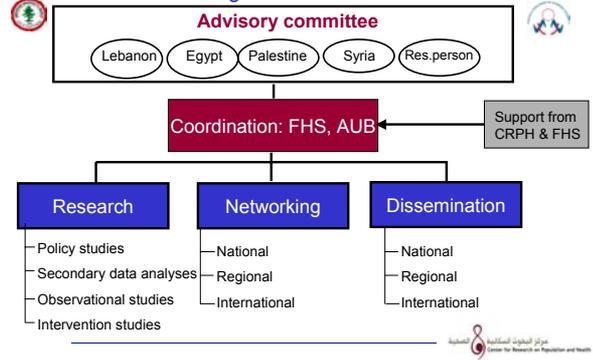


Adopted Strategies

- Dissemination**
 - Recognition of the importance of initiating dialogue with the main three pillars surrounding the childbirth episode: women, services and providers
 - > Involving different players in the process of research and dissemination
 - > Collaborating with the media
 - > Assigning a focal person



Regional Network





Lessons Learnt

- > The importance of widening the dialogue with different stakeholders,
- > Learning to use more provider-friendly language
- > Strengthening the links of collaboration through more participatory research
- > Developing the necessary "cadre" in charge of planning and executing dissemination and networking agendas

KEY: Effective communication



COMMUNICATION SESSION E

TO DEVELOP A COHERENT LEGISLATION ON PREVENTION: THE GERMAN EXPERIENCE

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University of Bielefeld

Purpose

Preventive Services are predominantly public services. Therefore the legislator has to provide the appropriate legal framework. Prevention in most of the European countries suffers from an information deficit, a training deficit, a deficit in social coverage and a management deficit. The new comprehensive German legislation tries to improve all of these.

Introduction

The legislator describes the aims of the new legislation as Maintaining health and quality of life, Preventing the development of disease, Early detection of disease, Coping with disease, Creating healthy living conditions, Maintaining the ability to work, Avoiding early retirement due to disease, Delay the necessity of nursing. Its overall long-term goal is the Stabilisation of social security systems through Improvement of health chances, Reduction of inequities, Barrier-free access, Support for communication.

Results

A set of 4 laws is presently designed: German Law on Strengthening Prevention (GLSP), Law on the Foundation for Prevention and Health Promotion (FPHP), Law on the Federal Agency for Health Information (BzgA), Adaptations in the Social Law Books. Until the 01.01.2006 a new state sponsored Foundation for Prevention and Health Promotion has to reach an agreement between all stakeholders on common priorities, to develop concrete objectives and to define benchmark indicators. Otherwise the German "Laender" will be automatically in charge. For the funding of preventive activities an evidence base is required by law as well as defined quality standards. A scientifically evaluated pilot model has to be published and regular monitoring be assured by the foundation and the Federal Robert Koch Institute in Berlin. The new Foundation has the mission to implement the legislation, to determine health objectives, to develop measures and activities, to participate in activities on health information, to support and execute measures for healthy settings, to define quality standards, and finally to agree on a prevention programme.

Discussion and conclusion

The new legislation improves coordination, takes into account the setting approach (Ottawa Charta), enforces implementation and provides a defined budget. Experience may show, that in some aspects there is over-regulation, lack of subsidiarity, limited funding, lack of integration of private insurance, lack of tax incentives and of focus on priorities. Nevertheless the law is an important step into the right direction and provides enough flexibility to adapt to first experience as it does not attempt to define the content of prevention programmes but regulates only the procedures of action.

Keywords: Prevention, legislation, health policy

A COHERENT LEGISLATION ON PREVENTION: THE GERMAN EXPERIENCE

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Preventive services are predominantly public services. Therefore the legislator has to provide the appropriate legal framework. Prevention in most of the European countries suffers from an information deficit, a training deficit, a deficit in social coverage and a management deficit. The recent proposal for a comprehensive German legislation tries to improve all of these.

A LAW ON PREVENTION: ISSUES OF CONCERN

GUIDING PRINCIPLES

- 1) Great Responsibility because of population wide impact!
- 2) Comprehensiveness sufficient to induce effects?
- 3) Special effort required for Vulnerable Groups.
- 4) Evaluation of Impact upon Economy a key strategy!
- 5) Subsidiarity in the hierarchy (decentralisation)
- 6) Empowerment of the people (health promotion)

A LAW ON PREVENTION: ISSUES OF CONCERN

CRITERIA OF PREVENTIVE SERVICES

- 7) Efficiency of services & programmes (EBPH; QA)
- 8) Intersectorality lead by the PHS
- 9) The PHS: from provision to Supervision & Support
- 10) Accountability by best practice and benchmarking
- 11) Representation of Stakeholders (health conference)
- 12) Support for Participation of citizens & patients

New Legislation

German Law on Strengthening Prevention (GLSP)

Law on the Foundation for Prevention and Health Promotion (FPHP)

Law on the pre-existing Federal Agency for Health Information (BzGA)

Adaptations in the Social Law Books

Chapters of the GLSP

General Regulations (§ 1-8)

Information Basis (§ 9)

Health Objectives and Coordination (§ 10-12)

Responsibilities (§ 13-14)

Measures/Activities (§ 15-20)

Pilots (§ 21-22)

Financial Means (§ 23-24)

Reporting (§ 25-26)

Coordination

Framework Agreements between Stakeholders

Common Council on Prevention

If not established within 1 year after introduction of the GLSP the governments of the Laender shall act by decree

Financial Means

The Stakeholders together contribute as before
250 mio € (plus additional 23 mio €)

Funds hold by FPHP amount to 500 mio €

Law on FPHP

Establishment of a Foundation acc. to Public Law

Purpose: Implementation of GLSP

- To determine health objectives
- To develop measures and activities
- To participate in activities on health information
- To support and execute measures for healthy settings/“Lebenswelten”
- To define quality standards
- To agree on a prevention programme

Critique

Positive:

- Coordination
- Consideration of Settings
- Enforced Implementation
- Budgeting

Critique

Negative:

- Over-regulation
- Subsidiarity lacking
- Insufficient funding (?)
- Private insurances exempted
- Lack of focus on priorities (?)
- Lack of tax incentives

PUBLIC HEALTH: THE WORLD IN OUR HANDS

Executive Board, Bonn, May 2005

WORLD FEDERATION OF PUBLIC HEALTH ASSOCIATIONS

German Forum

- Maintaining health and quality of life
- Preventing the development of disease
- Early detection of disease
- Coping with disease
- Creating healthy living conditions
- Maintaining the ability to work
- Avoiding early retirement due to disease
- Delay the necessity of nursing.

Law on FPHP

Autonomous Federal Agency of the MoH

Purpose: Health Information acc. to GLSP

On prevention

On prevention of addiction

On prevention of infectious diseases esp. AIDS

On donation of blood and organs

On pregnancy and abortion

Questions

A: What relevant legislation does exist ?

B: What are the perspectives?

C: What are the strategic issues?

Summary

GOAL

Stabilisation of social security systems

OBJECTIVES

Additional "Column"

(Acute Care, Rehabilitation, Nursing plus Prevention)

Health Behaviour & Living Conditions

("Verhalten und Verhältnisse")

Multiplicity of Stakeholders

(health, nursing & accident insurance, pension fund, Laender)

Common Health Objectives

Quality Assurance

General Regulations

TERMINOLOGY

Primary, secondary, tertiary prevention & health promotion

Approach

Improvement of health chances

Reduction of inequities (gender, age, social class)

Barrier-free access

Support for communication

Common Health Objectives

Agreement on common priorities

Development of concrete objectives

Definition of benchmark indicators

To be provided by the FPHP

Living Conditions

Health Behaviour

Acc. to Social Law Books

“Lebenswelten” (Settings)

HOUSING (the community)

WORKING (the employer)

LEARNING) (the schools)

RECREATION (the owners of e.g. sport facilities)

PLAYING (the owners of e.g. playgrounds)

Quality Assurance

Requirement of Evidence Base

Quality Standards to be agreed

Pilot Models to be evaluated by scientists, the final analysis to be published

Regular Reporting by FPHP and RKI

WHOSE EVIDENCE, ANYWAY?

Rosa Giuseppa Frazzica
CEFPAS

Purpose

To assess the evolution of the information and knowledge generation in terms of patients confronting health professionals with scientific evidence derived from mass media, internet, and other informed sources.

Introduction

The era of information technology and the knowledge generation - which is the present one - pose intriguing, yet silent challenges of panendemic importance to present and future health professionals and to the system in general. Patients empowered with self-acquired scientific evidence will challenge the knowledge, skills, behaviour and professional credibility of doctors and nurses of all continents in search of rapid, effective and efficient answers to their health problems. Is the system ready for this?

Methods and materials

CEFPAS has designed a Region-wide longitudinal study Data that includes the health personnels reaction when confronted with the evidence, the patients perception of the ensuing behaviour and its impact. The study involves a sample of: 400 Doctors (120 Community Paediatricians and 280 General Practitioners), 400 Specialists (Surgeons, Internists, Oncologists, Cardiologists, Pneumologists, Dermatologists); 400 nurses; 1200 patients, 400 of whom hospitalised and 800 among the general population. Following 2 focus groups discussions and testing, the questionnaires are being validated and are ready for use. Quali-quantitative methodologies and triangulations will be mainly utilised for the analysis.

Results

The project received an enthusiastic response by the sample that participated in the testing of the tools, with the population being very interested and participative. Expected results will be very useful to face this important problem that sees, probably for the first time in such a massive way, health personnel no more in the dominant role, in terms of knowledge, but critically judged by their own patients.

Discussion and conclusion

Many have pointed out that this study is opportune and timely. Its results will open the way to more effective and efficient care, with better educated providers for a better informed population and, mainly, better quality of life for all.

Keywords: evidence based approach, information technology, better care



CEFPAS
Centre for Training and
Research in Public Health



- A Sicilian Regional Government Institution
- An organisation similar to Local Health Organisations
- It started its activities in 1996

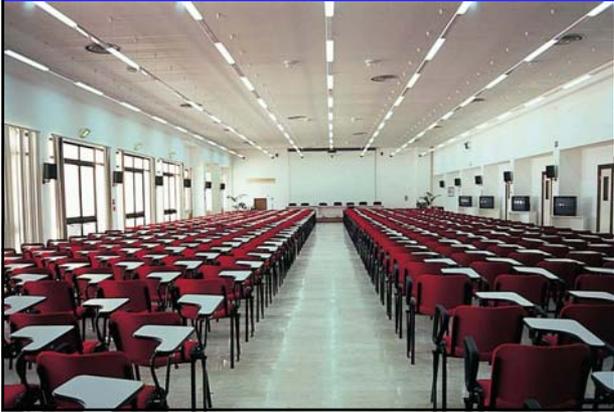


- 16 buildings for 26.000 sqm of covered surface:
- 11 buildings for training
 - 1 gymnasium for sports & rehabilitation

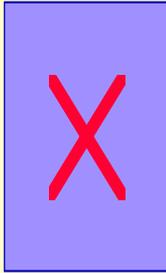


- 1 hotel with rooms conference space
- 3 dormitories with 210 rooms

The Auditorium



Whose evidence anyway?



Author: Frazzica P.

Purpose

To assess the evolution of the *information and knowledge generation* in terms of patients confronting health professionals with "scientific evidence" derived from mass media, internet, and other "informed" sources.



Context

The era of information technology and the knowledge generation poses important challenges to present and future health professionals and to the health system in general.



Context

Patients are more and more aware of their own rights, in terms of quality, quantity and costs of care, and are determined to get the best.



Context

Patients are empowered with self-acquired "scientific evidence" and increasingly use it.



Sources of "evidence"

- Friends and family
- Printed material
- Television
- Internet



Reasons for the "evidence"

- People need rapid, effective and efficient answers to "their" health problems
- They want to be informed and participate to the diagnostic and therapeutic processes



Quality of "evidence"???

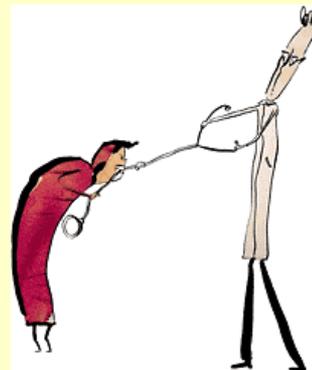


What does this mean?

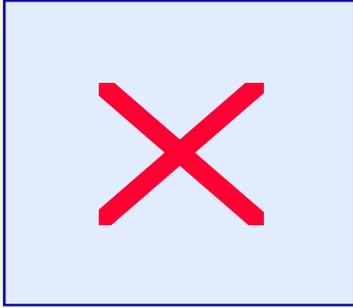
Patients will increasingly challenge the knowledge, skills, behaviour and professional credibility of health personnel of all continents.



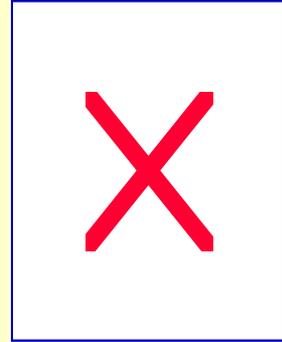
Is the system ready for this?



How will health personnel react when confronted with "the evidence"?



How will patients interpret health personnel reaction and what action will they take?



The project

CEFPAS has designed a Region-wide longitudinal study to look at the evolution of:

- health personnel's "reaction" when confronted with "the evidence";
- patients' perception of personnel behaviour and its impact on future medical choices.



Instruments

Questionnaires directed to:

- 120 Community Paediatricians
- 280 General Practitioners
- 400 specialists
- 400 Nurses
- 400 hospitalised patients
- 800 General population



Methods

- Focus groups to discuss, test and validate the questionnaires
- Quali-quantitative methodologies and triangulations will be utilised for the analysis.



Preliminary Results

- The project received an enthusiastic response by the sample that participated in the testing of the tools
- The population was very interested and participative



- Health personnel are "critically judged" by their own patients in terms of knowledge, skills and behaviour;
- Professionals may lose the actual "dominant role" relative to the patient;
- They may lose personal credibility.



State of the art

The study is under way



Conclusions

- Many have pointed out that this study opportune and timely
- Its results will open the way to more effective and efficient care



Our motto...

- Better "educated" providers
- for a better "informed" population and, mainly,
- a better quality of life for all.



Thank you !

MEETING THE CHALLENGE OF INJECTION DRUG USE AND HIV EPIDEMIC IN ARMENIA

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World Bank/MOH

Purpose/Overview

The purpose of this study has been to analyze the Armenian laws and policies to find out whether they are able to adequately respond to the problems of illicit drug use and HIV in the country.

Background

Injection drug use (IDU) and HIV rates in some countries of the former Soviet Union (fSU) are still skyrocketing. Although Armenia is a relatively low HIV incidence country, the risk of a national HIV/AIDS epidemic is high due to existence of factors similar to those which created fertile soil for the spread of HIV in Russia and Ukraine. In Armenia, as in other countries of the fSU, the spread of the virus is driven mostly by IDU. Decisive policy action at the national level is needed for an effective response to HIV and IDU.

Methodology

A comparative analytical approach was used. Illicit drug- and HIV-related policies and their possible contribution to the HIV epidemic in Armenia were compared with the ones in other countries of fSU where the relationship between the legal framework and HIV has been documented.

Results

The analysis indicates that the Armenian Drug Law can be characterized as “zero tolerance” toward illicit drugs. Criminal statutes require imprisonment or institutionalization for purchase and possession even for small amounts of illicit substances, as well as for their consumption. Since it is well documented that in countries with injection-driven HIV epidemics, prisons are a powerful factor in HIV transmission and since the estimated HIV prevalence rate among Armenian prisoners is around 6% compared to 0.1% among the general population, incarceration of non-violent illicit drug users raises serious concerns. Hundreds prisoners that are released from the country’s prisons annually may become a bridging population spreading HIV to the general population.

Another important determinant of an effective response to epidemic is protection of human rights of people vulnerable to HIV. The findings of the study indicate that the Law of the Republic of Armenia on HIV/AIDS provides for compulsory testing of at-risk groups of population including IDUs. In addition to that, the legislation in Armenia does not have statutes that specifically ban the release of confidential HIV information. Vice versa, the Armenian Health Law, the Law on Personal Data and the Law on HIV/AIDS permit disclosure of medical information in cases envisioned by law. Further, while the equality or non-discrimination is a fundamental principle of human rights law, in Armenia the guarantees to non-discrimination are mostly illusory, because Armenia has not passed specific anti-discrimination laws designed to protect vulnerable groups. Obstacles to the adoption of comprehensive human rights-based approaches to HIV in Armenia are apparent also in policies relating to harm reduction initiatives. While experience from other regions shows that harm reduction activities must form a critical part of the response to HIV/AIDS, yet, under Armenian drug law, harm reduction activities are either banned or allowed only on a limited basis.

Conclusions

Overcriminalization of illicit drugs and the lack of human rights-based approaches to the problems of HIV and IDU result in marginalization of IDUs, make them hard to reach by public health workers and thus reduce the effectiveness of prevention and treatment programs. In some countries of the fSU these policies resulted in generalized HIV epidemics, which is a real threat for Armenia either. Meeting the challenge of injection-driven HIV/AIDS epidemic in Armenia requires a concerted effort which would combine respect, protection and fulfillment of human rights of IDUs, reconsideration of the policy emphasis on overcriminalization of drugs and law enforcement and rebalancing social priorities, away from claims of morality and intolerance.

Keywords: HIV, injection drug use, policy

Meeting the Challenge of Injection Drug Use and HIV Epidemic in Armenia



Karine Markosyan, PhD, MPH

Armenia

International Policy Fellowships
Program

Open Society Institute

Problem Definition

- The former USSR has been experiencing an unprecedented increase of IDU-driven HIV epidemic
- 332 HIV cases have been registered in Armenia from the beginning of the epidemic
- Estimated prevalence of HIV among general population in 2002 was < 0.1%

Factors contributing to the spread of HIV in Armenia

- High growth rate of HIV infection in neighboring countries
- Socio-economic crisis
- Increased poverty
- Unemployment
- Out migration

IDU in Armenia

- There is an apparent linkage between HIV and IDU in Armenia
- More than a half of HIV cases registered in the country are IDUs
- The HIV prevalence among IDUs is around 15%, which is much higher than in any other group of population

Purpose of the Study

- to analyze the Armenian laws and policies to find out whether they are able to adequately respond to the problems of illicit drug use and HIV in the country

METHODOLOGY

A comparative analytical approach was used. Illicit drug- and HIV-related policies and their possible contribution to the HIV epidemic in Armenia were compared with the ones in other countries of fSU where the relationship between the legal framework and HIV has been documented.

Zero Tolerance Approaches to Narcotic Regulation in Armenia

- Criminal statutes require imprisonment or institutionalization for purchase and possession even for small amounts of illicit substances, as well as for their consumption
- Thresholds for trafficking penalties are very low - small-scale dealers or producers of narcotics are punished as severely as industry kingpins .

Consequences of law enforcement approaches

- In countries with injection-driven HIV epidemics, prisons are a powerful factor in HIV transmission .
- The estimated HIV prevalence among Armenian prisoners is around 6%
- People that are released from the country's prisons may become a bridging population spreading HIV to the general population

Inadequate Protection of human rights of IDUs (1)

- The Law on HIV/AIDS provides for compulsory testing of at-risk groups of population including IDUs
- There are no statutes that specifically ban the release of confidential HIV information.

Inadequate protection of human rights of IDUs (2)

In Armenia the guarantees to non-discrimination are mostly illusory, because

- Armenia has not passed specific anti-discrimination laws designed to protect vulnerable groups
- The right to equal access to health care is not enforced when the IDUs are concerned
- Harm reduction activities are either banned or allowed only on a limited basis

CONCLUSIONS

- Overcriminalization of illicit drugs and the lack of human rights-based approaches to the problems of HIV and IDU result in marginalization of IDUs.
- Controversial status of harm reduction initiatives limits their promise to reduce the HIV risk of IDUs
- In some countries of the fSU these policies resulted in generalized HIV epidemics, which is a real threat for Armenia either

RECOMMENDATIONS

Meeting the challenge of injection-driven HIV/AIDS epidemic in Armenia requires a concerted effort which would combine

- respect, protection and fulfillment of human rights of IDUs,
- reconsideration of the policy emphasis on overcriminalization of drugs, and
- rebalancing social priorities, away from claims of morality and intolerance

Thank You



The policy paper is available at
www.policy.hu/markosyan

NEW PROJECTS IN A HEALTH CARE SERVICES SECTOR - LEARNING AND PRACTICING PROJECT MANAGEMENT

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Purpose

The main question of this study was to look for what kind of the non-routine development activities have been undertaken by the health care units and how they have been implemented - along with the several-years period of changes in the health sector. This was done on the example of the transitions in Poland after year 1989.

Introduction

Change introduction and its management in the health organizations is one of the core public health competencies. Effectively fitting the organization operations and strategy to the (constantly) changing environment is an important challenge so good in a health area as in every other sector. One of the way to analyze this phenomenon is to look for non-routine activities of the organizations especially for projects undertaken. Project management is one of the important skills one should learn and put into practice in order to effectively implement changes.

Methods and materials

The review of over 450 literature articles describing - each - a range of changes introduced in the Polish health care services organizations between the 1989 and 2004 have been done. All the descriptions have been classified into (one or several of) the 25 project categories arbitrarily established together with the information about the organization where the project(s) took place - such as its kind, dimension, location, property status etc. Over the 1500 such description have been put together. This database allowed the cross-sections analysis, especially the correlations of different characteristics of the projects. Examples of those analysis are: the number of projects of a given category by the year, type of the projects by the kind of the organization (hospital, outpatient clinic etc.), by its location and so on - all of that - time-correlated. Such approach allowed also another study, namely the influence of the changes introduced into the health system as a whole - on the reactive (or proactive) behavior of health care organizations. Parallel analysis of the tools used to plan and manage the projects and their transformation have been done as well.

Results

The distinct correlation between the time (increasing year) and growing number of undertaken projects in nearly each of 25 categories have been detected. The majority of projects undertaken have fallen into the categories connected with pro-market changes in the organizations, observed due to the transformations in the health sector in Poland after the year 1989 as: new technology acquisition, personnel cutbacks and re-training, patients satisfaction monitoring and improvement. In contrast (and to some extend - contradictorily) : strategic planning, introducing the new forms of care have not be of the main interest during the analyzed period of time. The kind (and reference level) of health care organization as well as its geographical localization influenced the time, kind and scale of investigated the projects. The positive evolution of methods of planning and implementing the projects throughout the examined period of time have been observed as well.

Discussion and conclusion

Two main conclusions could be pointed out. First, the analysis shows the image of the evolution of a health sector quite well correlating with the changes undertaken by the health care organizations.

Second, proposed approach is not country-specific and may be applied to monitor the evolution of the health sector and its influence on its organizations - not limited to the health care uniquely.

Keywords: projects, management, health care organizations

New projects in a health care services sector - learning and practicing Project Management.

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1/19

Organizational reality

Apart from routine activities of high quality - **each organization** should undertake the **NEW enterprises** – the activities aimed to fit to the (constantly) changing environment

More **turbulent** environment – more actively the organization should change

2/19

NEW enterprise = PROJECT

Project = **temporary** and **unique** activities undertaken usually in order to reach the strategic aims of an organization

Project Management Institute (PMI)

3/19

Projects = Innovations

Innovations are recognized as:

- Signs of active **fitting to the environment** change
- Required in an organization to support its **development**
- Brake down the **routine** which might block the organizational change

4/19

Purpose of THIS study

Identify the **main area** where the **projects** have been undertaken by Polish health services organizations (HSO) during the important changes of health care system between 1989 and 2004

Find out the **interrelations** between the projects and evolution in the health system at the country level.

5/19

Method

Meta-analysis:

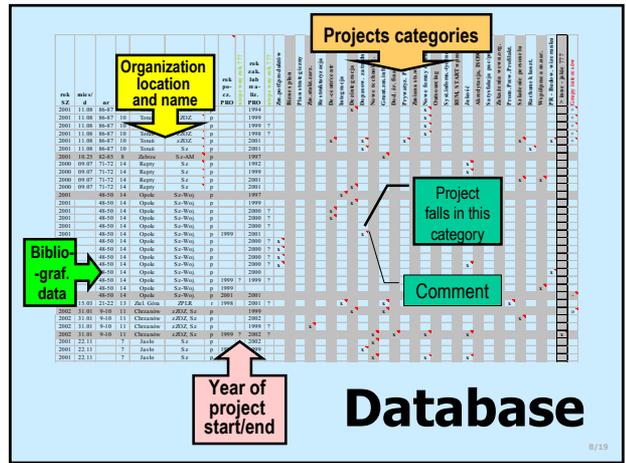
Review of project reports and plans

- of health service organizations either
- published in professional journals or
 - prepared during educational programs for project management

6/19

Analysis

Each project has been analyzed, assorted in one or few of **27** arbitrary set main categories and put together with the details about the organization and the reference into a database



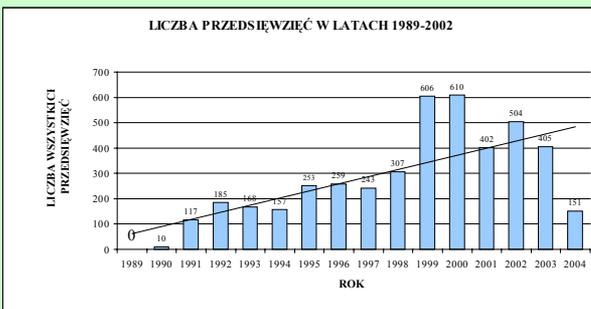
Categories

- Portfolio changes
- Business planning
- Strategic planning
- Personnel restructuring
- Decentralization
- Organizational integration
- Management changes
- New technologies
- Infrastructure changes
- Privatization
- Private-public partnership
- New/alternative forms of care
- Outsourcing
- Information systems
- RUM/START databases
- Accreditation, ISO9000
- Patient satisfaction
- Personnel satisfaction
- Hospital Infections
- Quality
- Promotion and prevention
- Personnel training
- Cost
- New source of income
- Marketing
- Public relations
- Ownership change

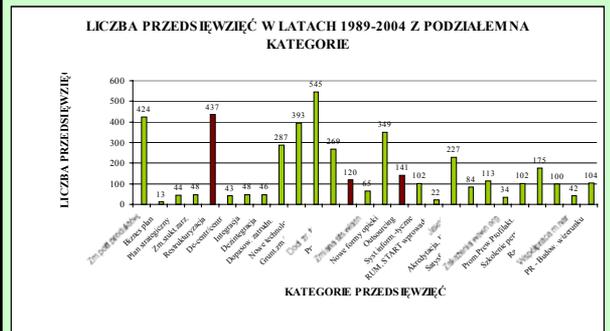
Possible "cross-sections"

- What projects have been of special interest at different **levels** of health care system?
- Are there any difference between **public** and **private** health services innovative behavior?
- Does the **size** of a health-care organization influence the undertaken projects?
- Is the **location** of organization a factor?
- What is the **time-correlation** of those in between 1989-2004? What are the reasons?

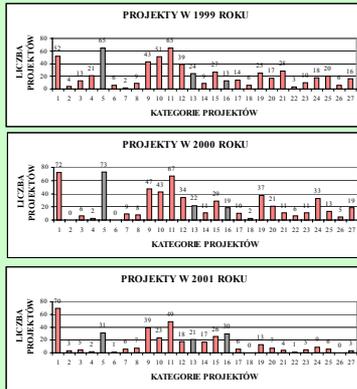
Total number of analyzed projects 1989-2002



Total number of analyzed projects 1989-2004 per category

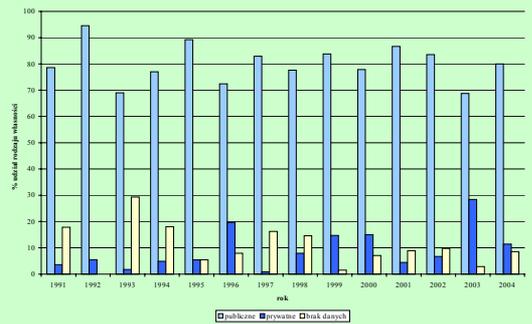


Number of projects throughout the years



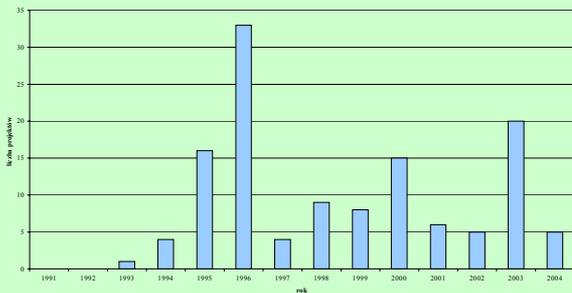
13/19

Project activity in public and private sectors



14/19

Number of projects in one category - quality, over the years



15/19

Achievements

- A **database** of the 1700 of projects created
- The **evidence** of 15 years of health system evolution reviewed
- A **methodology** proposed to monitor the organizational change
- **Functional** approach, not country-specific

16/19

Results

Majority of projects have fallen into the following categories of pro-market changes of the HSO, observed due to a post-socialistic transformations in the health sector in Poland as:

- + New technology acquisition,
- + Personnel cutbacks and re-training,
- + Patients satisfaction monitoring and improvement

Of **least interest** have been:

- Strategic planning and
- Introducing the new forms of care

17/19

Results

The number of projects of a given category per year throughout the analyzed period **correlate** with the identified changes in the organizational environment.

The level of HSO as well as its geographical localization influences the time, kind and scale of the projects.

18/19

Thank you

COMMUNICATION SESSION F

CONTINUOUS EDUCATION IN PUBLIC HEALTH AS A CHALLENGE FOR INTERNATIONAL COLLABORATION

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Nofer Institute, School of Public Health

Purpose

The purpose of this work is to present the continuous education as a challenge for collaboration partners of different nationalities within Europe.

Introduction

EUROPEAN Union enlargement is a great challenge for all European countries in respect to public health issues, common health policy, and improvement of health systems management, mainly through the development of training resources and capacities for various nations under different cultural and economic circumstances

Methods and materials

EUROPHAMILI (EUROpean Public Health And Management training pILot Initiative), the programme developed thanks to support of Leonardo da Vinci is the modern training course in the field of management in public health. That covers different public health management issues from a totally European perspective. The 3 month course which hasn't been funded by European Commission since 2004 takes place once a year and is hosted by a different country each time (France, Great Britain, Poland, France). The contents and training methods are updating every year. Teachers participating in all teaching units are flexible in designing innovative and high quality training programmes that best respond to constantly changing situation in Europe. Free movement of professionals and services in Europe possess great challenge for management in health care. Presentation of the general challenges, obstacles and perspectives in public health management within Europe must be the essential core in creating training policy all over the Europe. Cross-border cooperation between countries having different health care systems indicates that nationality and place of residence are not the most important factors to get the needed professional medical help.

Results

Designing, constructing and implementation of new, innovative program for people who are interested in widening their professional knowledge and skills or wanting to get new ones was the great challenge for the group of participating teachers. Analyse the conditions in one hand of success and in another hand of failure health care systems was the contribution to implement different view on public health management. finished program which every year may be update is the result of our collaboration

Discussion and conclusion

Time is money and people are looking for new innovative and practical ways of training. Now days continuous education is important in career progression. Taking into consideration demands for training in public health management all over Europe, according to constantly changing systems it is important to remember that people from different countries must collaborate in preparation and delivery new educational programs.

Knowledge about that is essential in continuous development of EUROPHAMILI and permanent enlargement the group of participants. Keywords: continuous education, public health management, international collaboration

Dorota SZOSLAND

Nofer Institute, School of Public Health **Lodz - POLAND**

Continuous education in public health as a challenge for international collaboration

XXVII ASPHER
Yerevan, September

**XXVII Annual ASPHER
Conference Yerevan 17-20 September 2007**

XXVII ASPHER
Yerevan, September

Presentation the continuous education as a challenge for collaboration partners of different nationalities within EUROPE to improve the management of health

XXVII ASPHER
Yerevan, September

International collaboration in public health

Getting to know about health threats in various countries

- ▶ Learning the way of fight against health threats in various countries

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International collaboration in public health

New needs of different population groups

- ▶ New threats in health care financing: increasing of health care costs, the selection and implementation of new technologies, the caring of the health professionals, the satisfaction of citizens needs through adequate services design

International collaboration in public health

Bringing closer together professionals in public health

- ▶ Developing the common program in the field of public health taking into consideration the issues specific for individual country

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International collaboration in public health

Organisation of health services to satisfy professionals and patients mobility

- ▶ Improvement of health systems management

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European management training course

- Covers different public health management issues from a totally European perspective
- Contents and training methods updating every year
- Teachers flexible in designing innovative and high quality training program best responding to changing situation in Europe

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European management training course

Designed for:

Health service professionals interested in management

Post-graduate university students with a degree relating to work in the field of health care

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European management training course

The fundamental concepts:

Transnationality: trainees, trainers and final jury from different countries

- **Interculturality:** transnationality of trainees and trainers; training session taking place in a different country each time

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European management training course

The fundamental concepts:

• **Interprofessionality:** training open to professionals of the health care from various countries

• **Alternation:** three structural concepts: teaching units, professional studies, intercultural module

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Essential core in creating training policy all over the Europe

- Free movement of professionals
- Free movement of services
- Free movement of patients

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Essential core in creating training policy all over the Europe

- Health care systems
- Gross Domestic Product in various countries
- % GDP devoted to health care
- Health inequities
- Trans-national partnership
- Cross-border cooperation

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International collaboration in public health training

Development of training resources and capacities for various nations under different cultural and economic circumstances

- ▶ Equipment trainees in health related subjects to understand and face the increasing challenge of the new European health sector

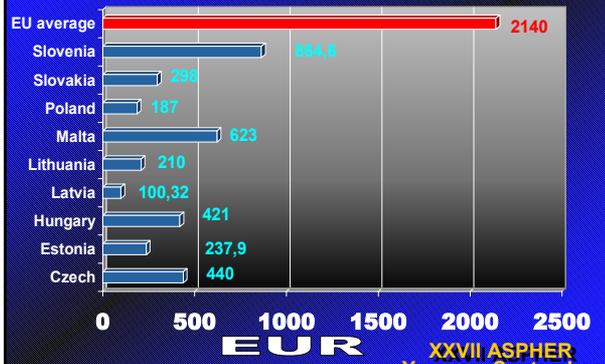
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Healthcare Expenditure as a Percentage of GDP 2004 Eurostat



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Healthcare Expenditure 2004 Eurostat



XXVII ASPHER, Yerevan, September

International collaboration in public health training

Bringing together participants and trainers from across the Europe

- ▶ Improving the quality and access to professional continuing education by using innovative ways of teaching

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CONCLUSION:

- Continuous education is important in health care management and in career progression all over the Europe
- There is a great need for innovative and accessible training tools that will established a bridge between initial training and follow up training within enlarged European Union

XXVII ASPHER, Yerevan, September

CONCLUSION :

- International training integrating the European dimension, experience and knowledge in the practice of health care management is innovative on the market of an education
- People from different countries have to collaborate in the preparation and delivery new educational programs to acquire or develop skills and abilities on a life long learning basis



INTERNATIONAL COLLABORATIVE PARTNERSHIP IN HEALTH MANAGEMENT EDUCATION

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Purpose

To demonstrate benefits of multilateral and multicultural collaboration in health management education

To illustrate efficient synthesis and synergy of different perspectives, views and approaches working together in needs assessment, course preparation and delivery

Introduction

In 2005, the American International Health Alliance (AIHA) has requested different academic institutions in the USA, Armenia, Kazakhstan and Georgia (all of them involved in the health management partnership programs in the past) to prepare and deliver series of health management courses to promote capacity building of the national healthcare leaders and administrators in two of the FSU countries (Ukraine, Turkmenistan).

A substantial collaboration efforts have been made by all parties involved to overcome various complexities of collaboration to achieve shared goals and values.

The results of still ongoing cooperation of four educational institutions are reviewed.

Methods and materials

Based on results of participants needs assessment and the nature of their corporative goals and tasks performed, two separate health management education programs for each of countries have been collaboratively prepared by the international faculty team for participants in Kiev, Ukraine (around 60 HIV/AIDS clinic administrators and providers) and in Ashghabat, Turkmenistan (local academic faculty and outpatient and in-patient healthcare providers).

Results

Two series of one-week teaching modules for both locations, encompassing various aspects and views on the role and functions of health care leaders, basics of health economics and finance, communication skills and strategic management have been delivered over the period of February-May, 2005.

Complexities found in different stages of collaboration (course priorities assessment, format of delivery, etc.) were successfully solved just by working together as a team to achieve synergy both in the conceptual vision and in teaching practice.

Specific benefits of multicultural collaboration in health management education, addressed to quite specific groups of participants are viewed in the context of transferring novel approaches and managerial capacity skills and evidence coming from the best practices of various countries. Participants evaluation reports were analyzed and found completely positive for both locations.

Discussion and conclusion

One of the main lessons of the international partnership in preparing and conducting the healthcare management course was a recognition that the collaboration was not only an opportunity of mastering of interpersonal and process skills over a series of classes and other tutorial events, but

also it was a completely "new product", or an outcome, which is a synthesis or a synergy of different perspectives, views and approaches to enhance ultimately the efficiency of the courses provided.

Keywords: partnership, healthcare training, capacity development

International Collaborative Partnership in Health Management Education

Mihran Nazaretyan, Bernardo Ramirez, Maksut
Kulzhanov and Otar Gerznavia

SHCMA/AUA, Yerevan, Armenia

UCF, Orlando, FL, USA

KSPH, AlmaAty, Kazakhstan

DPH, Tbilisi SMU, Georgia

Main goals of collaborative partnership

- Promote capacity building of national healthcare leaders, hospital/clinic administrators and local faculty in countries of social and economic transition by...
- delivering series of modular courses in health management and administration for healthcare leaders

Geography of HME classes delivered by our partnership

- Russia
- Georgia
- Armenia
- Kazakhstan
- Ukraine
- Turkmenistan
- Bosnia and Herzegovina



Target population

Educators

- Local faculty and trainers

Practitioners

- Hospital and clinic directors/administrators
- Head nurses from health care facilities
- MoH and municipality health services administration staff
- Public health specialists

Others interested or authorized



Main challenges to overcome

- Overcoming assertiveness and other natural complexities of collaboration
- Efforts to achieve shared goals and values between different partners, coming from various countries
- Customers' needs assessment
- Joint curriculum preparation
- Leveling synergy in the course delivery process
- Closing evaluation and feedback loop

Opportunities

- Cooperation and team-work in the past with US and European-based universities and programs through the USAID/AIHA/OSI-sponsored partnerships in Armenia, Kazakhstan and Georgia
- Participation in ToT seminars and workshops
- Experience in "on-line" virtual conferences and discussions
- Common understanding that the collaborative partnership is not just teamwork, but professional development...

“Branding” the collaborative partnership...

- What makes us and our services different?
- Qualities and characteristics of our partnership
- Distinctions when working as “collaborative partners” vs. “single-provider” model
- What is the “feature-benefit” model of services offered by the collaborative partnership?
- Improving the visibility of the partnership

What makes us different?

- Thoughtful synthesis of different perspectives on health management education, and then...
- We don't confined to a specific “job description”, we are not “an employee”!
- And we do not belong to any company for life!
- We constantly ask ourselves and answer questions such as: “what do we do that adds remarkable, measurable, distinguished, distinctive value?”...

Qualities and characteristics of collaborative partnership

- As a professional group, we bring novel trends, approaches and managerial skills in health management science to develop professional identity for all recipients of the HME course
- We focus on an adult educational model, assuming participatory behavior, reports and project preparation and presentation, role-play, discussions, etc.
- We provide a case-study based learning
- We appreciate inclusiveness, that is multicultural and social diversity considerations

Distinctions of “collaborative partners” vs. “single-provider” model

- Pluralistic and comprehensive approach when presenting to students various topics of public health and health management
- Professional synergy and cultural diversity in preparation and presentation of teaching modules
- Enrichment of various topics in HME: different styles and perspectives, different schools and academic traditions, different views...



- Participatory (“jam session”) character of lecturing/teaching process

“Feature-benefit” model

- Selection of the best evidence of contribution capacities offered by collaborative partners to meet strategic needs of customers/students
- Reliable, identifiable and distinguishable teaching program to satisfy client expectations
- Creating a feeling of individualized attention for every single learner, along with presenting a large choice of team improvement opportunities

What's in “the net” after all?

- Collaborative partnership *per se* is not only an opportunity for mastering interpersonal and process skills, but also...
- It is an outcome, that is a synthetic balance of different perspectives, views and approaches to enhance efficiency
- The values created over the partnership belong not to a single partner, but to the partnership and they must be kept visible
- In cases when it becomes overwhelmingly intense, unbalanced and tiring – “divorce” is without too much pain...

INTEGRATION AMONG HEALTH PROFESSIONALS IN SICILY

Pina Frazzica, arnone@cefpas.it

- 1) Arnone Roberta, Di Mattia Lino
- 2) Blangiardi Franco, Tebaide Angela

- 1) CEFPAS
- 2) LHO Ragusa

Purpose

To diminish fragmentation and increase collaboration among stakeholders in health care delivery, especially among GPs and hospital Specialists, in order to reduce inappropriate prescriptions of hospitalizations, laboratory and x-ray services by GPs and improve health services quality mainly by optimizing resources and reducing wastes and waiting lists.

Introduction

The project was developed in response to the preoccupations expressed by WHO of the heavy fragmentation in service delivery with consequent non co-ordinated, ineffective and inefficient results and poor quality of care to the population. The project, under the program TUFH (Toward Unity for Health), means to answer to the challenge put forth by WHO to search for feasible and sustainable solutions to the problem of fragmentation. CEFPAS project was one of the 12 selected worldwide and was particularly valued for its innovation.

Methods and materials

The methodology included monthly meetings among all stakeholders involved: GPs working in 3 Health Districts; clinical specialists coming from 18 Hospital Departments, Managers of 2 Laboratories and 3 Radiological Services at community level.

During the meetings, critical issues were selected and thoroughly addressed in order to reach a common understanding. To do this, different methods have been used:

- 1) Sharing of experiences, with all points of view being considered;
- 2) Round table discussions;
- 3) Data collection through questionnaires and joint analysis of results;
- 4) Data collection from existing records and shared analysis of results;
- 5) Writing protocols of collaboration using "Continuous Quality Improvement" and "Evidence Based Medicine" approaches.

Results

1. The main result is the creation of a common platform among stakeholders that usually don't share their different perspectives and experiences on common issues and often have poor communication and poor interrelations among them. This is detrimental to the health system and, more generally, to the quality of care to the population.
2. Eleven health indicators were jointly selected. The initial data provided the baseline and data will be collected periodically to monitor expected improvements.
3. The first data collection on prescriptions by GPs shows:
 - a. hospitalizations requested by GPs: only 3%, which need to be increased as GPs should filter hospitalization demands;
 - b. appropriate hospitalizations: 96%, which is highly appropriate
 - c. CAT scans for suspected neoplasia carried out within 7 days was 72%: this needs to be increased.
 - d. protein electrophoresis was 18%, which needs to be reduced.

4. Creation of a questionnaire for GPs and Hospital Doctors aiming at exploring the use of EBM and at identifying major difficulties experienced in the working relationship.
5. Results of questionnaires were presented and discussed together. This brought about more understanding and better co-operation among all stakeholders.
6. Common protocols on critical conditions were finalised and put into place.
7. A system has been activated for direct communication between GPs and Hospital Doctors in order to assure continuity of patients care.

Discussion and conclusion

The project has achieved its main goal. The groups of stakeholders have worked well in an atmosphere of fruitful collaboration. The results obtained have contributed to improving patients care, reducing unnecessary laboratory and radiology investigations, shortening waiting lists for specific services. Mainly, it has created the basis for a new culture that aims at reducing fragmentation in health care delivery and improving collaboration for more cost-effective services and higher quality care. The ultimate benefits involve the health system and the population. Due to the enthusiasm which the project generated, additional stakeholders have now committed themselves to the continuation of the project for a more effective way of working together towards a more concrete unity for health.

Keywords: Integration, Protocol of collaboration, Common platform



Centre for Training and
Research in Public Health



- A Sicilian Regional Government Institution
- An organisation similar to Local Health Organisations
- It started its activities in 1996

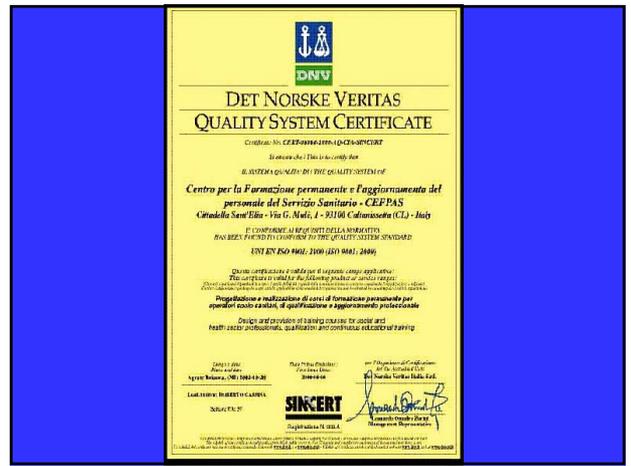
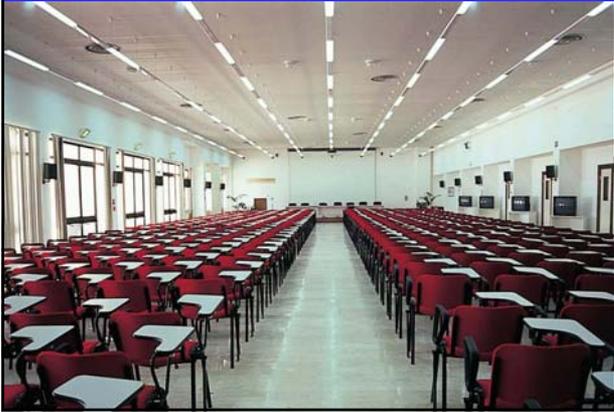


- 16 buildings for 26.000 sqm of covered surface:
- 11 buildings for training
 - 1 gymnasium for sports & rehabilitation



- 1 hotel with rooms, conference space
- 3 dormitories with 210 rooms

The Auditorium



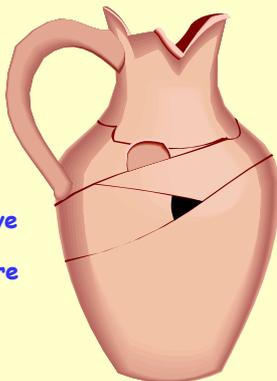
Integration among Health Professionals



Authors: Frazzica P, Di Mattia P, Blangiardi F, Tebaide A, Arnone R.



The project was developed in response to the preoccupations by WHO of the heavy fragmentation in service delivery with consequent non coordinated, ineffective and inefficient results and poor quality of care to the population.



CEFPAS' project was one of 12 selected worldwide and was particularly valued for its innovation.



Purpose

Reduction of waiting lists for health services offered by Emergency, Laboratory and Radiology Departments through the integration among GPs and hospital specialists of the above mentioned departments (18).



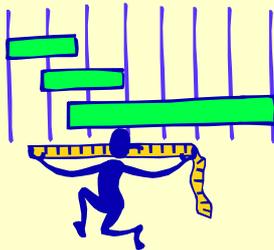
Project team

- 1 GP for each Health District
- the Head of Primary Care Service
- 1 representative of Outpatients Clinic
- 1 Head of Laboratory Department
- 2 Heads of Emergency Department
- 1 Head of Radiology Department
- 1 Medical Director
- 1 representative of CEFPAS



Methodologies

- Definition of a set of health indicators to assess the appropriateness of GPs prescriptions, the waiting times and the departmental organisation through round tables discussions;
- Data collection through questionnaires and joint analysis of results;



- Data collection from existing records and joint analysis of results;
- Workshops in each Health District to develop collaborative protocols ;
- Implementation of collaborative protocols and training;
- New data collection to measure the outcomes.



Local Health Organisation n. 7 Ragusa

Health Districts:

- Modica
- Vittoria
- Ragusa



Health District of Modica

Involved:

- 86 GPs
- 1 Radiologist and
- 1 Laboratory physician of the Outpatient Clinic
- 2 Laboratory & Radiology Departments,
- 2 Emergency Wards



Health District of Vittoria

Involved:

- 77 GPs
- 1 Radiologist of the Outpatient Clinic
- 2 Laboratory and Radiology Departments, 2 Emergency Wards



Health District of Ragusa

Involved:

- 77 GPs
- 2 Radiologist and 2 Laboratory physicians of the Outpatient Clinic
- 2 Laboratory and Radiology Departments, 2 Emergency Wards



Results

- Creation of a common platform among the stakeholders to share experiences;
- Development of a questionnaire for GPs and Hospital Doctors to explore the use of EBM;
- Finalization of common protocols on critical conditions;



- Creation of a system for direct communication in order to assure continuity of patients' care;
- Selection of 11 Health Indicators.



- The initial data provided the baseline and data will be collected periodically to monitor expected improvements.
- Initial data collection 2-14 December 2002



Indicator for the Medical Direction

- Hospitalisations (urgent and non urgent) consequent to GP's prescriptions/GP's prescriptions;
- Mean percentage: 90 %
- Comment: almost all requests were for urgent hospitalisations. Non urgent hospitalisations are consequent to a direct contact between patient and hospital.



Indicator for the Medical Directorate

- Hospitalisations (urgent and non urgent) consequent to GP's prescriptions /Total admissions
- Mean percentage: 3%
- Comment: the admissions consequent to GP's prescriptions are too few.



Indicator for the Emergency Wards

- Hospitalisations consequent to GPs prescriptions with confirmed diagnosis
- Mean percentage: 96%
- Comment: high appropriateness.



Indicator for the Radiology Departments

- Chest x-ray reports confirming the diagnosis in the GPs requests
- Mean percentage: 56%
- Comment: just sufficient appropriateness.



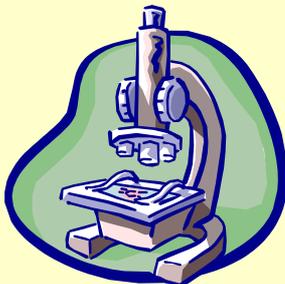
Indicator for the Radiology Departments

- CAT carried out within 7 days from the GPs request for suspected tumour
- Mean percentage: 72%
- Comment: the organisational and functional process is acceptable but needs to be improved.



Indicator for the Laboratory Departments

- Prescriptions of cholesterol and triglycerides (in the same request)/ total number of requests
- Mean percentage: 31%
- Comment: acceptable.



Indicator for the Laboratory Departments

- Prescriptions of protein electrophoresis/ total number of requests
- Mean percentage: 18%
- Comment: inappropriate prescription. Liver disease.



Indicator for the Laboratory Departments

- *Pathologic protein electrophoresis*
- Mean percentage: 36%
- Comment: inappropriate prescription.



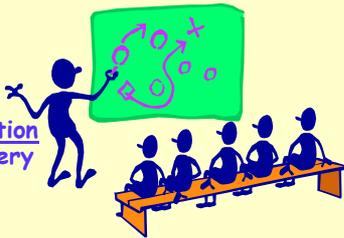
Conclusions

The results obtained have contributed to improve patients' care, reducing unnecessary laboratory and radiology investigations, shortening waiting lists for specific services.

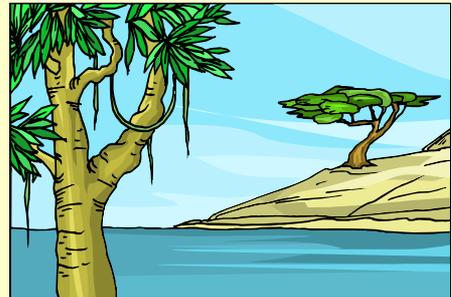


Mainly, it has created the basis for a new culture that aims at:

- reducing fragmentation in health care delivery
- and improving collaboration for
- more cost-effective services and higher quality care.



The ultimate benefits involve the health system and the population.



Due to the enthusiasm which the project generated, additional stakeholders have now committed themselves to the continuation of the project for a more effective way of working together towards a more concrete **UNITY FOR HEALTH.**



Thank you !

BUILDING PUBLIC HEALTH ASSOCIATIONS IN THE TRANSITION COUNTRIES OF SOUTH EASTERN EUROPE: THE EXAMPLE OF ALBANIA

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Purpose

The Albanian Forum of Public Health (AFPH), an umbrella organization including different public health associations operating in Albania, was established in March 2004 with support of the European Public Health Association (EUPHA) and the Open Society Institute (OSI).

Introduction

Ever since its establishment, the AFPH has been an open arena wherein opinions and options for rational health policies comprising all relevant issues of the new public health are discussed, formulated and documented near the Albanian Ministry of Health.

Methods and material

Results

Notwithstanding the laudable mission of the AFPH, there is an emerging need to establish a regional Public Health Association in South East Europe as a basic prerequisite for sustainable development of public health in these countries. Most conveniently, this regional umbrella organization should have a supporting Secretariat based in one of the South East European countries. Nevertheless, there is a clear call for international funding with participation of different agencies and bodies (OSI, CIDA, EUPHA, and the Stability Pact).

Discussion and conclusion

A regional association in South East Europe would enable the organization of annual conferences in the most renowned institutions in the region. Also, a regional collaboration among public health associations would be a suitable start for development of research in South Eastern Europe. Furthermore, the existence of a regional public health association would make feasible the establishment of a scientific public health journal for South East Europe in the English language.

Keywords: Albania, Professionalisation, Public Health Associations

Building Public Health Associations in the Transition Countries of SEE:

The Example of Albania

Enver Roshi, Ulrich Laaser
On behalf of PH-SEE project

Public Health collaboration in South East Europe (PH-SEE)

- Since 2000, a collaborative network (PH-SEE, a project of the Stability Pact) is working on a common set of teaching materials and has developed a common database for public health in the region.
- Also, a minimum indicator set for regional health monitoring has been developed and practiced in postgraduate teaching programs.

EUPHA-OSI Project (1)

- A project on “*Support of public health associations as key links between government, the scientific community and the population in Central and Eastern Europe*” was initiated in 2002 by the OSI and EUPHA with the following aims:
 - To foster a major role for public health associations as venues for the dissemination of evidence-based public health research that is applicable to government policy;
 - To encourage a link between public health associations and the general population;
 - To promote multidisciplinary networking between public health professionals and institutions; and
 - To establish a strong public policy role for public health associations.

EUPHA-OSI Project (2)

- Four countries were selected for the implementation stage in 2003, being ***Albania*** (twinning partner: ***German Association for the Health Sciences and Public Health***), Latvia (twinning partner: Society for Social Medicine, Finland), Lithuania (twinning partner: Faculty of Public Health, Royal College of Physicians, United Kingdom), and Slovakia (twinning partner: the Netherlands Public Health Federation).

EUPHA-OSI Project (3)

- The Albanian Epidemiological Association (AEA), a non-governmental organization operating in health field, implemented the OSI-EUPHA project from May 2003 to May 2004. The twinning partner of the AEA was the German Association for the Health Sciences and Public Health (DVGPH).

The aims of the Project

- To increase awareness of public health professionals from all disciplines about public health challenges of Albania and the need for a common multi-professional association;
- To establish a Public Health Forum in which all stakeholders and associations in public health are participants.
- To increase the awareness of policymakers and the community about public health challenges in Albania.
- To enhance and foster evidence-based policy.

Instruments

- Conferences with appeal to the public, regional workshops to collect information and establish a broad network among public health specialists and the community, and distribution of a monthly newsletter to all public health professionals operating in Albania were the instruments engaged to achieve these aims.

Achievements (1)

- As a result of this project, the awareness of public health professionals in Albania was increased by the distribution of a monthly newsletter.
- Furthermore, the AFPH was officially established in March 2004 as an umbrella organisation for existing associations as well as interested individuals. The Forum is an open arena wherein opinions and options for rational health policies comprising all relevant issues of the new public health will be discussed, formulated and documented near the Albanian Ministry of Health.
- These developments in Albania have been strongly supported by the twinning partner (DVGPH) and the PH-SEE network.

Achievements (2)

- The awareness of policymakers and the community was further increased by the organisation of a first conference on public health in September 2003. Over 60 participants, including public health experts and policymakers, attended the conference. In 2003, three regional workshops were organised to include the different districts of Albania. In 2004, the second national conference was organised in March, attended by 40 public health experts. Also, plans to develop regional collaboration with other national associations

AFPH – Memorandum of Understanding (1)

- The AFPH is a not for-profit and non-governmental organization.
- The AFPH is an umbrella organization. As such, non-governmental organizations, which operate in the health field and other relevant sectors in Albania can become institutional members of this Forum.
- Nevertheless, individuals not adhering to any associations can become individual members of the Forum.

AFPH – Memorandum of Understanding (2)

- Nevertheless, individuals not adhering to any associations can become individual members of the Forum.
- Individual members of the AFPH can be all Albanian citizens, aged at least 18 years regardless of their gender, political attitudes, religion, and region of the country. Professionals who wish to pursue a carrier and/or work in public health, regardless of their bachelor degree, are strongly encouraged to join the Forum.
- Membership is based on a voluntary approach.

AFPH – Memorandum of Understanding (3)

- The activities of the AFPH are regulated and coordinated by an Executive Board, which is responsible for the organization of meetings and conferences with participation of all public health specialists and civil society in Albania.
- Each institutional member of the Forum elects a representative for the Executive Board according to their own statutes. At a first stage, the actual Presidents or Heads of the organizations (which aim to join the AFPH) may be the born members of the Forum.

AFPH – Memorandum of Understanding (4)

- The individual members of the Forum (i.e. those who are not engaged in any other associations) elect two representatives for the Executive Board for a period of 2 years.
- The Executive Board elects a chairperson and a vice-chairperson for a duration of 1 (one) year.
- The chairperson and the vice-chairperson can not be re-elected, unless all institutional members represented in the Executive Board have experienced such a position. Therefore, each institutional member of the Executive Board will head the AFPH in a (yearly) rotation base. The individual members of the Board can be elected as chairperson and vice-chairperson, however, they are not subject to this rotating scheme.

AFPH – Memorandum of Understanding (5)

- All members of the Executive Board (including the chairman and the vice-chairman) have the same voting rights. Decisions are made by simple majority of the members of the Executive Board present in the meeting if they constitute more than 25% of the total membership including the 2 individual board members.
- At the same time, an Advisory Board will be established by decision of the Executive Board for a period of 3 years composed by the most renowned public health specialists in Albania, as well as international experts who have a long career in public health. This Board will advise and provide counselling not only to the AFPH, but also to all non-governmental organizations, which may not want to join the Forum.

AFPH – Memorandum of Understanding (6)

- Individual members of the Forum will pay an annual membership fee of 10 (ten) €.
- Institutional members will pay an annual membership fee of 50 (fifty) €.
- The AFPH is an open arena wherein opinions and options for rational health policies comprising all relevant issues of the New Public Health will be discussed, formulated and documented near the Albanian Ministry of Health. This will be a suitable start to enhancing counselling and advocacy for efficient and equitable policy-making in Albania.

The need to establish a regional Public Health Forum in South East Europe

- Notwithstanding the importance and contribution of local public health associations, the funding limitations pose serious difficulties for the future of such “enterprises”.
- Therefore, there is an emerging need to establish a regional Public Health Forum in South East Europe with a supporting Secretariat based in a “neutral” place (such as e.g. Monte Negro).

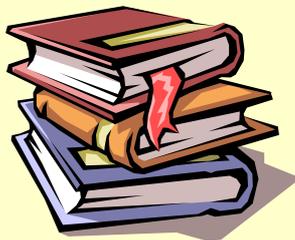
The need to establish a regional Public Health Forum in South East Europe

- This regional (umbrella-type) association would need mid-term (3-5 years) international funding (mixed funds from the Open Society Institute, Canadian International Development Agency, EUPHA, and the Stability Pact).
- A regional association in South East Europe would enable the organization of annual conferences in the most renowned institutions in the region.

The need to establish a regional Public Health Forum in South East Europe

- Also, a regional collaboration among public health associations would be a suitable start for development of research in South Eastern Europe.
- It would facilitate consortia research proposals as requested from different funding agencies.
- Furthermore, the existence of a regional public health association would make feasible the establishment of a scientific public health journal for South East Europe in the English language.

Thank You !



THE IMPORTANCE OF SUSTAINABLE PARTNERSHIPS FOR STUDENTS

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Purpose

The creation of sustainable partnerships in public health may have a lot of benefits. But what are the benefits for students and how can they contribute to sustainable partnerships? Sustainable partnerships between universities have many advantages for the students of these institutions. Especially when universities of different countries manage to create a long-lasting relationship. On the other hand, students may influence universities through a European Student Network.

Introduction

International experience is becoming more important everyday. Studying abroad at another university is one of the best ways to gain international experience. The current development is that students more and more desire to study at a foreign university. Every university should be aware of this growing need and should anticipate on this. The Faculty of Health Sciences (FHS) at the University of Maastricht therefore has a policy which stimulates students to study abroad. Sustainable partnerships is the best way to make sure that students have an opportunity to visit and study at another university in a foreign country. Exchange programmes between universities will benefit the students in many ways. For example, last year FHS launched the “International Classroom”. Every year students from foreign countries can come to Maastricht University to study several courses taught in English. At FHS, they will study among international and Dutch students which is additional benefit. Through established relationships and exchange programmes students find it easier to make contact with students from other universities. Students will benefit a lot of contacts with foreign students. They can learn about for example health care systems or health policies and programmes in other countries. This will enhance their insight of how to deal with public health problems in their home country. On the other hand students will learn how to function within an international context. The likelihood that students will have to work with people from other countries in their future occupation is rising. Thus, an early preparation of students for an international working environment is very important.

Students already discovered the importance of international partnerships, because last year a group of students at the ASPHER conference launched the first European Public Health Student Network. Students felt and still feel the need to have contact with each other and learn from each other. That is the reason why we, as students, came together last year and are present at this year’s conference. One of the ideas of the network is to create a virtual forum which public health students can visit to discuss any topic they like. In addition, students would like to create a database with information on all the relevant public health courses offered at the European universities. Selection of a course at a foreign university becomes much easier.

With this the question remains: How can students contribute to sustainable partnerships? A European Public Health Student Network also benefits universities. Why does it benefit them?

An university is an institution that lives because it has students. The contact that establishes between students through a student network may stimulate a sustainable partnership between universities. Students will take initiative to contact students at other universities. These students may influence the decisions of their home university through for example a student board or association.

Discussion and conclusion

Sustainable partnerships will benefit students in many ways. However, it may be the students themselves who will have an influencing power on the creation of sustainable partnerships between universities all over Europe. The development of ASPHER European Public Health Student network proves that students think it is very important to establish international contact between students and universities.

Keywords: Students, Sustainable Partnerships

The importance of: Sustainable Partnerships for Students

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Sustainable partnerships:

1. What are the benefits for students?
2. How can students contribute?



Benefits of sustainable partnerships

- *Sustainable partnerships enable students to study abroad.*
- *Exchange programs between universities facilitate studying abroad.*
- *For example University of Maastricht offers:*
 - *International Classroom*
 - *Bachelor European Public Health*
 - *Master of Public Health, several specializations*



Importance of studying abroad

- *International experience prepares students for an international working environment.*
- *Studying public health in an international context provides relevant knowledge.*
- *Discussing health topics with foreign students stimulates to broaden views and perspectives about public health.*
- *Own experience: internship in Kenya.*



First European Public Health Student Network

- *Launched last year at the ASPHER Conference in Sicily*
- *International contact through virtual forum*
- *Future plans: for example database about public health courses in the European region*



How can students contribute?

- *European Student Network may stimulate sustainable partnerships between universities.*
- *Initiative of students to contact other universities may influence universities to create sustainable partnerships.*



Conclusions

- *Sustainable partnerships between universities benefit students, because it enables them to study abroad.*
- *Studying abroad and international contact is important to students.*
- *Initiative of students may stimulate the creation of sustainable partnerships between universities.*



Questions?



COMMUNICATION SESSION G

ASPHER: DAMP SQUIB OR THE POWDER'S KEEPER

Jeffrey none Levett, jelevett@otenet.gr
National School of Public Health

Purpose

A personal farewell review of ASPHER based on 20 years of experience with some questions and ideas for the future for improving partnership.

Introduction

ASPHER has grown over the past 1&1/2 decades through activities leading to the European Masters, the Athens and Acropolis Memoranda, PEER review, the inauguration of the IJPHE, the OSI-ASPHER link and the PH- SEE Network. Its birth four decades ago took place in a dark cool cellar in a remote mountain location, with animated discussions touching upon the future of public health in Europe.

Methods and materials

Instructive talk, experience, memory and humour.

Results

To remain effective and proactive ASPHER, public health and its workforce must be continually reinvigorated. This is one message from the GA. The future of public health more than ever resides to a significant extent with ASPHER, which has to improve its enabling role of member Schools to provide the requisite education and training. Its know-what must also be developed. Its prestige can improve if ASPHER can tease out answers to certain questions. What does European society expect from ASPHER? What does ASPHER expect of Europe and the respective countries with respect to public health? How willing is Europe to use science or to employ experts to find answers to social problems? How willing is its population to support the principle of solidarity in health? How much do we believe that health is an integral part of the socio-economic equation? As a result of a collective know-how, European society remains alert to unpleasant surprise and ASPHER is a repository of this know-how. However, ASPHER has a long way to go in order to better underscore prevention, the principle of first do no harm and the protection of the population from health threats. It must help to provide the mindset and capacity to detect, understand and mitigate the recovery from damage to the health status of the population. Even if public health has impressive components of accumulated wisdom, protective legislation, and administrative acumen it still has a long way to make its mark. To do so, it must use all the available acumen, expertise and talent. This paper will attempt to elucidate some of these points. In the words of my title, ASPHER must become the "Keeper of the powder" of public health.

Discussion and conclusion

The metaphor derives from Charles Gillispie [Science and Polity in France], who examines the transition from bureaucracy to technocracy and from medieval superstition to scientific logic. Lavoisier, the father of chemistry became the Guardian of France's gunpowder [Regie des poudres]. By analogy ASPHER must become both a catalyst and the guardian of public health and its related education. Keywords: sustainability, solidarity, partnership



XXVII ASPHER GENERAL ASSEMBLY

17-20 September 2005
Yerevan Armenia



ASPHER

ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH IN THE EUROPEAN REGION

GOOD NEWS and MIXED NEWS

I have some good news and some mixed news:

GOOD: In Armenia experts predict that vine-growing farmers will gather 40,000 more tons this year, than in 2004;

Mixed: Although "I have miles to go and promises to keep before I sleep", this will be my last ASPHER meeting, in the certain knowledge that I can not step twice into the same river.

ASPHER: Damp Squib or the Powder's Keeper?



Jeffrey Levett

National School of Public Health, Athens
Former President, ASPHER

A small contribution to the program of the General Assembly (Yerevan) and a personal farewell address to ASPHER

Full text available upon request

Firecracker versus Catalyst?

- Metaphor comes from *Science and Polity in France*.
- Charles Gillispie examines transition from bureaucracy to technocracy; from medieval superstition to scientific logic.
- Lavoisier, became Regie des (gun)poudres,
- ASPHER must become better catalyst and more proactive Manager as it continues its impressive course.
- As it approaches its 40th year to heaven it must consolidate its unique history, advocate for population health and move to the front rank of globalisation.

To Wonder, To Ponder

- Given wealth of talent in our Schools, why not a more dynamic ASPHER. Does it relate to
- Sheer geographic size of the ER? Distance between Schools? Variety of size and substance? Culture or language? Polarization or centralisation w/i ASPHER? Does it reside w/i PH itself or the lack of a theory to make it respectable? Is it a result of hostile forces from industry, private enterprise and the political arena?
- Is it simply political and will not gain stature until we tease out the political determinants of health.

PH is about People & Politics

- ASPHER must become more than the amalgamation of its Schools & each School must develop a more European (regional) perspective becoming more integrated with the Association's activities.
- ASPHER must become more developmental and autonomous.
- It requires passion, commitment and an occasional flavor of greatness as here in Yerevan.

In the Presence & Spirit of Greatness



*DA Henderson in Person
George Soros in Spirit*



The only comparison I am willing to make, is that they are arithmetically alike. The number of lives saved by DA Henderson, must have a similar magnitude to the monies spent on meaningful causes by George Soros.

Smallpox eradication
Theory of reflexivity in financial and political systems

Public Health in the Political Arena

- DA Henderson provides us with one insight into what public health endures in the political arena.
- It came during the 1981 Senate Labor Committee hearings.
- As a famous heart surgeon Denton Cooley arrived to testify 'it was a sight to behold' with Senators rising and lining up to touch the great doctor's coat, while ASPHER's guest of distinction DA Henderson, a man whose work has saved millions of lives through his smallpox eradication work, quietly sat going over his testimony notes.
- We are truly in the presence of greatness.

George Soros & Cybernetics

He is scheduled to address the ACS on his theory of reflexivity in financial and political systems, which is quite cybernetic.

His "doctrine" of preventive action in a constructive fashion applied to open systems, is more likely to lead to change and improvement than in closed ones. It is equally applicable to the health sector in the Balkans.

Norbert Wiener "Mr. Cybernetics"

He wanted science deployed for poverty reduction and the improvement of human well-being.

He would be appalled at the growing internal health disparities and widening differences in Eastern countries and with Europe as well as growing polarization as a result of globalization.

"Know-how and efficiency are good but know-what, effectiveness and equity are better".

True for the health systems and for the health of the public

Yerevan, Armenia: Awful presence of traumatic history and of suffering.

Armenia has lived through the turmoil of the failing Ottoman Empire & the beginnings of the Soviet era.

Its peoples have suffered from genocide, earthquakes & war.



Commonplace Inequality & Polarization

- Lynching, rule of Jim Crow, beating of Armenians by Russian Cossacks, torture, vagrants in London and American towns were forcibly hounded out of town; stature differences [rich v poor teenagers] were upto 15 cm.
- Hundreds of thousands of IDPs [Balkans]; Disparities: developed/developing, center/periphery, private/public, good governance/mismanagement; wealth distribution: 70/30% [1970] / 90/10% [2000].
- International polarization in health and welfare is poignantly reflected in the paraphrased words of George Orwell, that a westerner's arm is thicker than a third world leg.

Newer things in Public Health

- Analysis of war and how its effects on civilian populations are climbing the risk factor ladder with introduction of peace studies into the public health arena (Zagreb).
- PH Watch (2004) and the "Alternative World Health Report" first bottom up approach to global health, new constituency and vision. Report puts political accountability first, challenges global health governance and sets itself up as a watchdog of conduct of international organizations.
- "To make poverty history" [Ilona Kickbusch] we need to tackle health as in the 19th century golden age of public health. Balkans is no stranger to catastrophe and accountability & healing the crisis are difficult [Martin McKee]. PH-SEE Network is doing a good job.

Future of Public Health

- More than ever resides with ASPHER
- To further its cause all acumen, expertise and talent must be used. "People are coming .. working and going away" [Jacek Sitko] and I add leaving no trail in the dust, no print of their passage.
- Much goes on back stage, but a greater catalytic effort is necessary to get the growls and the grunts, the hurrahs and the hoorays to the surface.
- The Newsletter and the IJPHE require help from ASPHER's members.
- The General Assembly is a milestone to progress and provide a sound basis for international corporation.
- Yerevan makes an important contribution to that goal.

ASPHER's Ongoing Work

- Thanks and congratulations for Accreditation Procedure Document (APD) and Vademecum for the EMPH.
- ASPHER has been good and prompt, and rightly so, in expressing sympathy following such horrible and outrageous events as 11th of September, Madrid and London.
- More timid in taking a stand on Kosovo and Iraq.
- Excellent decisions in awarding the Stampar medal. He was the "world's greatest administrator" [Winslow]; "a crusador for unanimity" [Time] magazine he was.
- Medal reads "Public Health investment harvests rich rewards". Inspirational and wise for PH has made the world better.

Advocacy of Public Health

- Important role in the formulation of a European mindset for public health education and the European Union's enlargement process [see recent special theme issue of the BMJ].
- Health and human rights interwoven to provide a new compass for public health [Jonathan Mann].
- Declaration of Skopje on Peace, Public Health and Human Rights (2001), expresses the social conscience of public health emerging from the Balkans; recently adopted and internationalized by WFAPH.
- To promote our value system, remind Society of its considerable debt to public health and its responsibility to reinvigorate it

Questions that Tease & for ASPHER to Tease Out

- "How can we train students to function properly all over Europe?" [Anders Foldspang, D&D meeting Athens, 2003]
- What do we expect of Europe and our respective countries with respect to public health?
- How do we relate to Lisbonne and the challenges of Bologna? What does Europe (Commission, Union) and our countries (citizens) expect from us?
- How willing is Europe to use science and to employ experts to find answers to social problems?
- How willing are our populations to support the principle of solidarity in health?
- How much do we believe that health is an integral part of the socio-economic equation?



Disaster-The Deucalion Flood from Greek Mythology

Catastrophic Appearance of new Misfortunes

- Climate change is most serious problem we face [Sir David King, Nature 2004]
- Worse case scenario abrupt climate change predicts floods and famine [Swhartz and Randell [Pentagon 2004].
- Close to Mount Ararat and the Ark should make us pause.
- Environmental matters and the environment are inherently public health issues.
- Patrick Vaughan stressed these issues in ASPHER.



Disaster-The Deucalion Flood from Greek Mythology

Public Health Involvement with Environmental Matters

- Concern more for the hole overhead than any on earth
- More important when the richest country is dismantling federal health, safety and environmental laws.
- Some satirist provides consolation when he thanks god for the billions of lungs in which pollution can be adequately housed.
- In addition to Patrick's suggestions we should improve planning for disasters and urge ASPHER to examine the significant educational needs of disaster management and public health. Creeping global climate change is a greater threat than terrorism.

Patrick Vaughan current Editor of the Bulletin of the World Health Organization

Global Response to Misfortune

- For world to survive, global response to misfortune and misery has to be equal in energy but much more sustained than the recent deep ocean event that jolted the axis of our one and only earth.
- ASPHER's response should be appropriate, sure and sustained as it continues to develop into a European wide organization with clout.



Opportunity from Disasters & could be Disasters

- In the wake of Katrina we have witnessed a third world response in a first world country.
- Many of those who stayed on in New Orleans, did so because they lacked resources to evacuate.
- Tulane closed for the first semester, students have been accepted as guests at other universities[solidarity] and will emerge from disaster as a smaller and more focused unit [Walter Burnett].
- Positive knock-on effects of Athens Olympics for China should be exploited and there should be renewed commitment to UN and MDGs somewhat reshaped for Balkans.



Public Health Non Sotto Voca

- Public health may have insufficient expertise and resources to solve broad problems of social injustice but its small voice should be raised even louder.
- It can be done without diverting public health from what it can and should do, namely, to advance practical techniques for disease and injury prevention, enforce standards of scholarship, and educate policy makers..



aspher Aspher ASPHER ASPHER ASPHER





ASPHER's Voice of Health within an Enlarging Europe



- Within an enlarged and safer Europe the language and voice of health may very well be the only key to a better future for its citizens.
- ASPHER's voice must be in harmony and unison.
- Where cultures, religions and national languages come together, health is a common denominator, a universal mother tongue or subliminal lingua franca.
- In presence of greatness and history I say farewell grateful for my 20 ASPHER years 15 representing Athens SPH.
- I wish you all success and Godspeed.

FICTION 23 (MYTHISTORIMA)

A little further

*we will see the almond trees in
blossom
the marble gleaming in the sun
the sea breaking in waves
a little further,
let us rise a little higher.*

Un peu plus haut

*Pour voir fleurir les
amandiers*

Le marbre briller au soleil

*Les vagues onduler sur la
mer*

Un peu plus haut

*Allons encore un peu plus
haut.*

Nur ein Weniges noch

*Und wir werden die Mandeln blühen
sehen*

Den Marmor in die Sonne leuchten

Und das Meer sich wiegen

Nur ein Weniges noch

Nur ein Weniges laßt uns höher hinauf.

Ancora poco

e vedremo i mandorli fiorire

i marmi risplendere al sole

e il mare e le sue onde

Ancora poco

solleviamoci ancora un pò sù



Un poco más

veremos florecer a los

Almendros

los mármoles brillar al sol

el mar rompiendo en olas

un poco más

levantémonos un poco más alto.

ΜΥΘΙΣΤΟΡΗΜΑ ΚΓ'

Greek Coffee at Jeff's House on Lycavitos

Διεύθυνση: jeffvett@otenet.gr

θα ιδούμε τις αμυγδαλιές ν' ανθίζουν

τα μάρμαρα να λάμπουν στον ήλιο

τη θάλασσα να κυματίζει

λίγο ακόμα,

να σηκωθούμε λίγο ψηλότερα.

Γ. Σεφέρης (1900-1971) Νόμπελ Λογοτεχνίας 1963

Thank you and farewell

DEVELOPMENT OF PROFESSIONAL PUBLIC HEALTH EDUCATION IN TAJIKISTAN

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Purpose

Discussion of the situation with establishment of Public Health School in Tajikistan, general situation, achievements and future goals

Introduction

In many countries of the world methodology of protection and strengthening of population health is changing in response to growing costs of medico - preventive services, changes in medico - demographic profile of health and reforms in public health policy.

Indicated changes involved revision of the existing concepts of public health and transformation to new understanding of medical aid service, strengthening of health and influence on population life style.

Transition to the concept of new public health required preparation and retraining of administrative personnel and specialists at all levels of public health, including practical, which was a main reason for establishment of public health departments at many medical universities of Europe, Asia, Africa and America.

After announcement of independence of Tajikistan economic crisis started as result of social changing, disintegration of trading and economic relationships, inflation and other conversions of transition period. On going processes of reformation of economic relations, the appearance of various forms of property, change in life conditions, etc., unavoidably contributed to an increase of the problems, related with population health.

Therefore, from the moment of the beginning of reforms, the system of public health in Tajikistan gives priority to strengthening primary medico - sanitary aid, with its reorientation to the primary preventive maintenance and strengthening of the health of population with involvement in the process of reformation of public health service.

It is necessary to mention that the country lack personnel for public health services, trained in accordance with new requirements, in particular administrative, financial – economic spheres, especially noted deficit of human resources in sanitary-epidemiological service, organizationally - systematic divisions of Central Republican Hospital, centers of formation of the healthy life style and etc.

For the time being Tajik state medical university (TSMU) reorganized medico - preventive department into faculty of public health.

Results

With financial support of OSI New York and Tajikistan, professors and teachers of profile departments of TSMU and Tajik institute of postgraduate training of medical personnel passed through retraining program in the school of public health of Kaunas Medical University. Professors

also participated in different courses and seminars on public health in Moscow, Kiev, Israel, Italy, Bulgaria.

After retraining program professors and teachers developed strategy of the faculty and curricula (modules) for the masters of public health.

Strategy of public health department in Tajikistan provides multilevel training for specialists in this sphere – bachelor degree, sub-permanent appointment, magistracy, graduate study, doctoral study, the courses of qualification improvement. The basic task of strategy is the professional training of specialists, acknowledged both on the regional, and at the international level, competitive on the labor market of public health, competent, critical, freely managing its profession and oriented in the adjacent spheres, capable of effectively working in the specialty at the world standards and ready to professional constant growth. It is also necessary to focus department on scientifically - research activities in the solution of vital problems of public health, social medicine, management and public health economy, policy, information, etc., based on the theories, which facilitate an increase of qualification of teaching staff.

It is necessary for department to render practical aid to agencies and institutions of both public health and other sectors with highly qualified consultative and managerial help in development of services and programs on retention, protection, strengthening and restoring of public health, that facilitate an improvement in the quality of life of the population of Tajikistan.

Discussion and conclusion

We are glad to introduce newly established Public Health School in Tajikistan and discuss possible plans and recommendations for the future development of PHS in Tajikistan

Keywords: PHP

Development of Public Health School in Tajikistan.

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Dushanbe, Tajikistan
September, 2005

INTRODUCTION

In 2002 the Government of Tajikistan approved the National Concept of Health Reforms, emphasizing priority for strengthening Primary Health Care and promoting the concept of New Public Health.

In 2003 OSI Tajikistan and Public Health Network programs initiated project on building capacities for Public Health in Tajikistan.

Kaunas University of Medicine was selected as the potential training partner and a relevant model in development of the project, due to experience in building undergraduate and postgraduate teaching programs.

Public health needs:

- **Introduction of international standards in individual and public health sector.**
- **Necessary training of existing medical personnel and new specialists.**

Development of medical human resources/capacities is the main strategic goal of public health.

The Mission of SPH - Tajikistan

- Providing a high level of postgraduate training in public health and management of PH, development professional skills and competencies, formulating a value system for health professionals.
- Stimulating health researches which improve qualification of teachers, promote evolution of ideas and concepts on PH and strengthen development of evidence based PH and health care.
- Active participation in health strategy development, policy implementation and evaluation.
- Collaboration with other organizations with the view to education, planning and research in PH or health management in order to respond to needs expressed by society.

Long term Strategy of SPH - Tajikistan

To play the leading role in education of public health specialists in Tajikistan, and to become an internationally acknowledged multidisciplinary training center.

Short Term Objectives of SPH - Tajikistan

- To train highly competent PH specialists, responsible for reformation of Tajikistan health care system, who is able to apply modern knowledge in practice.
- To achieve accessibility of PH studies for high school graduates and health professionals.
- To assure high quality training programs in PH, achieving the standards of Association of SPH in the European Region (ASPHER).

- **SPH model:**

Faculty of PH is a part of Tajik State Medical University

And

Department of public health at Tajik Institute of postgraduate studies for medical specialists.

SPH model in Tajikistan.

- **SPH model:**

- Bachelor degree (4 years)
- MA degree (2 years)
- Postgraduate studies and PHD
- Qualification improvement training.

SPH model in Tajikistan

- **MA program**

I. Main subjects:

- Public Health;
- Public Health policy and strategy;
- Public Health research methods;
- Environmental and occupational health;
- Public Health management and economy;
- Behavioral studies in public health;
- Universal competencies.

II. Elective courses.

III. Research activities.

Total: 80 credits

SPH model in Tajikistan

Model was discussed with Public Health specialists in Tajikistan and was approved by the Ministry of Health of Tajikistan and international experts at the early stages of the project implementation.

SPH model in Tajikistan

- **Education.** SPH focused its activities on education and researching in the following spheres of public health:
 - Environmental and occupational health;
 - Prevention of diseases and propaganda of healthy life style;
 - Management and reforms in public health.

SPH model in Tajikistan

Accreditation

- Tajik State Medical University;
- Ministry of health;
- Ministry of education.

SPH model in Tajikistan

Teaching staff:

(multidisciplinary approach)

- Tajik State Medical University;
- Tajik Institute of postgraduate studies for medical specialists;
- Teachers from other High Schools.

SPH model in Tajikistan

- **Target group** of PH MA training program:
 - Graduates from medical faculties;
 - Doctors working in public health system;
 - Public Health managers;
 - Non medical specialists willing to get specialization in Public Health.

Project steps

Step № 1: Preparation period (July 2003 – December 2003):

- Need Assessment;
- Round Table;
- Partnership agreements;
- Creation of coordination group.

Project steps

Step № 2: Implementation (January 2004 – December 2004):

1. Creation of administrative group;
2. Creation of working group;
3. Training of trainers:
 - local training (English, computer courses);
 - Basic course, SPH Kaunas;
 - Flagman course, Moscow;
 - Summer course, Moscow.

Project steps

Step № 2: Implementation (January 2004 – December 2004):

4. PH library;
5. Studying plan and 4 training modules (public health management and economy, languages and electronic information systems, leadership and communication, public health policy and strategy);
6. Pilot training and evaluation;
 - 4 modules (November/December 2004)
 - Evaluation/Accreditation
7. Basic education infrastructure.

Project steps

Step № 3: Final (January 2005 – December 2005):

1. Developed 4 modules (Public health, health care, Research methods in PH, Environmental and occupational health, Elective courses)
2. New educational program (September 2005 – 50 students were accepted)

Conclusion

1. Coordination structures and project team were created during first year of project activities.
2. There was created basic infrastructure.
3. Developed training programs.
4. Public Health faculty is opened at TSMU and 50 students accepted for the 1st year of education.

QUALITY DEVELOPMENT OF PUBLIC HEALTH TEACHING PROGRAMS IN CROATIA: LESSONS LEARNT

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Purpose

The aim of this paper is to present the process of managing change and lessons learnt during the process of self-evaluation and peer-assessment. It brings together (a) the critical review of the contextual South-Eastern European framework, (b) the experiences in building bridges between academic and professional societies, needs and requests and (c) lessons learned in curriculum development, redefinition of the list of competences and modularisation for the eleven different Master programs.

Introduction

Since the beginnings in 1927, the Andrija Stampar School of Public Health in Zagreb has been recognized as the leading institution in education for health in South-Eastern part of Europe. Last decade, many factors are influencing training for public health professionals: some of them are related to the long tradition and challenges in health policies and healthcare systems reform, the others are linked to the changes in higher education in Europe, based on Bologna Declaration.

In the year 2002, the Andrija Stampar School of Public Health started the three-year joint project with OSI and ASPHER with the main to develop the modern curriculum, based on modular system in line with the ECTS. It was a great opportunity for all faculties to make in-deep review of the existing programs as well as to redesign the content and learning objectives following the present changes in health care and higher education in Europe.

Results

In summary, lessons learnt are as follows:

1. Traditional positive experiences in multiprofessional training, supportive policy and a legal framework, European trends, Bologna Declaration and readiness to change are the enabling factors in process of change. However, all those factors are, at the same time, the weaknesses - Master program "isolationism", orientation (mainly) to specific professional skills, still unclear relationship between specialization and Master programs, lack of clear vision and understanding of modularisation, resistance to change, etc.
2. Specific meanings of terms (terminology), still present in South Eastern part of Europe, is described as an obstacle in development of the list of competences and professional post description. Public Health, Social (or Socialist) Medicine, Community-oriented or Community - based Health, Health Promotion, Health Education, Disease Prevention, Primary Health Care etc are mixed not just as the words but also in deep meaning in everyday practice. Still actual question is - is this the problem of semantics or politics?
3. The process of curriculum development is a challenging process. The main challenge is to re-orient teaching objectives towards learning objectives. The main constraint for academic society is to accept that the program's contents are in great part unsuitable because they do not treat the problems important for everyday practice. On the other hand, the main problem for professional society is to be too much oriented to technical skills in practice - lack of re-thinking public health in European dimension, stressing ethical issues, human rights and professional values based on mixed traditional and new health problems.

4. In-depth peer-evaluation of the present Master programs showed that some additional contents are needed. At the same time, the 20-65% overlap of the topics in different Master programs was recognized. Number of total hours and ECTS varied from program to program, there were no electives in most Master programs. Based on this analysis, the eleven Master programs are redesigned. This paper is describing all those innovative Master programs based on the list of compulsory modules (Common Core Curriculum and Specific Core Curriculum) and the large number of electives («Basket» modules»). At present, the Master programs are offered for participants particularly from South-Eastern Europe.

Keywords: PH Master program, South Eastern Europe

QUALITY DEVELOPMENT OF PUBLIC HEALTH TEACHING PROGRAMS IN CROATIA



27th ASPHER Annual Conference, Yerevan, 2005

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Croatia: Contextual framework



Present challenges:

Terminology
Health care reforms
European collaboration
Bologna process

Croatia: Contextual framework



Croatia: Contextual framework



- ✦ The new winds?
- ✦ The new direction of sailing?
- ✦ The new way of sailing?
- ✦ The new sailors?

From tradition to innovation



Andrija Štampar School of Public Health,
Medical School,
University of Zagreb, Croatia

Founded in 1927
The leading institution for graduate, postgraduate and continuous education in PHC and PH

Ten principles written by Andrija Štampar, 1926



It is more important to enlighten the people than to impose laws.
It is most important to prepare the ground in a certain sphere and to develop the right understanding for questions.
The questions of public health and its improvement must not be monopolized by medical authorities, but has to be cared out by everybody, for only by joint work can the progress of health can be obtained.

Ten principles written by Andrija Štampar

First of all the physician must be a **social worker**; by individual therapy he cannot attain much, social therapy is the means of success.

Economically the physician must not be dependent on his patient, because it hinders him in the accomplishment of his principle tasks.

In matters of people's health **no difference** is to be made between the rich and the poor.

It is necessary to form a health organization, in which the physician will seek the patient, not the patient to seek the physician; for this is only way to gather an ever increasing number of those health we have to care for.

The physician has to be the **teacher of the people**.

The question of national health is of **greater economic than humanitarian** importance.

The **principle fields of action** of a physician are **human settlements** and not laboratories and consulting room.

A. Štampar School of Public Health: The main approaches

- To raise the standards of PHC and PH education in Europe and worldwide
- To achieve the present integration into the international community of public health schools
- To preserve and maintain specific components in education

Traditional Master programs

- Family Medicine
- Occupational Medicine
- School Medicine
- Epidemiology
- Public Health
- Medical Informatics
- Leadership and Management

Managing change

The catalyst:
ASPHER-OSI project

QUALITY DEVELOPMENT OF
PUBLIC HEALTH TEACHING
PROGRAMS IN CROATIA



Strengths and Weaknesses for Change

Strengths

Readiness to change curriculum according the new trends in PH and PHC education

Readiness to keep the "unique"/specific approaches in education, based on (national) positive experiences

Readiness to improve the quality of education using quality assurance and benchmarking

Weaknesses

Resistant to change: "Hidden" interests of professional groups and departments

Lack of understanding the new trends in education: national vs. international trends, orientation towards market

Lack of clear (future) visions: "final product"

Strengths and Weaknesses for Change

Strengths

Policy Formulation and the Legal framework:

National Health Care Law, 2003
(*Orientation towards Health*)

The Law on Scientific Activities and Higher Education, 2003
(*Orientation towards ECTS and European dimension in health*)

Weaknesses

Policy Formulation and the Legal framework:

Lack of clear National Strategy Health21 and Health For All

Lack of clear vision and well-understanding of modularisation and ECTS.

Lack of financial support and low motivation

Strengths and Weaknesses for Change

Strengths

Well-defined programs of master and doctoral studies

Weaknesses

Not well-defined relation between academic and professional societies
Lack of evidence-based arguments and evaluation (what and why to change?)

Strengths and Weaknesses for Change

Strengths

Resources for change (number of faculty staff, learning environment)
Readiness to change (high motivation)

Weaknesses

Departments' "isolationism", lack of integration, hidden interests
Resistant to change (low motivation)

Process of curriculum development and lessons learnt

Process:

Need assessment:

Focus groups - experts, professionals, students

Lessons learnt:

How they know if they do not know?

Process of curriculum development and lessons learnt

Process:

List of competences:
Building bridge between academic and professional societies
List of specific competences for each subject

Lessons learnt:

Difficulties in understanding competences
Challenges in competition, lack of integration and collaboration

Process of curriculum development and lessons learnt

Process:

Review of the present Master programs and curricula analysis

Lessons learnt:

Enabling factors for successful work:
In-depth analysis (self-evaluation) and ASPHER peer-evaluation

Process of curriculum development and lessons learnt

Process:

Review of the present Master programs

Lessons learnt:

Needs for additional programs:
Family Medicine
Occupational and Sports' Medicine
School Medicine
Epidemiology
Public Health
Medical Informatics
Leadership and Management
Environmental and Occupational Health
Health Ethics and Human Rights
Health Promotion and Health Education

Process of curriculum development and lessons learnt

Process:

Review of the present
Master programs

Lessons learnt:

Gap between learning objectives and contents of the studies
ECTS varied from program to program
No electives in most programs

Process of curriculum development and lessons learnt

Process:

Review of the present
Master programs:

Some contents are included in most of the Master programs (20-65% overlap)

Lessons learnt:

Common Core Curriculum
Specific Core Curriculum
Electives ("Basket")

Quality development: useful learning process



**ERASMUS MUNDUS APPLICATION:
A MASTERS CONSORTIUM APPROACH FOR HIGH QUALITY SERVICES TO
THIRD-COUNTRY STUDENTS AND SCHOLARS**

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Ecole Nationale de la Sant Publique

Purpose

The purpose of this paper is to highlight an example of how six European Schools of Public Health organised their partnership to ensure that their European Master in Public Health meets the expectations of the Erasmus Mundus label in terms of high quality facilities and services provided to third-country students and scholars. This project was presented to the Erasmus Mundus programme on May 31st, 2005 since it provides EU-funded scholarships for third-country nationals participating in these Masters Courses.

Introduction

The six partners who presented their European Master of Public Health, EUROPUBHEALTH, to Erasmus Mundus call for proposals are: Ecole Nationale de la Sant Publique (France), University of Rennes 1 (France), Escuela Andaluza de Salud Publica (Spain), Institute of public health of the University of Copenhagen (Denmark), The University of Sheffield (United Kingdom) and the Institute of Public health of Jagellonian University in Cracow (Poland).

Initially, the main objectives of the partner Schools, which already had experience of working together at a national, European, or international level, were to create a consortium to construct a European Master of Public Health within the framework of the ECTS and the Bologna declaration, and to make higher education in public health in the European Union attractive for students from all over the world.

Methods and materials

The main challenges of this project were: to re-engineer different curricula and training methods already developed by each partner to fulfil the objectives, to draw up all the proposals related to the recruitment, counselling, and support in terms of quality facilities and services to the students and teaching staff concerned. The partners used various means to exchange ideas and practices, and to come up with an agreement on the whole project: an organisational chart, common terms of reference, work schedule and meetings objectives, distance-work tool (on-line platform), lobbying/promotion.

In a context where international mobility of students is increasing, the reinforcement of the attractiveness of our higher educational systems becomes a strategic stake that must be achieved through high quality facilities and services. In order to fulfill those objectives, the masters partners followed three steps:

- inventory of the existing facilities and services in each institution and type of information needed by 3rd country students and scholars
- international benchmarking on methods and tools used by international offices in higher education institutions
- definition of common quality standards in terms of facilities and services

Results

The main results show that the development of this type of project is feasible under several conditions: a good mutual knowledge, an experience in working together in different programmes

and high investment of the all partners in the construction of the programme: the existing programmes must be restructured and accepted by the consortium. The added value was:

- for the partner institutions: the exchange of pedagogical approaches and mobility practices, the building up of a common culture, and common rules for continuous quality improvement, the development of cooperation with third country higher education institutions
- for the students: the participation to a high quality multicultural training course in public health, with high quality services and support.
- for the scholars: the possibility to collaborate in the training but also in European research projects, with a guaranty of high quality services and facilities.

Discussion and conclusion

Further steps will consist in integrating the facilities and services in the overall quality assessment of the programme. In a need for continuous quality improvement and best practices exchanges among the masters partners, it might be possible to organise Erasmus and Leonardo mobility programs for European students, teaching staff and international office personnel.

Keywords: Erasmus Mundus consortium, european partnership, high quality services

**ERASMUS MUNDUS APPLICATION:
A MASTERS CONSORTIUM APPROACH
FOR HIGH QUALITY SERVICES TO THIRD-COUNTRY
STUDENTS AND SCHOLARS**

Fanny Helliot – National School of Public Health (ENSP) – France

ASPHER XXVII Annual Conference - Yerevan, Armenia

19 September 2005

EUROPUBHEALTH CONSORTIUM

- **6 major higher education institutions in public health**
 - Ecole Nationale de la Santé Publique (ENSP), France
 - Faculty of law and political science of University of Rennes 1, France
 - Escuela Andaluza de Salud Publica (EASP), Spain
 - Institute of public health of the University of Copenhagen, Denmark
 - Institute of public health of Jagellonian University in Cracow, Poland
 - School of Health and Related Research of the University of Sheffield, Great Britain
- **A history of bilateral or multi-lateral co-operations**
- **Good geographical representation**
- **Complementary competencies, renowned in their respective countries**

GENERAL METHODS AND TOOLS

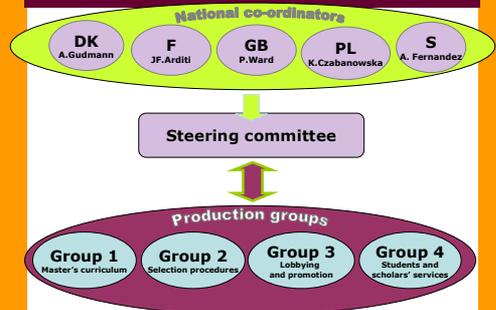
Consortium

- Organisational chart
- Terms of reference
- Work schedule & meetings' objectives
- Distance-work tool: on-line platform
- Lobbying/promotion strategy

Internally (ENSP)

- Audit of training course managers
- Work with masters' co-ordinators
- Communication:
 - newsletter
 - information sessions

**ORGANISATIONAL CHART
general co-ordination ENSP**



**THE STAKE OF HIGH QUALITY FACILITIES
AND SERVICES**

"Erasmus Mundus Masters consortia must be able to welcome and host third-country students / scholars by providing high-quality hosting facilities and services, such as an "international office" with adequate opening hours and linguistic coverage, housing facilities, coaching, language courses, activities aiming at social integration, assistance with visas and social insurance, etc. Ideally, facilities and services provided should also cater for the needs of grantees with a family (e.g. visas and insurance for family members, child care facilities, etc.) and with special needs."

Erasmus Mundus call for proposals

**EXAMPLE:
STUDENT & SCHOLAR SERVICES**

- International benchmarking
 - Outside the consortium (Internet), visits of international offices
 - Within the consortium
- Inventory of services and facilities provided by each institution
- Definition of good practices & common quality criteria

COMMON ACHIEVEMENT: WELCOME GUIDE

- Checklist of the main mobility steps:
 - decision-making process (necessity to promote the master),
 - preparation before leaving,
 - arrival at the host institution,
 - studies at the institution and stay in another European country
 - going back home: alumni and networking
- Selection of most frequently asked questions at any step of the mobility
- Agreement on a common table of content and structure

WELCOME GUIDE



- Before you leave home
- Living in <institution's country name>
- Living in <institution's city name>
- Studying at <institution's name>
- Other Frequently Asked Questions

Questions

How do I open a bank account?
 When do I get my accommodation? Can I request my first choice of residence? Can I change my accommodation once I get to city center?
 How do I get access to the library? How can I get my e-mail access?
 I'm a new student. Can I get temporary work on campus and food?
 I'm a new student. How do I contact students of the same nationality? How do I join Sports or Social Clubs?

Thank you for your attention

<http://www.europubhealth.org>



EUROPEAN PARTNERSHIP: A SOLUTION FOR THE CHALLENGE OF THE INCREASING DEPENDANCE OF AGEING PEOPLE

Hlne Malterre, helenemalterre@hotmail.com
Ecole nationale de la sant publique (France)

Purpose

What measures can be taken to deal with ageing population and increasing dependence in Europe, now and in the future?

Introduction

Countries have adopted different solutions to deal with similar social and demographic problems: special allowances. Although the legal systems are different, it may be possible to transfer some solutions from one state to another as a socialist Europe gradually takes shapes. What is the best way of testing these practices and encouraging dialogue? Who is the best qualified to lead this movement, to ensure that is durable and that it becomes part of professional culture of the French government service? The directors of establishments for the elderly and more generally hospitals have to implement these health and social policies and are the heart of the system surrounding the elderly. This year, a placement abroad was included in their training course to meet this objective which has already produced some guidelines for ensuring the success of these exchanges and shown some of pitfalls to be avoided.

Methods and materials

This can be illustrated using the example of a placement in the Wenckebach Klinikum gerontology hospital in Berlin and the various partnerships that could result.

Results

The French Ecole Nationale de la Sant publique (ENSP-National School for Public Health), which is responsible for training health management personnel, has been making a concerted effort to broaden the international scope of the management training course, both by extending the theoretical content and by this two month immersion placement. International co-operation has taken a new direction with a commitment to actions encouraging the transfer and exploitation of savoir faire. Each applicant has to show the value of his placement for his professional career. The choice of an establishment similar to the establishment selected in France for work experience as well as being located in a similar area, the capital of the country, made comparison easier. Once in situ, it was necessary to set out the objectives of this exchange as well as presenting the French system to everyone. To develop the dialogue satisfactorily, the choice of a placement in the services was considered necessary to be able to understand how the operation operated, all the more so as the director was himself a doctor. This immersion made it possible to monitor elderly patients at the stages of treatment, from the time they were admitted to the time they were discharged. This observation period lowered the barriers of rank and gave an informed, considered view of staff. Many questions were raised about maltreatment, the training of staff in France and on their salaries.

Discussion and conclusion

A command to the language is possibly not an absolute necessity but it helps to understand the system and to communicate with the staff. It is for the director to develop the partnership but there must be dialogue at treatment level as it is here that the solutions adopted elsewhere will be implemented. A partnership between institutions and countries that are completely different is difficult to organise and calls for time and objectivity. It is essential to know just a little about the country beforehand. In all cases, the attitude of the director abroad and his own country is also important: understanding without judging and explaining the differences. This course is only a

preliminary to developing a partnership between the ENSP and his hospital. However, as director it appears of fundamental importance to encourage frequent meetings (at least once every two years alternately in each country) to ensure the durability and solidity of the experience acquired in this placement after the training period for the future of European social policies.

Keywords: elderly people, establishment, partnership

PARTNERSHIP BETWEEN EUROPEAN ESTABLISHMENTS :

A possible solution to better deal with ageing population and increasing dependance?

THE EUROPEAN CONTEXT

- ageing population and increasing dependance
- different solutions tested (special allowances, setting up institutions)...
- ...But not coordinated despite the “social Europe”

A POSITIVE EXPERIENCE: PRACTICAL PLACEMENTS OF FRENCH DIRECTORS IN EUROPE

- A placement included in the training course of trainee-managers of the French National School of Public Health
- Choice of the placement: the example of the Wenckebach Klinikum

ASSESSMENT

- Difficulties:
 - Comparison with a different health system
 - Language barrier
- Interests:
 - A new view of system around ageing people
 - New perspectives about work organisation

ASSESSMENT

- Keys to success
 - A good preparation with the placement tutor
 - A placement not only in the manager's office but in the services
 - Different meetings after this placement to build sustainable and concrete partnership

COMMUNICATION SESSION H

INNOVATION IN TRAINING HUMAN RESOURCES FOR HEALTH THROUGH QUALITY DISTANCE LEARNING PROGRAMMES

Rosa Giuseppa Frazzica

Salvatore Giambelluca; Danilo Greco;
Maura Cascio; Valentina Botta; Vanda Anzaldi
CEFPAS

Purpose

CEFPAS the Centre for Training and Research in Public Health of the Sicilian Regional Government has invested in developing Distance Learning (DL) products and its goal is to make its specialised, advanced training widely available. It also aims at making its DL contents learner-friendly and accessible to all those who cannot take a conventional classroom course. In July 2004, CEFPAS was involved in the national experimentation on e-Learning for health sector personnel promoted by the Ministry of Health (MOH) with a DL course on Interventions and strategies of Health Education in Adolescence.

Introduction

In 2004 the Ministry of Health has chosen 64 Distance Learning Providers and CEFPAS was one of them to keep, develop or increase the knowledge, the expertise and the performance of health professionals.

Methods and materials

CEFPAS designed its DL model with end-users in mind and with the objective of removing barriers to its usage. It also provided innovative technology that is easy-to-manage and easy-to-use, comprehensive and ready to be activated either at home or at work. CEFPAS DL model lessons are easy to follow because they include animation, film clips, graphics, and sound, which enrich and make the learning experience more enjoyable. The language used in the DL course proposed by CEFPAS, which is targeted to a national audience, is Italian. In order to use the multi-media CD-Rom training course correctly, trainees can choose from a wide variety of tools and services: the Courses Home page; Interactive maps; Interactive tools; Navigation tools. Most important are the interactive tools as they allow trainees to use effectively materials selected by the trainer for Learning support (Tutoring on line, by phone and e-mail) and other resources (Web Link; Glossary; Bibliography). To support Learning Processes (LP), CEFPAS has activated a Web Area whereby access to the system is allowed by recognition of the course member through personal identification. This Web Area is provided with a Guest Book for those trainees wanting to give advice on how to improve the LP.

Results

69 Providers recognized by the MOH are taking part to the National experimentation on e-Learning for health sector professionals involving about 136.000 users of different professional typologies. 187 health professionals from 13 different Italian Regions have taken CEFPAS e-learning course Intervention and strategies of Health Education in Adolescence, women being 89% of the sample.

Following is the distribution of trainees by professional typology:

- 39% Social and health workers
- 37% Dieticians
- 20% Psychologists
- 4% Professional educators

The training activity was evaluated in terms of learning and client satisfaction. The former consisted in the administration of an on-line multiple-choice questionnaire, which allowed to assess the learning elements of the training activity. The results showed that 86% of the participants passed the test.

The most significant data regarding the satisfaction evaluation were:

- a) Relevance of the issues 83%
- b) Training quality 83%
- c) Effectiveness 76%

Discussion and conclusion

Since January 1996, CEFPAS has been developing high quality classroom training activities for social and health personnel. In April 2003, a team was created to develop innovative, high quality e-Learning products, promote DL initiatives and support trainers in the pedagogical characteristics of on-line education. Nowadays, DL is one of the most important components of CEFPAS training programme.

According to our experience, DL main benefits are:

- Increase in the number of trained health personnel: CEFPAS DL courses have attracted 96% new participants.
- Accessibility: training contents become accessible to users in different geographical areas.
- Scaffolding: there is a ever-growing amount of inter-related information.
- Interaction: users, trainers and tutors are linked up, sharing ideas, information and developing joint projects.

Keywords: e-learning, quality, interaction



Innovation in Training Human Resources for Health through Quality Distance Learning Programmes

Authors: R. G. Frazzica; S. Giambelluca; D. Greco; M. Cascio; V. Botta; V. Anzaldi



Centre for Training and Research in Public Health



- A Sicilian Regional Government Institution
- An organisation similar to Local Health Organisations
- It started its activities in 1996



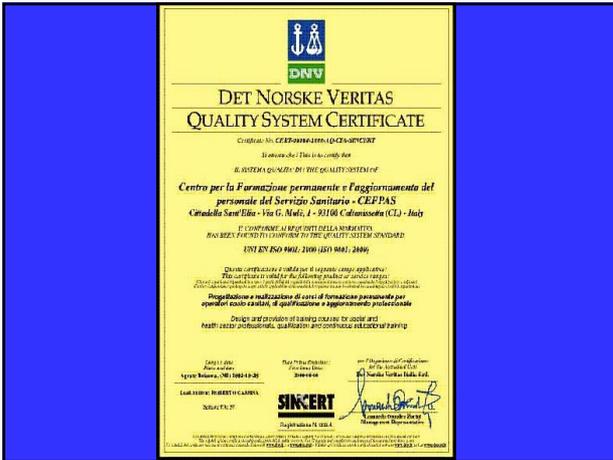
- 16 buildings for 26.000 sqm of covered surface:
- 11 buildings for training
 - 1 gymnasium for sports & rehabilitation



- 1 hotel with rooms and conference space
- 3 dormitories with 210 rooms



The Auditorium



CEFPAS, has invested heavily on e-Learning activities



e-Learning experience



- In 2003, the e-Learning team was created to focus on developing e-Learning activities
- In April 2004, CEFPAS became a Distance Learning Provider making its advanced training widely available

Definition of DL by ECM

- DL includes ECM training activities transmitted to users in various locations
- It uses printed information, videotapes, floppy disks, Cd-Rooms, Multi-media events and allows its unlimited usage in different places at the same time.



the ECM National experimentation

14

Interventions and strategies of Health Education in Adolescence

Interventi e strategie di Educazione alla Salute in adolescenza

CEFPAS

HOME
MAPPA
TUTOR
LINK UTILI
GLOSSARIO
BIBLIOGRAFIA
ESCI

SCENARI E TEORIE DI RIFERIMENTO PER LA PREVENZIONE A SCUOLA

A. Pellai
B. Tamborini

1 di 11

Interventions and strategies of Health Education in Adolescence

- Duration: 20h
- Marks: 12
- Applications: 280
- Participants: 198
- Renunciations: 11



187 participants completed the course

Distribution of participants by profession

- Social and health worker 81
- Dieticians 70
- Psychologists 36

Total participants: 187



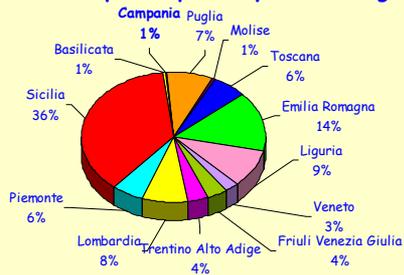
Distribution of participants by Italian Regions

187 health professionals from 13 different Italian Regions have taken part in CEFPAS' e-learning course



73 participants (36,86%) work in Sicily

Distribution of participants by Italian Regions



**Innovative technology:
easy to manage and easy to use**

20

"Interventions and strategies of Health Education in Adolescence"

The fruition of the course is "off line"

**Auto-Install
Auto-run**



DL lessons include:

- Animation
- Film clips
- Graphics
- Sounds



Interactive TOOLS

The user interface allows participants to use the interactive educational and training materials selected by the trainers



The home page key allows access to the first page of the course:
Instruction, Staff and Authors, Credits, Enter the course



Home Page Content

Instructions

Contains all the information in order to use the multi-media Cd-Rom correctly.

Staff and Authors

It includes detailed information and CV of the key people responsible for the project implementation (scientific referees, trainers, Cefpas' staff).

Credits

This page shows those who have developed the multi-media Cd-Rom (Scientific referees, trainers, Cefpas' staff and the Interactive Multi-media Society).



Enter the course
by clicking on this key, participants can start to use the course.

Interactive Map



The interactive map allows one to surf the contents through the course structure and to enter into each lesson

Interactive Tools



Learning support and resources include documents, exercises, case studies, graphics, and self-assessment resources selected by trainers to go deeper into each theme of the course

Web Link

this allows users to visit the web sites related to the theme of the course

Interactive TOOLS



Glossary

Contains all the keywords used in the course, organised in Alphabetical Order.

Bibliography

A list of books, articles, and documents that are useful in studying "Interventions and strategies of health education in Adolescence" in depth.

Exit

This key allows users to exit the course.

Navigation tools

The lower menu bar allows participants to move through the pages in the course. Navigation tools are at the bottom of each page and they allow users to return to the previous one, move forward to the next and return to the lesson's home page.



Links

By clicking on a link users will access other learning supports and resources such as Author's Biography, case studies, articles, glossary, bibliography and so on.

Navigation tools



Turn the speaker on. This tool shows the presence of the audio, making the learning experience easier for the participants.



This tool makes it possible to repeat the content of the page, with "Flash Animation", as many times as the participants wish.



This allows the user to see, in animation, the first page linked up with other 3 or 4 pages.

What communication tools are used for?

Communication tools



DL Services



Tutoring on line

Gives participants the help they need to consult the contents through e-mail and forums.



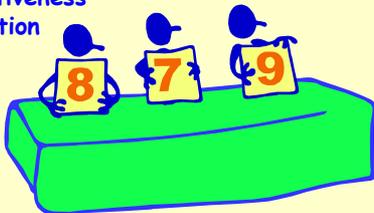
Help desk

Requests for help in the case of technical problems may be sent to the "help desk" either by e-mail or by telephone.

Main results

CEFPAS in the E-Learning National experimentation

- The training activity was evaluated in terms of:
- learning effectiveness
- client satisfaction



Learning evaluation

To support the learning process, Cefpas has activated a Web Area, to be found on the Centre's WEB SITE

Como FAD
Interventi e strategie di Educazione alla Salute in adolescenza
Area ad accesso riservato
Inserire nome utente e password per accedere

Nome utente	<input type="text"/>
Password	<input type="password"/>
	<input type="button" value="OK"/>

www.cefpas.it

Test on line

Access to the system is allowed by recognition of the course member through a personal identification (user's ID) and a password

Oggi è: Martedì, 13 Luglio 2004 Area comune
Benvenuto Maura Ignazio Cascio Calendario Staff
Test apprendimento
Agenda FAQ
In evidenza
Si ricorda di compilare ed inviare il test di apprendimento entro il 20/08/2004
Cliccare per uscire dall'area riservata

Test on line

The test consists in the administration of an on-line multiple-choice questionnaire

2 attempts to complete the Test are allowed



4/5 of the answers must be correct

The results showed that 86% of the participants passed the test

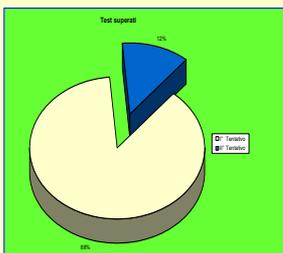
Learning evaluation

First attempt

The results showed that 88% of the participants passed the test.

Second attempt

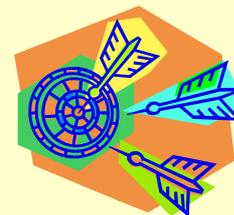
The results showed that 12% of the participants passed the test.



The results showed that 6 participants didn't pass the test.

Satisfaction evaluation

The most significant data regarding the satisfaction evaluation were:



- Relevance of the issues 83%
- Training quality 83%
- Effectiveness 76%

What are the main benefits?

Rapid increase in the number of trained health personnel

Cefpas' DL course has attracted 96% new participants.

Accessibility to training information becomes possible to users over large geographical areas



Scaffolding: there is an ever-growing amount of inter-related information



Interaction: users, trainers and tutors are connected for sharing ideas and information, developing projects

What future developments are foreseen in Distance Learning?

The future

- Increasing development of e-learning products
- More research on quality
- Assessment of effectiveness



USING ON-LINE VIRTUAL CLASSROOM AND VIDEO-CONFERENCING SYSTEMS AS A TOOL FOR PUBLIC HEALTH EDUCATION AND RESEARCH AT THE TRNAVA UNIVERSITY IN SLOVAKIA

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Trnava University, Faculty of Health and Social Work,
Department of Hygiene and Epidemiology

Purpose

The purpose of this presentation is to present the activities which our department is using the video-conferencing and on-line virtual teaching/learning technologies for, to discuss the advantages-disadvantages of these technologies and to share and discuss.

Introduction

The Department of Hygiene and Epidemiology at the Faculty of Health and Social Work of the Trnava University has been introducing in the last couple of years new teaching/learning technologies into its educational and research practice.

The two main tools which at our department are more and more widely used are the video-conferencing technology and an online virtual classroom system.

We have used the video-conferencing for three courses included in our public health curricula taught by a lecturer from Denmark. Our department organised last year a series of lectures focused on improving the research skills and on widening the public health knowledge of the Trnava University students. We have also widely used this technology as a communication tool for research purposes.

The online virtual classroom system has been used for learning, teaching and research purposes. Several department members took part on different on-line courses provided by the University of Iowa. The annual Summer School of Rural and Environmental Health organized at our faculty is divided in two parts: the on-line part which includes one lecture weekly for 6 weeks via this virtual classroom system and the on-site part.

We also started a discussion series through this system oriented towards public health professionals throughout Slovakia focused on different relevant public health topics.

I find these teaching/learning technologies certainly edge-cutting and I refer with this presentation to the theme #4 of the conference.

Methods and materials

I compared these two learning/teaching technologies focusing on the technical requirements, simplicity of use and advantages/disadvantages from the viewpoint of the students and the lecturers. I based my comparison on experiences I gained during the activities I described above and on opinions I obtained from speakers and students taking part on these projects.

Results

According to the technical requirements we can say that the online-virtual classroom is more convenient. It requires only a dial-up connection and a computer with a relatively low level of technical parameters. This tool is interactive—there is a possibility of easy and convenient communication via audio and via direct messaging system where the participants can communicate

through typing messages. One of the best advantages of this system is its virtuality-the fact that neither the students nor the speakers have to be in their office or classroom. The minimal technical requirements ensure that it is possible to connect nearly from wherever where there is a connection. On the other side there is the video-conferencing system which has higher technical requirements and it is suitable for classroom sessions. The speaker might be abroad but there is a good „personal contact “between the speaker and the students because they can see each-other. Both the students and the speakers appreciate this contact and find it to be a big advantage of this system.

Discussion and conclusion

Both of the technologies I described above are suitable for certain things. The virtual classroom is more suitable in the cases when the participants are from all-over the country/world because they can connect to the session from where they are and be part of a highly realistic class. The video-conferencing system is more convenient in cases when the speaker is abroad although it has higher technical requirements. All in all I am sure that both of them are a good solution how to make the education and research more effective and to save money and time.

Keywords: Learning/teaching technologies, virtual classroom, video-conferencing

Using on-line virtual classroom and video-conferencing systems as a tool for public health education and research at the Trnava University in Slovakia

Marek Majdan

Department of Public Health, Trnava University, Trnava, Slovakia

XXVII. Annual ASPHER Conference, Yerevan, Armenia, 17-20 September, 2005

Purpose of the presentation

- Present two internet based technologies used at the Department of Public health of the Trnava University
- Discuss the advantages-disadvantages
- Share our experiences

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Two technologies

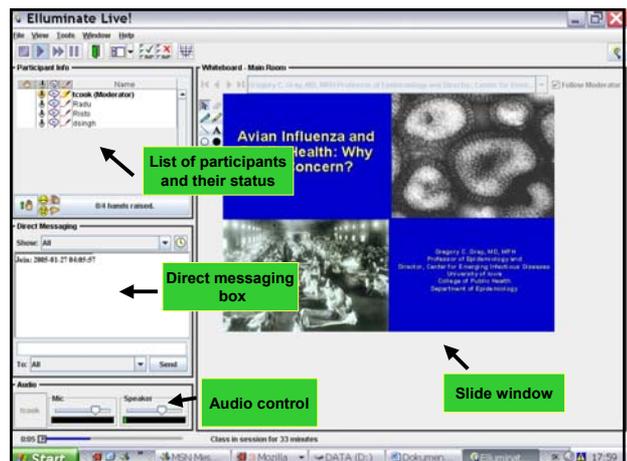
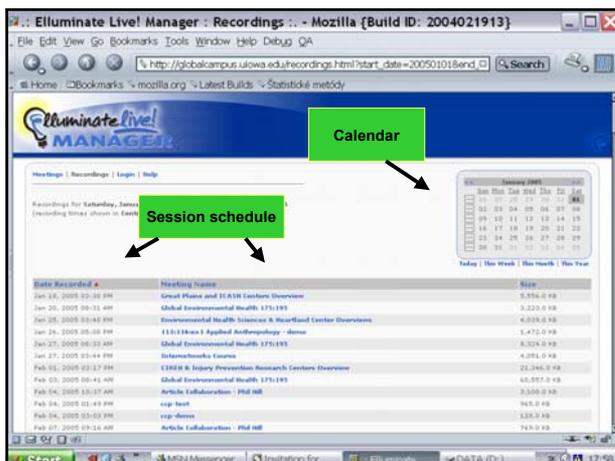
- Virtual classroom
- Video – conferencing system

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Virtual classroom

- An internet based tool
- Allows meeting of several persons from around the world in one „room“
- Useful as a teaching – learning tool and research communication platform

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Technical requirements

- Speakers – microphone
- PC
- Internet connection

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Advantages

- Minimal technical requirements
- User friendly, easy to use
- Convenient – not necessary to be in the classroom or office neither for the speaker neither for the students – participants
- Interactive – communication between participants via audio or messages
- Possibility of recording the sessions
- Possibility of a video-window

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Our experiences

- Summer Institute at Trnava University – electronical part
- Department members took part on several on line courses
- Communication tool in research, between participants of projects
- Series of meetings of public health professionals from Slovakia to discuss the issues of public health

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Two technologies

- Virtual classroom
- **Video – conferencing system**

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Video conferencing system

- An internet based communication tool
- Allows meeting of a speaker and his audience, two or more persons at once on one screen
- More suitable for teaching an on-site class by a teacher being connected from a different place

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Video-conferencing



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Technical requirements

- Depending on the type of camera there is needed or not a computer and a microphone with a speaker
- A high-capacity internet connection is needed in order to connect

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Advantages

- Suitable for classroom sessions with a speaker being abroad
- Allows a good contact between the speaker and the audience – they see and hear each other
- Possibility of sharing files (slides) between the sides connected

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Our experience

- Three courses were last year taught by a lecturer from Denmark using this system
- Series of lectures focused on widening the public health knowledge of the students at our university – speakers from abroad
- Communication tool in research

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Conclusions

- Every one of these technologies is suitable for different things
- In general they can save time, money and make the teaching process more effective
- Improves the communication possibilities and opens the door for wider international cooperation
- Need to be implemented in a bigger extent

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ACCREDITATION SYSTEMS DASHBOARD FOR SCHOOLS OF PUBLIC HEALTH

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Faculty of Health Sciences, American University of Beirut

Purpose

The purpose of the paper (“Paper”) is to emulate a novel Accreditation Systems Dashboard (“Dashboard”). The Dashboard was developed at the Graduate Public Health Program, Faculty of Health Sciences, American University of Beirut, Lebanon. The outcome is a product that could be replicated in other schools of public health.

The metaphor is an airplane cockpit with a pilot and a dashboard. The pilot is the dean (or director) of a school of public health. The Dashboard is a panel of gauges and instruments providing the pilot with balanced measures, as indicators of performance. The visual display, in the form of report cards, provide the pilot with information on where we are, where we want to go (or destination), and the gap between the two indicated in measurable terms.

Introduction

Whereas in general, ‘accreditation’ stands as a form of a seal of approval by an external accrediting body, the Accreditation Systems Dashboard is strictly an internal management tool.

The Dashboard was designed and applied: (1) to serve as a guideline for implementing an accreditation self-study initiative; and (2) to establish a platform for strategic planning. The methodology used in constructing and operating the Dashboard falls within the framework of the Conference Theme: “Flexible learning: Cutting-edge learning techniques and technologies”.

Methods and materials

Three types of methods and material were used: (1) Kaplan and Norton Balanced Scorecard (BSC) methodology; (2) Techniques and tools for implementing the Government Performance and Results Act of 1993; and (3) Turning Point National Program methodology.

Application of methods to the University educational setting entailed establishing a ‘performance improvement unit’ positioned at the Faculty of Health Sciences Office of Dean. The unit is staffed by one part-time leader, and Office of the Dean staff as team members. The idea being that unit functions are part and parcel of day-to-day operations.

The Dashboard is the ‘nerve center’ of the Accreditation System. The scope of work of the unit is data collection, analysis, reporting, and ‘outcome management’ (Paul Ellwood).

Performance improvement unit activities are organized as projects. The relationship between them is reiterative and cyclical. The projects are:

Project I: Performance Standards. (‘Where do we want to go?’)

Statement: Planning relevant and doable mission, vision, theme, goals, objectives and initiatives. School functions that are covered are: instruction, research, and service.

Deliverable: Strategic and Operational Plan

Activities: Formation of project work groups with activities of members coordinated by team leaders

Project II: Performance Measurement. (Axiom – ‘What gets measured gets done’)

Statement: Measures that assess achievement against standards

Deliverable: (1) Key performance indicators, with balanced measures. (2) Computer-based databases on students, faculty, curriculum, and outcomes

Activities: Data collection, tabulation and analysis

Project III: Performance Reporting. (“If we do not know where we are, how can we get there?”)

Statement: Reporting of progress against standards

Deliverables: Performance report cards

Activities: (1) Designing and operating the Dashboard; (2) Feedback to and from managers; and (3) Developing regular reporting cycles

Project IV: Performance Improvement. (“If you always do what you always did, you’ll always get what you always got” - Arthur R. Tenner & Irving J. DeToro)

Statement: Change and outcome management

Deliverables: Evidence of narrowing the gap between where we are and our destination
Activities: Create a learning environment whereby decisions and activities are based on performance measurement information

Results

The results are a performance-based information system using state-of-art methodologies that track school of public performance against pre-set mission, goals and objectives.

Discussion and conclusion

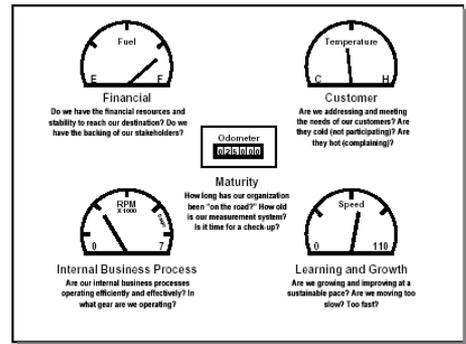
Conclusions suggest that the innovative model is applicable to other schools of public health.

Keywords: Accreditation Systems Dashboard

ACCREDITATION SYSTEM DASHBOARD

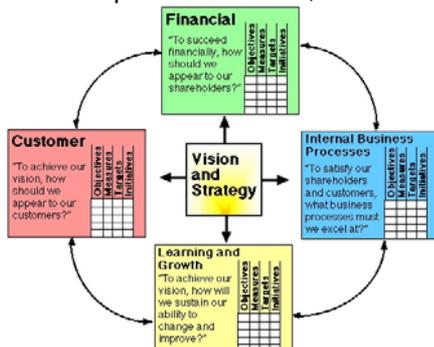
Nadim A. Haddad, M.D., M.P.H.
Senior Lecturer
Faculty of Health Sciences
American University of Beirut
Lebanon

The Balanced Scorecard As A Performance Dashboard

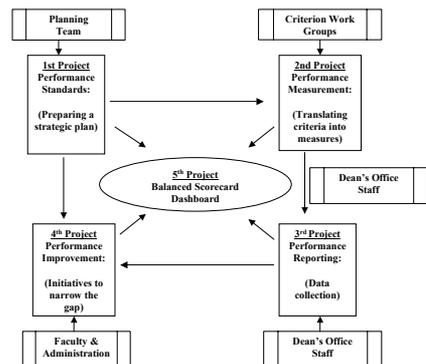


GPRA, 1993, Volume Two ,p.28

BSC Perspectives: Kaplan and Norton, 1992



Accreditation System: Five Projects



Balanced Scorecard Dashboard

- A public health program Balanced Scorecard Dashboard is a visual display of a group of Accreditation System Indicators (ASI) that measures efficiency of operations, and effective performance against self-imposed standards. The display is a summary report on 'where we are', 'how far are we from the destination', and 'how well we are doing'.
- The metaphor is an airplane cockpit with a pilot and a panel of instruments and gauges essential for navigation. In accreditation of public health programs (or schools of public health) the pilot is the director (or dean).

Accreditation System Indicators

- Accreditation System Indicators (ASI) are balancing measures that assess the degree to which actual performance of an organization increases the likelihood of desired outcomes that are consistent with the expectations of internal and external stakeholders.
- The balance that is measured is between and among four perspectives: (1) clients, (2) internal processes, (3) learning and growth, and (4) financial performance.
- Indicators are composed of: numerators, denominators, and statements of inclusions or exclusions. The elements in the Indicators bear a cause and effect relationship between and among the public health program structure, process and outcome.

Type of Indicator	Indicator Name	Description: Ratios, Rates Inclusions, Exclusions	Report Card
Accreditation System Indicators			
Financial Performance: Learning & Growth	Cost per-Faculty Development	Difference between unit actual and planned cost	
Financial Performance Internal Processes	Cost per	Difference between unit actual and planned cost	
Internal Processes; Clients			

Type of Indicator	Indicator Name	Description: Ratios, Rates Inclusions, Exclusions	Report Card
Accreditation System Indicators (Cont'd)			

GROWING A PUBLIC HEALTH WORKFORCE IN SANDWELL, UK

John Middleton, john.middleton@rrt-pct.nhs.uk
sandwell Primary Care trusts; Birmingham University

Purpose

to demonstrate innovative new learning techniques
to illustrate flexibility in public health workforce development

Introduction

The new English Department of Health Public Health policy “Choosing Health” promises an expansion of the public health workforce. It proposes a range of roles such as the 'personal health trainer' some of which have still to be created. The Choosing Health model is individualistic and creates the perception that health problems that have been collectively created through unhealthy economic and environmental conditions, can be individually and therapeutically cured.

Sandwell is a small administrative district serving 300,000 people in the West Midlands of England. We are the 11th most socially deprived council area in England and have one of the lowest life expectancies in England. We have a high proportion of our population from ethnic minorities and very high levels of the population lacking basic skills.

We have a long track record of developing local people as community health educators, public health advocates, public health nutrition workers and community researchers. Our evidence to the second National Health Service report on public health capacity by Derek Wanless has informed the development of the new public health worker concept.

Methods and materials

Our model raises the community's understanding of health promotion and gives people skills to deliver health improvement in their own communities whilst at the same time earning their income from the health services, indirectly benefiting their own health and the economic health of their community. The training model is an escalator providing taster courses for community members with no health service experience to seed the idea that they can find work in such roles as community exercise programme leaders, public health nutrition, occupational health and safety, community health survey and advocacy work and in more formal public health support roles such as health statistics and data management.

The higher levels of the escalator then offer longer courses enabling people to achieve national qualifications and work with public health departments from this level further opportunities for public health work in health protection, health promotion occupational health statistics and epidemiology. Further development of the programme is being explored with co-financing from regional economic development agencies and from the European Social Fund. Birmingham University public health department, Warwick University Business School and University of Central England Community Development department are key partners in the delivery of training programmes.

Results

Over 500 people have been through programme of training and experience as community advocates, peer educators and community survey workers. Some have ascended through public health management and technical roles. Examples will be used to illustrate the programme.

Discussion and conclusion

The programme is regarded as a very high local priority for the Sandwell primary care trust. It is lead by a Head of Public Health Workforce Development on behalf of the Director of Public Health. A strategy for the overall development of the public health workforce is being developed which will demonstrate a wide- ranging effort to increase public health capacity and overall knowledge and understanding of health problems in the local community.

Keywords: public health training; workforce development; community capacity

ASPHER 2005: Growing the public health workforce in Sandwell, UK

Dr John Middleton Director of Public Health,
Honorary Reader, Birmingham
University School of Public Health

ASPHER 2005: Growing the public health workforce in Sandwell, UK

English Public health policy context

History of public health
workforce developments in Sandwell

Some case histories

Future strategy for Sandwell
and academic public health practice
in Sandwell, Birmingham
and the West Midlands, UK

ASPHER 2005: Growing the public health workforce in Sandwell, UK

English Public health policy context

Expert patients programme 2000-

Wanless report on public health capacity
January 2004:

need to expand the public health workforce, including help for individuals on health maintenance

'Choosing health' public health consultation, May 2004:

'Choosing health' White paper English public health policy,
November 2004:

new role of 'Health trainer' to give individuals guidance on fitness, nutrition, health advice

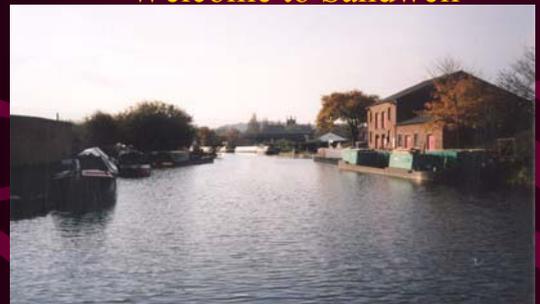
The 'Health dividend' King's Fund, 2002 ,
good corporate citizenship and community regeneration



Welcome to Sandwell



Welcome to Sandwell



Neptune forge 1930



Neptune health park, 1999



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- Peer education- Young people- sex and relationships 1996-present :350
- 'Age well' -older peoples health and social care rights advocacy, services : 50
- Health profilers- Community health research: 30
- Stop smoking advisers: 8 formally employed; 30 community trainees
- Community nutritionists: community café workers 5,
- Food interest groups: 10 x 8 people
- Safe Cycling supervisors:16
- Health walk supervisors: 10
- Gentle exercise programme leaders for older people: 24
- Community health advocates-the community health network : 6
- 'Expert patients' West Bromwich and South Asian projects: 20

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Sandwell development- piece meal and ad hoc

- Sandwell Health Forum- priority re teenage pregnancy and peer education programme 1995-1998
- Sandwell Health Action Zone principle- to create as much employment as possible for local people 1998-2003
- Towards 2010 health service rebuild sets regeneration of the community at the centre of policy 'good corporate citizenship'
- Holly Lodge School, Smethwick approved for first English 'NHS school' March 2005.

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Sandwell development- piece meal and ad hoc

- Volunteering
- Sessional workers
- Paid employed workers
- Promotion

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Young people's peer education programme

Sandwell sexual health peer educators in action



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Jason Evans, 26

Peer education volunteer 1996
Peer education group leader 1997
West Hill College Degree in community development
Senior health promotion officer 1998-99
Community development specialist 1999-2001
Community economic development specialist, 2001-2005
Locality manager for Tipton, 2005



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'Agewell'

Health and social care rights and advocacy, skills development and services

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Edna Barker, 71

Retired admin worker
'Agewell' volunteer 1999-
Employed via Health Action zone 10 hours a week for 12 months 2003
Community development worker with older people in Wednesbury to April 2006
Training courses in evaluation, combatting ageism and discrimination



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'Silver surfers' at the Sandwell Independent Living centre



**Learning disabilities –
'Options for life' -a
self build housing
project**



**Sandwell healthy living
network :**

Food, fitness, feelings and
finding out

**Sandwell healthy living network
Fitness related projects**

Healthy walks
Safe cycling
Gentle exercise for older people including 'Extend'



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Increasing the supply of healthier food in Sandwell



From this....

...to this



Increasing demand for healthier foods

Food interest groups will provide a focus for *conversation* and *decision-making*

between...health professionals, community groups, schools, food businesses and local residents.



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Salop Drive
Community
agriculture project



Salop drive cucumbers



Salop drive and Ideal for All Growers



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'Tipton Tim', 25
Volunteer, Salop Drive Community agriculture scheme, 2000
Trainee 2001
City and Guilds qualifications in Horticulture 2004
Chief gardener 2005



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Ali Al-Osaimi, 30
Biomedical sciences degree
Drugs and young people study in the Yemeni community, reported 2001
Yemeni community association health needs profile 2001-02
Community health network manager 2003-



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Sandwell Community Health Network
Workers in Indian, Pakistani, Yemeni, Bangladeshi, Irish and African-Caribbean communities- community advocacy and health information
SSATHI- the South Asian health projects
Structured health promotion programmes and expert patients programmes in diabetes mental health and coronary heart disease
Sandwell Public Information Network (SPIN)
Central web based and other health information services with information workers in community and voluntary sector



Sandwell Community health network and Sandwell South Asian health projects (SSATHI)



Health Trainers



- Choosing Health - Personal Care workforce
- Responding to public demand
- Based on smoking cessation advisors
- “Spearhead” PCTs leading the development from 2006-7

The role/remit of Health Trainers



- Personal, tailored advice and support
 - Lifestyle and wider issues
- Work with motivated individuals
 - Part of primary care services
 - Accessible to whole community
- Health Trainers in Sandwell are additional and complementary to existing roles – health assessors, walk leaders, community advocates



ASPHER 2005: Growing the public health workforce in Sandwell, UK

Sandwell future development

Head of public health workforce development April 2005

Lead for health trainers

Early implementer for English health trainers initiative September 2005

Developing competency training for public health practitioners

Training general NHS workforce

Developing other public health roles eg. Exercise, food, health information

Willingsworth High School bidding to be the second in Sandwell, by September 2006

Implement Public health and primary care practice unit in new Lyng Health Centre with Birmingham University

Evaluate programme



THE CHALLENGE OF BOLOGNA: THE EUROPEAN PUBLIC HEALTH TRAINING IN TRANSITION

Roza Adany, adany@jaguar.dote.hu
School of Public Health, University of Debrecen, Debrecen, Hungary

Purpose

The Bologna Declaration, which has been signed by the Ministers of Education of 29 European countries in 1999 in order to establish the European area of higher education by 2010, represents the greatest challenge and opens new vistas in the field of public health education, too. More and more European countries join to the Bologna Process, together with countries signed up at Bergen (the site of the 4th Bologna ministerial conference), making a total of 45 participating countries. The aim of the process is to make higher education systems in Europe converge towards a more transparent, more flexible and easily comparable system which the different national systems would use as a common framework based on three cycles bachelor, master and doctorate trainings.

Introduction

Concerning the European dimensions of public health activities the achievement of greater compatibility and comparability of the systems of public health education in Europe has a special importance. With full respect for the diversity of societies and their public health problems, as well as for the autonomy of universities, a framework proposal attractive to the member schools should be developed by ASPHER.

Methods and materials

As an example and good basis for discussion the Hungarian system developed can be proposed for consideration and adaptation by other Schools.

Results

The BSc in Public Health programme (240 credits) provides training in the basic public health disciplines and develops skills for useful participation in implementation of public health programmes. The master training in public health is based on an advanced core curriculum (60 credits) and divides into different directions (additional 30 credits): MSc in public health, health promotion, environmental health and epidemiology. The MSc degrees earned should guarantee competencies for planning, developing and evaluating public health programmes and activities, and qualify the graduates for leading positions in health and public health services. It seems to be important that in addition to master's level degrees, Schools must offer at least one doctoral degree. In the framework of postgraduate training, which prepares students to conduct high-quality, independent, collaborative research and policy analysis by offering multidisciplinary, applied research opportunities on a wide variety of topics, doctorate (PhD) degree in public health (180 credits) can be obtained.

Discussion and conclusion

The acceptance of credits among bachelor and master programmes in the field of health sciences guarantees the students mobility when their performance has been satisfactory and the credits to be transferred are appropriate to the receiving public health courses.

Keywords: Bologna process, three-cycle training, credit transfer

THE CHALLENGE OF BOLOGNA

THE EUROPEAN PUBLIC HEALTH TRAINING IN TRANSITION

Róza Ádány



School of Public Health
Medical and Health Science Center
University of Debrecen, Hungary

THE EUROPEAN HIGHER EDUCATION AREA

Joint declaration of the European Ministers of Education

Convened in Bologna on the 19th of June 1999



Joint declaration of the European Ministers of Education in Bologna on the 19th of June 1999

a key document which marks turning point in the development of European higher education and reflects a search for a common European answer to common European problems



Bologna Declaration

ACTION PROGRAMME

Goal: to create a European space for higher education in order to enhance the employability and mobility of citizens and to increase the international competitiveness of European higher education

Bologna Declaration

ACTION PROGRAMME

Specified objectives:

- the adoption of a common framework of readable and comparable degrees
- the introduction of undergraduate and postgraduate training
- ECTS compatible credit systems
- European dimension in quality assurance
- elimination of remaining obstacles to the free mobility



Ministerial conferences for the Bologna Process

2nd (2001) Prague „Towards the European Higher Education Area“



- Bachelor training
- accreditation schemes for higher education in Europe



Ministerial conferences for the Bologna Process

3rd (2003) Berlin „Realising the European Higher Education Area“



- Master level degrees
- ECTS
- joint degrees



Ministerial conferences for the Bologna Process

4th (2005) Bergen „The European Higher Education Area – Achieving the Goals“



- eLearning and distance education
- doctoral (PhD) programmes

Types of public health training existing presently in the European Higher Education Area

- BSc in Public Health
- Master in Public Health
- medical specialization in public health and preventive medicine
- inspector in hygiene and epidemiology
- MSc in Public Health
- MSc in Epidemiology
- MSc in Health Promotion
- MSc in Preventive and Social Medicine, etc



The challenge for ASPHER

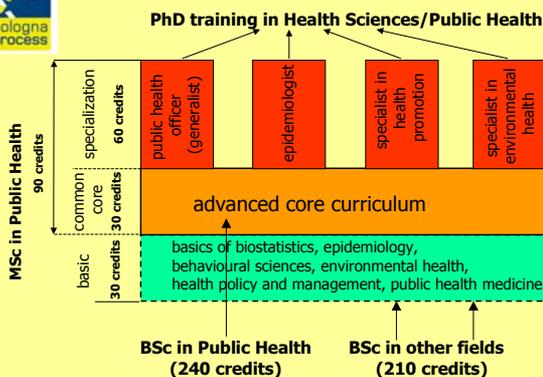
development a framework proposal attractive to the member schools

- structural organisation
- basic elements of the curricula
- competencies (values/appreciation, knowledge and skills) at different levels

with full respect for the diversity of societies and their public health problems/needs, as well as for the autonomy of universities



The Hungarian model for training structure



Outcomes of a European public health training reform in accordance with the Bologna Declaration

- common framework, basic modules, credit systems
- free mobility of students, teachers and (later) employees
- easily readable and comparable degrees
- concerted actions for quality improvement in training
- common research and health promotion actions, etc

CAPACITY BUILDING WITHIN PUBLIC HEALTH

Framework

Outcomes

Organisational development	→ responsive system
Workforce development	→ making „professionalism“ a basic value
Resource allocation	→ actions against inequalities
Partnership development	→ multiplying health gains
Professional leadership	→ sustainability

POSTERS

HEALTH-EXPRESS

Ulrikke Bryde Nielsen, ulrikkevo@m6.stud.ku.dk
The Institute of Public Health, Copenhagen University

Purpose

Only a very small amount of the Danish pupils eats the recommended amount of vegetables. The total daily intake of sugar has increased, and reports show that three out of four schoolchildren eat too much sugar compared to the recommended quantity.

Furthermore the amount of physical activity has fallen dramatically, which will lead to higher risk of overweight among the schoolchildren.

The high intake of calories and a minimum amount of physical activity can result in lifestyle diseases such as metabolic disorder, diabetes, some kinds of cancer and cardiovascular problems. Furthermore some suffer from anorexia, which is relatively common among children. All these illnesses can lead to physical, psychological and social problems. By having this organisation we hope to prevent the diseases and promote a healthy lifestyle

We seek to develop and sustain healthy lifestyle among Danish children from 11 to 14 years by improving their knowledge to healthy food and physical activity. We hope that our teaching will inspire the pupils to realize a health policy for the schools.

Introduction

The “Health express” is an organisation that wants to improve children’s health. The purpose of this organisation is to improve schoolchildren’s health by focusing on healthy food and a greater amount of physical activity.

Methods and materials

We want to teach the pupils at their schools for one day (about three to four hours). By using interactive games we want to inspire the schoolchildren – and hopefully the parents – to have a healthier lifestyle. The plan is to visit 10 schools each semester during the next years.

This project is mainly based on fundraising. We have until now only received a very small amount of money.

The “Health-express” was started by Danish public health students in 2003 and is run on a volunteer basis by students.

Results

We have taught three classes, and the evaluation from these lessons were very positive. During the coming semester we need training to be able to teach more pupils and we need more people to join the organization.

Discussion and conclusion

Keywords: Health promotion, healthy food, physical activity, schoolchildren.

EXPENDITURES FOR HEALTH CARE IN KAZAKHSTAN

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Balabaev, S.H. Elamanova
Kazakhstan School of Public Health, Republic of Kazakhstan

Purpose

This study aimed to provide comparison of expenditures for health care in different population groups.

Background

Modern economic of Kazakhstan is undergoing a new stage of its development. However, it does not reduce the urgency of such social problems as unemployment and poverty. These problems are the outcome of economic recession that took place in 1990-1995. As in other countries with transitional economies inequality in income distribution has increased in Kazakhstan. According to the State Agency of Statistics, in 2003 20% of population with the highest income held 40% of all incomes. Remaining 80% of population held 60% of all incomes. Based on poverty estimate of 4.30 USD established by the World Bank about one third of population in Kazakhstan lives below poverty line. Big gap in income distribution of different population groups determines difference in population access to health care.

Study population

Data were collected by Kazakh School of Public Health as part of the World Health Survey conducted by the WHO in 2002. Questionnaires were filled out by 4484 respondents. For the purpose of this study two population groups were defined: workers and nonworkers. First group included 3258 (72.54%) persons: 456 (10.15%) were state employees, 2122 (47.25%) -not-state employees, 574 (12.78%) - self-employed, 106 (2.36%) - employers. Second group included 1226 (27.35%) persons: 329 (7.35%) were housewives, 255(5.69 %) - unemployed, 4 (0.09%) - volunteers, 69 (1.54%) - students, 454 (10.12%) - retirees, 83 (1.85%) - people with poor health, 32 (0.7%) - other.

Results

Average expenditures for health care in first group were 12,8 USD per month. In second group they totaled 16,0 USD per month. In first group expenditures were as followed: state employees spent 13.4 USD, non-state employees - 12.3 USD, self-employed – 11.5 USD, employers – 29.5 USD. In second group: housewives spent 14.9 USD, unemployed – 10.7 USD, volunteers – 8.2 USD, students – 13.6 USD, retirees – 18.6 USD; people with weak health – 25.6 USD; others – 12.8 USD. Comparative analysis showed that expenditures for health care were approximately the same in first group with the exception of employers who had the highest expenditures of 29.5 USD. However, it did not significantly influence monthly expenditures estimate of first group since the total number of employers was only 2.36%. In nonworkers group the least expenditures were made by unemployed and volunteers: 10.7 USD and 8.2 USD per month respectively. The biggest expenditures were made by retirees and people with weak health.

Discussion

Low expenditures in unemployed and volunteers do not indicate good health but rather reflect financial inaccessibility of health care as the result of lack of stable source of income. High expenditures in retirees and people with weak health can be explained not only by poor health but also by hardship allowance and pension benefits that they receive from the state.

Keywords: Population, expenditures for health care, Kazakhstan.

BASELINE QUALITY OF LIFE SURVEY FOR THE EVALUATION OF SUPPORT TO MOBILE MEDICAL TEAMS PROGRAM IN LORI AND GEGHARKUNIK, ARMENIA 2004

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Arax Hovhannisyan
World Vision Armenia

Purpose

This study assesses pre-program level of health related quality of life of population in those regions where Medical Mobile Teams (MMT) program is implemented.

Introduction

Support to Mobile Medical Teams is a five year program to provide access to primary health care for isolated communities in Lori, Gegharkunik, Tavush and Syunik through Mobile Medical Teams, strengthening village level health structures and building links to district hospital for improved referrals.

MMT project strives to improve quality of care it provides through continuous comparisons of health care outcomes data over time. During the past decade, one of the more important achievements in the health care field has been the identification of the value of the patient point of view in monitoring the quality of medical care outcomes.

Methods and materials

A baseline Quality of Life (QOL) survey of 300 households in each region in 14 Lori and 12 Gegharkunik MMT villages was conducted in September-October 2004. The follow-up survey will be conducted in four years (at the end of the program) to measure the effectiveness of the program in improving functional status, well-being and overall quality of life of population served by MMTs.

A pre-post independent sample design was utilized. A weighted Simple Random Sampling stratified by residence and age was used. MMT population census records for each village were used as the sampling frame. The study participants were men and women aged 18 and older.

This study used International Quality of Life Assessment (IQOLA) SF-36 Armenian Standard Version as survey instrument. Information was obtained during interviewer-administered interviews.

Data were analyzed using SPSS 11.0 software. Data analysis was performed based on the guidelines developed by Health Assessment Laboratory (HAL)

Results

A total of 603 people participated in survey, 304 in Lori and 299 in Gegharkunik. The mean age of participants in Lori was 45 years and in Gegharkunik was 45.5.

In both regions quality of life indexes decreased with aging. In Lori population mean scores for all health domains were higher in women compared men, except physical functioning score. While in Gegharkunik population mean scores for all health domains, as well as both summary measures (Physical Component Summary (PCS) and Mental Component Summary (MCS) scores) were higher in men compared to women.

Comparing populations from two surveyed regions, mean score of mental health, social functioning, and bodily pain were significantly higher in Gegharkunik population, while vitality mean score was higher in Lori population. Assessment of physical status by residence revealed the lower PCS mean score for Gegharkunik population, while assessment of mental status showed the lower MCS mean score for Lori population.

Quality of life components in surveyed population were compared to the norms for the US general population. The mean transformed scores for all health domains were significantly higher in US general population.

Discussion and conclusion

Baseline QOL survey revealed that quality of life scores in Lori and Gegharkunik populations were low. Comparison of quality of life scores in both surveyed region showed that Lori population was more prone to frequent psychological distress, substantial social and role disability due to emotional problems. While Gegharkunik population was more prone to limitations in self care, physical activities, as well as to frequent tiredness.

Comparison of the main components of quality of life of surveyed population with the US general population norms revealed that population in surveyed regions had more problems with work or other daily activities as a result of both physical and emotional problems.

Keywords: SF-36, quality of life, general population

TITLE: MIDWIVES' SUPPORTIVE ROLE IN PREVENTION OF POSTPARTUM DEPRESSION

Roshanak Hassan Zahraei, rh_zahraei@yahoo.com
Student of Esfahan Medical University, Iran

Purpose

This research was conducted to determine the supportive role of the midwives in prevention of postpartum depression

Introduction

Postpartum depression is a mood disorder in women's reproductive period that has adverse effects on the mother- baby relationships, well as relationships between couples.

With respect to postpartum depression unpleasant effects, prevention from this disorder seems essential and practical and effective preventive ways should be detected. This research was conducted to determine the supportive role of the midwives in prevention of postpartum depression

Methods

This research is a quasi experimental study and the samples of this research were composed of 100 primiparus women in the Beheshty hospital of Isfahan. The sampling method was systemic randomization.

The subjects filled out a questionnaire consisting from two parts. The first part was related to demographic specifications and the second part was the Edinburgh postpartum depression inventory. Data analysis has been done by SPSS statistical soft ware.

Results

Mean depression scores in the two groups (supported and unsupported) were determined. Mean score of depression in the supported group was 9.439 and for unsupported group was 12.60 having a significant statistical difference. ($P=0.004$).

Discussion

According to the findings, support is a very effective factor in the prevention of postpartum depression in the participants and the midwives' supportive care significantly reduces postpartum depression.

Keywords: Key words: Supportive role of Midwives. Prevention, Postpartum depression.

COMPARATIVE STUDY ON THE EFFECT OF OCCUPATION AND SOCIO-ECONOMIC STATUS OF MOTHERS ON THEIR CHILDREN'S HEALTH TREND

Ahmad Ali Bozorgzad, ahmad_bozorgzad@yahoo.com
Roshanak Hassan Zahraei
Phd Student of Islamic Azad University
Najafabad

Purpose

Comparative Study on the effect of Occupation and Socio-economic Status of Mothers on their Children's health trend.

Introduction

Nowadays woman play active major roles in scientific, artistic, social, economical and political fields of life as well as other domains of human life.

Regarding their important responsibilities in the society pregnant women's health as well as their infant's as a susceptible class of society look crucial especially for those mothers working out of home with double hard responsibilities.

Low weight infants and premature delivery as noticeable problems of this century can both cause mortality, IQ changes, nervous complications in children or even mental retardation, behavioural disorders, cerebral plays and visual and audial disorders.

Former Studies have reported working pregnant mothers with Socioeconomic problems may have low weight infants or early delivery. So the researchers decided to carry out a research in which the effect of mothers, occupation and socioeconomic status on the weight and time of delivery in women between 14 to 49 years of age referring to all hospitals in Isfahan city of Iran in 2004 was investigated.

Methods and materials

This is an analytic cohort study on 2101 subjects randomly selected from women aged 15-49 years referring to delivery wards in all hospitals in Isfahan from march 20, 2004 till August 22, 2004.

There were five groups of study as 1- group one, 1611 housewives, 2- group two, mental physical occupations, 94 subjects, 3- group three, hard physical occupations, 38 subjects, 4 group four, mental occupations, 219 subjects, 5- group five, easy occupations 139 subjects.

Data collection tool

All medical files, interviews, observations, filled questionnaires were used to analysis the data by descriptive statistical method one way ANOVA , multi variable Regression analysis and logistic Regression Test, etc.

Results

There was a significant difference between the infants' mean birth weight in group 2, 4 and 5 comparing group 1.

- There was a significant difference between the birth age in group 4 comparing group 1. (Table 1,2,3)
- There was an invert significant association between birth weight and mothers' educational degree ($p=0.008$).

- There was a significant difference between the variables as type of mothers' occupation ($P < 0.001$), working shift ($p = 0.001$), working type (mental, physical, both $p < 0.001$), mothers' socioeconomic status ($p = 0.001$) and birth age and weight. (Table 4, 5).

Discussion and conclusion

Regarding the finding of this study, the average mean of working time for women working in physical and mental occupations is recommended to be decreased;

Working in different shifts is recommended to be omitted for pregnant women due to its negative effects on birth age and weight. A longer leave with no payment decrease is recommended for pregnant women during their pregnancy to diminish their occupational stress pregnant women are recommended to be supported with enough maternal care concerning appropriate nutrition and a better fetus weight gain.

Keywords: socioeconomic, fetus weight, occupation

A REVIEW OF QUALITY ASSURANCE IN THE GERMAN HEALTH SYSTEM: A COMPLEX TRANSITION PROCESS

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Jrgen Breckenkamp; Christiane Wiskow
University of Bielefeld

Purpose

The interest in quality assurance and management in health care has increased in the last decades as the financial crises in most health systems generated the need for solutions to contain costs while maintaining quality of care. In Germany the development of quality assurance and management procedures has been closely linked with health care reforms. Starting in the early nineties quality assurance and management issues gained momentum in reform legislation only 10 years later.

This review summarizes recent developments in medical quality assurance as related to the federal reform legislation in Germany. It provides an overview on the infrastructure and actors and of the current discussion concerning quality assurance in medical care.

Germany had to catch up on implementing quality assurance and management in the health system compared to other countries. Considerable progress has been made, however, it is recognized that the full integration of quality assurance and management will require long-term commitment in developing methods, instruments and communication procedures. The most ambitious project at present is the development of a comprehensive comparative quality assurance system for hospitals at national level, including public reporting. For the time being medical quality assurance in Germany is dealt with as a technical and professional issue while the aspects of patient orientation and transparency need further advancement.

Keywords: Quality assurance, quality management, medical quality, German health system

A REVIEW OF THE EVIDENCE FOR LONG-TERM USE OF NICOTINE REPLACEMENT THERAPY (NRT)

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Purpose

The aim of this review is to assess the prevalence of long-term use of NRT ≥ 1 year, and the average daily doses of NRT at twelve month after smoking cessation.

Introduction

Smoking is the greatest cause of preventable morbidity and mortality in the western world, making smoking cessation an urgent priority. In 1984, nicotine gum became the first medication approved by Food and Drug Administration (FDA) for smoking cessation.

Little is known about how common long-term gum use is in routine clinic programs. This information is somewhat difficult to come by.

The accessibility of NRT products are increased in Denmark during the last years. According to Lgemiddelkataloget we can expect prolonged use of NRT amongst 1-2 % whereas a cross-sectional survey finds 23 % long-term users. Therefore it seems relevant to look at the prevalence of this long-term NRT use.

Methods and materials

The clinical trials of NRT are identified by using four search strategies. Fifteen peer-reviewed articles are selected and examined.

Results

The prevalence of long-term gum users (≥ 1 year) shows that 20 to 25% of those who remain free of tobacco for one year may continue to use the gum. The average daily dose of gum at twelve month after smoking cessation is two to seven pieces 2 mg. gum. pr day. And the number of doses used pr day is stable over time even up to one year. These results, however, may be less informative for real-world situation. A Cross-sectional survey shows that long-term use of NRT is expected for 23 % and at the same level as for former smokers, irrespective of a success with smoke cessation

Discussion and conclusion

There is a fair identity between the results found in the literature for the extent of long-term use of NRT at the level of 20 to 25 % for those who remain free of tobacco. Also the daily doses of two to seven pieces gum are broadly supported. The studies however show a great numbers of loss to follow-up. There is clearly a need for more research in the area of the long-term use of NRT for treating tobacco dependence and preventing relapse. NRT is well tolerated when used for the short term, but more data are necessary on the safety of their long-term use.

Keywords: Smoking Cessation, Long-term use of NRT

**DEVELOPMENT OF AN USEFUL EVALUATION METHOD OF SHORT-TERM POST-EDUCATION COURSES FOR HEALTH PROFESSIONALS.
SYSTEMATIC EFFORTS IN HEALTH COUNSELLING A POST-EDUCATION COURSE FROM THE CLINICAL UNIT OF HEALTH PROMOTION IN HOSPITALS**

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Purpose

The purpose of this project is to find the best method of evaluation, which is possible for The Clinical Unit of Health promotion in hospitals, to use in the daily clinical work, to evaluate the post-education, SEH. The purpose was partly to evaluate if the post-education course was in agreement with the purpose for the education, and partly to research how a multiple choice test can be used as an evaluation tool, to evaluate if the participants expand their knowledge.

Introduction

There is no tradition for evaluation of short-term post-education courses for health professionals. The evaluations performed today evaluate/measure how those who participate in the course react to it.

The Clinical Unit of Health Promotion in Hospitals, Copenhagen, has developed post-education courses for health-professionals. One course, the Unit offers, is Systematic efforts in health counselling (SEH). The purpose of this post-education course is to develop the competence of the health professionals to carry out health counselling with patients and to expand the knowledge of the health professionals within clinical health promotion.

Theory

In 1959 Donald Kirkpatrick developed the evaluation-model The Four Levels. It describes four different levels of measuring effects of an educational course: The Reaction-, Learning-, Behaviour- and Result-level. It is one of the most used evaluation models in industrial organisation, where the employers are post-educated. According to Kirkpatrick, there is a one way causal connection between the levels, from the Reaction-level to the Result-level. The evaluator can also decide only to evaluate effects on one level.

The evaluation model is useful for evaluating the effects on SEH, but it has some limitation. The model does not take personal and contextual factors into account.

Method

Using the The Four Levels we chose to evaluate the effects on the Learning level. We chose only to evaluate the effect of expanded knowledge and we found that the most validated tool was a multiple choice test.

The other half of the project accounts the development of the concrete multiple choice test we used for the post-education SEH. We made a pilot-test of the multiple choice test to see how it performed in practice. We chose to give the multiple choice test as a post-test. We had a control group to measure the general knowledge of health professionals, who have not participated in the course.

Results

The results of the pilot-test showed that evaluation works in practice with a multiple choice test. All the participants filled in the multiple choice test. But the answers of the participants and the control group were alike and the proportion of correct answers was very high in both groups.

Conclusion

To evaluate the knowledge of participants with a multiple choice test as a post-test works in practice, but the contents of the test as well as the pilot test-design have to be adjusted, before The Clinical Unit of Health Promotion in Hospitals can use the test in the daily clinical work. A long-term goal will be that the multiple choice test will be implemented in the post-education course SEH and the use of the test will be expanded to other post-education courses for health professionals.

Keywords: Evaluation, Clinical post-education, multiple choice test

THE EXPERIENCE OF DEVELOPMENT OF EVIDENCE-BASED CLINICAL PRACTICE GUIDELINES

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Purpose

In 2000 the Expert Committee of leading specialists in various branches of medicine has been organized by the HealthCare Agency of the RK. The purpose of Committee's activity is development of evidence-based clinical guidelines.

Introduction

Within the framework of this project the group of methodologists for the collecting and the analysis of existing scientific researches was organized in the field of developed clinical guidelines.

Methods and materials

The Expert Committee defined five diseases (myocardial infarction, stroke, pre-eclampsia, acute appendicitis, tonsillitis) on the basis of parameters of level of morbidity, hospitalization, mortality of the population, cost and expenses of treatment. The development of clinical guidelines on chosen themes has been started.

Results

The primary goal was systematic search of information. We performed the review of existing randomized-controlled trials, cohort and cross-sectional studies, meta-analyses, case – control studies, evidence-based clinical practice guidelines, systematic reviews.

During search the following Internet databases were used: Cochrane Collaboration, PubMed library and the specialized thematic Web-sites.

About 200 specialized databases were overlooked and 60 clinical guidelines, about 300 randomized-controlled trials executed since 1992 were selected. Full text of 45 clinical guidelines and 30 randomized-controlled trials were received.

Discussion and conclusion

The appraisal of each selected scientific work was carried out on the basis of Evidence Table Templates designed by Scottish Intercollegiate Guidelines Network.

Thus, at present time the development of National clinical guidelines is at a stage of critical appraisal of the selected scientific data.

Keywords: EBM practice guidelines

**DENTAL PUBLIC HEALTH AND ORAL HYGIENE AMONG THE YOUNGEST
POPULATION IN MACEDONIA INCORPORATED IN THE TEACHEING CURRICULUM
BY THE MINISTRY OF EDUCATION**

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Purpose

Enhancing public, especially parents and children awareness of the extremely low quality of oral hygiene and the urgent need to improve the youngest children interest for their health thus the dental health as part of it promotes new healthy dental habits, which in a way is the purpose of this study.

Introduction

Research taken from January to February 2005 shows that the oral hygiene among the youngest was on a satisfactory level (almost 90% of them brushing teeth and learning to floss) only in the biggest cities, while the results in the smallest towns and the rural surroundings were very disappointing. Only 17% of the children had their own tooth brush, 20 it% was shearing with the other siblings or the parents but only 3-7 % were using it on an everyday basis. Using the authority of the Ministries of Health and Education and the growing linkage between them and the School for public health, a voluntary based dental health promotion was introduced in 5 kindergartens and 3 elementary school as a pilot program

Methods and materials

A small pilot program was launched in which we used the drawings of the students from the elementary school (on oral hygiene themes) to promote dental health in the kindergartens also using big plaster models (jaws, tooth, etc) and huge tooth brush to show the proper way to brush the teeth. We organized small competition "the whitest tooth" and gave presents such as small tooth paste and tooth brushes. We were supported by both Ministries (of health and Education) with leaflets and approval. For the students from the elementary school a visit to the dentist was organised were the check- up their teeth and try doing it to one another.

Results

The results were excellent. The children continued with their competitions and the use of the tooth brush becomes a routine. Only few (6) among the students from the elementary school didn't use the brush but the result from the kindergarten was 100% use.

Discussion and conclusion

Although it was conducted among very small and closed group of population, it was obvious that the habits are learned and easily accepted while young. The support from the policy makers is essential for the success of any program. Incorporating such health promoting programs in the children and students everyday' routine is of benefit both for them as well as for the community.

Keywords: dental, policy, link

THE RELATION BETWEEN RESEARCH AND POLICY ON DRUGS – HOW WAS AND HOW COULD BE

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Purpose

The goals of the study are:

To analyze the history of policy and research development in the area of drugs in Romania, to explain the evolution of it, to consult the experts in the field to give their insight, understanding and perspective about the process itself in which are involved, to show that the policy process cannot be evidenced based if do not exist an awareness about the importance, benefit of relying the decision making process on such approach, an active and continuous connection efforts bringing together various type of professionals and a willingness to pay research.

This target can be reached building the institutional capacity to create, motivate professional teams, adding in training process beside the technical aspects, the understanding about how global, deeply interconnected and determined are the different levels of society. Facilitating and strengthening this perspective, public health can harmonize his roles of knowledge driven, problem solving and social interaction

Introduction

It is assumed that the policy-making is better if it is research- informed but for this the existence of appropriate mechanisms and networks is essentially needed.

Methods and materials

Case study including: document analysis on main laws, formal papers of policy and strategy issued in the field of drug policy in Romania; in depth interview with key-informants represented by decision makers, researchers, providers of services, journalists; focus group with researchers and public health trainers, review of scientific reports elaborated in this area.

Results

From chronological perspective the research in the area came when structures and functions already existed. The theories and models dominating the interventions were imported and the training and gaining expertise were mostly assured by international agencies. The funds allocated to research were generally limited and received with delay accordingly with data collection requirements; institutions providing research made in kind efforts at financial, human and technical resources. The dissemination of findings remained limited. The policy makers – beyond the lack of continuity of their position influenced by election and professional dynamic dislike the delay till the launching of the final report, the hermetic style of data, and the fact that the information is not translated in answer to policy questions. The scientific world, showed reluctance towards the attempts of providing findings in a more “friendly” manner accusing diminished accuracy. The researchers experienced beyond research process related difficulties (lack of appropriate soft, of sufficient human resources) an attitude of indifference, hostility and methodological prejudices. Some findings were not accepted from political or social point of view. It is perceived the need about searching and analyzing more the reality of drugs phenomenon, the distance between formal and informal data but there is no real support in providing data.

Discussion and conclusion

To increase the national research input in national policy development, specific connection should exist between various institutions and more clarification about everyone role. The public health training should enlarge, complete the curriculum, the audience; the understanding about political, social interfaces of different phenomena should be taught before or simultaneously with others disciplines and promoted as basic knowledge not as advanced. Researchers working in the area of public health should learn to make the decision makers their allied, to acquire the capacity of involving and impressing more the decision makers. Specific features and limitations of research in drug fields (sampling, data collection), the speech and argumentation technique, communication skills should be developed. A general awareness about the importance of need assessment and intervention evaluation should be built. Not in the last, when international expertise is offered, the national institutions should pay more attention in creating and assuring the further sustainability.

Keywords: policy, research, drugs

CARDIOPROTECTIVE MEDICATION USE IN POST MYOCARDIAL INFARCTION PATIENTS AT NORK-MARASH MEDICAL CENTER

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Purpose

The purpose of the study was to evaluate the level of adherence to the existing treatment guidelines for prescription of different groups of cardioprotective drugs to post-myocardial infarction patients and to identify factors predicting the prescription of cardioprotectors to post-myocardial infarction patients at the Adult Cardiology Clinic.

Introduction

Patients with a history of myocardial infarction remain at high risk for recurrent cardiovascular events and mortality. Secondary prevention improves survival and decreases the risk of recurrent events in these patients. Recent treatment guidelines recommend universal prescription of antithrombotic agents, beta-blockers, angiotensin-converting enzyme inhibitors (ACEI), and statins to all patients with a history of myocardial infarction unless contraindications exist. This study was conducted in the scope of American University of Armenia and Nork-Marash Medical Center (NMMC) collaborative Quality Assurance Project to assess the situation with prescription of cardioprotective medication in post-myocardial infarction patients at NMMC.

Methods and materials

A cross-sectional record-review study of cardioprotective medication prescription in post-myocardial infarction (MI) patients was conducted at the Adult Cardiology Clinic (ACC) of the NMMC. The inclusion criteria were patients diagnosed with coronary artery disease with an acute myocardial infarction or a history of prior myocardial infarction. Records of all 133 patients with myocardial infarction whose primary visit to ACC was during 2004 were reviewed. The prescription rates were calculated with inclusion of only those patients having no contraindication for the given group of medication. For each group of medications, the factors significantly associated with prescription rates were found through logistic regression analysis using STATA 7.0 software.

Results

The prescription rate for aspirin was 96.1%, beta-blockers 60.8%, angiotensin-converting enzyme inhibitors 60.2%, and statins 13.6 %. The prescription patterns of statins were improved as compared to the available data from 2003 (6.3%, $p=0.03$). The only factor significantly associated with aspirin prescription patterns was gender of patients with less frequent prescription in women. No significant predictors were found for prescription of beta-blockers. Hypertension and ejection fraction < 40 were significant predictors for ACEI prescription. Stent placement and cholesterol testing were significantly associated with prescription of statins.

Discussion and conclusion

In terms of adherence to the existing treatment guidelines for post-MI patients, the study revealed a considerable treatment gap for statin prescription. The rates of ACEI and beta-blockers prescription were higher, but still lower than the recommended levels. The highest extent of adherence to guidelines was observed for aspirin prescription. Comparison of prescription rates of cardiovascular drugs in post-MI patients across different institutions showed higher prescription rates for beta-blockers and ACEI at NMMC as compared to several western outpatient clinics. The rates of statin prescription were lower than that reported from the majority of western outpatient settings. Several

hypothesis were suggested to explain the treatment gaps of cardioprotective medication prescription, such as low affordability of drugs, focus of ACC providers on invasive procedures, and unsatisfactory exposure of providers to recent evidence-based guidelines recommending broader indications for cardioprotective medication prescription.

Keywords: cardioprotective medication, myocardial infarction, prescription

RISK FACTORS ASSOCIATED WITH THE DEVELOPMENT OF ATOPIC DERMATITIS AMONG CHILDREN IN YEREVAN: A CASE-CONTROL STUDY

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Purpose

This study identifies the possible relationship between exclusive breastfeeding, early solid food diet, family history of atopy, and antibiotics exposure during the first year of life and clinical manifestation of AD in children.

Introduction

A number of studies show that breastfeeding offers a safe and effective mode of protection against Atopic Dermatitis (AD) during the first years of life. However, the issue of protective effect of breastfeeding remains controversial. Therefore, further research is needed to confirm these associations.

Methods and materials

A case-control study was conducted among children aged from one to seven years in Yerevan. Cases were selected from Allergy Department of Republican Children's hospital in Yerevan. Controls were selected from pediatric district polyclinics in Yerevan. Information regarding infant and family history and infant-feeding pattern was obtained from the mothers of children during telephone interviews. Eighty-five cases and 155 controls were interviewed. Descriptive analysis was used to determine characteristics of cases and controls. Multivariate logistic regression was used to examine the relationship between AD and study variables and control for potential confounding and effect modification. Scoring system was created for risk factors of AD. Odds ratios and 95 % confidence intervals were calculated by logistic regression to investigate the relationship between risk factors' scores and the development of AD.

Results

The adjusted OR for exclusive breastfeeding less than 3 months and solid food introduction after 4 months of age was 1.16 (95 % CI 0.46-2.97), for exclusive breastfeeding for more than 2 months and solid food initiation during the first four months of life was 1.43 (95 % CI 0.47-4.32), and for exclusive breastfeeding less than three months and solid food initiation during the first four months of life was 10.99 (95 % CI 2.93-41.29) compared to exclusive breastfeeding for more than four months.

Family history of atopy, surroundings without parks or gardens and antibiotics exposure were strong risk factors for AD. Allergy of father seemed to be stronger risk factor for the development of AD in children than allergy of mother. Highest risk (OR=17.92; 95% CI 3.18-100.90) for AD was for children from families with double atopic risk. We found potential effect modification between allergy in mothers and antibiotics exposure during the first year of life.

The risk of development of AD increased with increasing of final risk factors' score. The odds ratio increased from 3.4 (95 % CI 1.43-9.56) for lowest score to 43.76 (95 % CI 14.57-131.49) for highest score.

Discussion and conclusion

This study indicates that not early cessation of exclusive breastfeeding and nor early initiation of solid food separately could be the risk factors for the development of AD during the first seven years of life. The combination of these two factors increases the risk of AD almost ten times.

Exclusive breastfeeding for at least 3 months should be recommended for all infants to prevent development of AD. When exclusive breastfeeding is impossible solid food should be avoided during the first 4 months of life.

For children from families with atopic risk exclusive breastfeeding at least 3 months and avoidance of antibiotics exposure become particularly crucial. General practitioners should avoid baseless prescription of antibiotics to children with family history of atopy.

Keywords: atopy, children, breastfeeding

A MULTIDISCIPLINARY TEAM EVALUATES THE POTENTIAL EFFECTS OF LOCAL PROGRAMS ON THE HEALTH OF THE POPULATION THROUGH HEALTH IMPACT ASSESSMENT (HIA)

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Purpose

To assess the potential effects of local policies and programs on the health of the population, on that of the environment and of animals, through a multidisciplinary team approach, providing to local politicians the scientific evidence on which to base their decisions.

Introduction

Politicians and administrators generally proclaim that citizens and their well-being are at the heart of their work but often this is not the case. HIA offers an innovative approach for evaluating policies and programs based on scientific evidence and congruent with the population comprehensive health needs. Regardless of the sectors they originate from, HIA assesses decisions influence on the health and on the quality of life of the target population.

Methods and materials

CEFPAS, the Centre for Training and Research in Public Health of the Sicilian Regional Government, is implementing a HIA initiative in the province of ragusa, Sicily. This 2 year project evaluates province and town determinations that may have an impact on local populations health.

The project focuses on the integration of individual and public health interventions and uses operational platforms placed at community level that become natural bases for alliance negotiation and synergy development. The multidisciplinary team is composed of politicians, economists, GPs, hygienists, specialists, veterinarians, farmers, environmentalists, representatives of citizens groups and CEFPAS personnel. The population representatives have a proactive role in the management of the assessment process and in the use of its results.

The project is composed of 5 main stages:

- screening: creation of the instrument
- scooping: definition of the assessment process
- assessing: evaluation was carried out
- reporting: elaboration of the recommendations
- monitoring: evaluation of HIA influenced on the decision making process and in its sustainability.

A preliminary stage was carried out in order to flowchart the detailed steps used to approve local determinations. This was necessary in order to decide on the most appropriate time to intervene with the HIA. The instrument of analysis was tested and validated through retrospective assessments.

Results

A set of instruments was developed tested and validated and was used to carry out the first retrospective assessment.

A retrospective evaluation was carried out on two deliberations dealing with:

- waste disposal
- purchase of an electromixer

A document with recommendations was produced and presented to the Mayor and to the City Councillors. Concerning the waste disposal, it was suggested that a safe system to store the special waste laying near the industrial sheds was necessary as the one currently used was considered unhealthy for the population.

The purchase of an electromixer to substitute the existing one in the city purification plant received a positive note from the HIA team because, with this deliberation, the municipality prevented possible negative effects to the environment and to population health. The Mayor welcomed with enthusiasm the initiative and committed himself to continue to support this co-operation asking the HIA team to undertake prospective evaluations on emerging issues.

Discussion and conclusion

Through HIA, politicians and administrators are now concerned about the various health determinants - not only about those strictly related to health services. They also start to appreciate the possibility of carrying out evidence-based decision-making putting the health of the population at the centre of their work.

Public health professionals are enthusiastic to take part in truly preventive efforts in their communities.

The population starts to recognise the benefit of evidence-based information for possible lobbying purposes, to protect their personal as well as their community's health.

Keywords: HIA, managing health policy, alliance and negotiation.

TOWARDS UNITY FOR HEALTH

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Purpose

To diminish fragmentation promoting multi-professional integration in services and care delivery.

Introduction

In Sicily collaboration among different health professionals hasn't been very effective. Cefpas is implementing this project in the Ragusa Province. It was developed in response to the preoccupations expressed by WHO of the heavy fragmentation in services delivery with consequent non co-ordinated, ineffective/inefficient results.

Methods and material

The project consists of 3 micro-projects:

- 1) Sustainable partnership between Hospital Specialists and General Practitioners to rationalize GPs requests of hospital services, satisfy population's needs, reduce wastes, optimize resources and improve the quality of services.
- 2) Prevention/control of Brucellosis through a sustainable partnership among health professionals and empowered Animal Breeders.
- 3) Health Impact Assessment (HIA): to assess the potential effects of local policy/programs on the health of the population, through a multidisciplinary team approach, providing local politicians with the scientific evidence on which to base their decisions effectively.

For integrating individual and public health interventions, operational platforms at community level are used as natural bases for alliance negotiation and synergy development.

Results

- 1) The first data collection on GPs prescriptions shows:
 - hospitalizations requested by GPs: only 3% - to be increased as GPs should filter appropriate hospitalization demands;
 - appropriate hospitalizations: 96% - highly appropriate;
 - CAT scans for suspected neoplasia done within 7 days: 72% - to be increased;
 - protein electrophoresis: 18% - to be reduced.
- 2) 100 questionnaires were administered to animal breeders to acquire information on their knowledge and behaviour related to Brucellosis. Analysis is underway.
- 3) A retrospective evaluation was accomplished on deliberations dealing with:
 - Waste disposal
 - Electromixer purchasing

A document with recommendations was presented to the local Government.

Discussion and conclusion

Reducing fragmentation improves cost-effectiveness and contributes to overall health. This project was greeted with enthusiasm by all stakeholders, who have worked well together in an atmosphere of fruitful collaboration.

Keywords: Integration, reducing fragmentation, common platform

MANAHEALTH – EXTENSION AND PROMOTION OF EUROPEAN PUBLIC HEALTH AND MANAGEMENT TRAINING INITIATIVE

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Purpose

The objective of the presentation is to demonstrate the new EU project which has in view further promotion and dissemination of EUROPHAMILI training course.

Introduction

Three successful sessions of EUROPHAMILI course in 3 consecutive years (2002-2004) made possible to apply to European Commission for new Leonardo da Vinci grant. The main task for MANAHEALTH project is enlargement the group of countries participating in training procedure to enrich the transnationality. Academic/professional partnership and innovative permanent education for a European health management is demanding of time. Bringing closer together professionals in public health management and the actors who are in charge of their initial and continuing education, improving quality and access to professional continuing education by using innovative ways of teaching are the aim of new project

Methods and materials

Very important is also widening the application of Europhamili results through a transfer and adaptation of products, tools and methods towards new geographical zones and new publics. The programme has been built on enlargement of the European Network of Schools of Public Health AESCULAPIUS. That has to be done through including new partners from various origin countries. Among new participants there are Bulgaria, Lithuania, Spain and Ireland.

New teachers from all participating countries have to be included in the process of training.

Very important is also widening the application of Europhamili results through a transfer and adaptation of products, tools and methods towards new geographical zones and new publics.

The programme has been built on enlargement of the European Network of Schools of Public Health AESCULAPIUS. That has to be done through including new partners from various origin countries. Among new participants there are Bulgaria, Lithuania, Spain and Ireland.

Results

New teachers from all participating countries have to be included in the process of training. Therefore methodological session for this group of teachers has been organized to share the experience of former Europhamili staff and discuss all aspects of education. After that session all new teachers have been involved in Teaching Unit they were interested in starting 2005 session.

Discussion and conclusion

Europhamili project was the pilot initiative which requires further promotion. There is a great need for innovative and accessible training tools especially within an enlarged European Union and Easter and South Europe. Health systems are confronted with new needs and management skills to work in new environment are essential.

Keywords: public health, international training, health care management

THE FOUNDATION OF THE CENTRE-SCHOOL OF PUBLIC HEALTH IN BELGRADE IN 2005

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on behalf of the C-SPH

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Purpose

The science and practice of new public health have the key role in promotion of people's health and the reform of the health care system. The development of the School within the Medical School and its connection with the University, will provide the School's autonomy on one side, and a multi-professional and interdisciplinary approach on the other side. The mission of the School of Public Health is to improve and preserve the health of people, prevent health disorders and provide an efficient and good-quality health care.

Introduction

The foundation of the Centre "School of Public Health" within the Medical School of Belgrade University is a precondition for the improvement of professional training in public health, provision of a wider scope of skills and a higher level of knowledge needed for solving health priority problems as stated in the Agreement on Cooperation and Understanding, concluded between the Medical School in Belgrade, European Agency for Reconstruction and the Ministry of Health of the Republic of Serbia.

Methods and materials

The evaluation of the programme is the key part of the School of Public Health which is inclined to the international standards and comparability. Thus the elements of internal and external evaluation will be incorporated into the process of the work of the school. The evaluation process will include the following elements: structure (building and the equipment), staff (number, education with the emphasis on the multi-professional skills and ability), contents (the number of courses during one year, ECTS for each course, as well as a detailed curriculum). An important component of the evaluation process will be the estimate of the satisfaction of the students, that is, the opinion of the students, as the key element on which the changes in way of improvement of contents of educational programmes and training will be based.

Results

The development of the School of Public Health will be monitored through a constant support of the panel of international experts and institutions. Development of partnership and joining the network are important elements of the School of Public Health's success. Cooperation with partners will be bilateral and multilateral, national and international, depending on the profile and potential of the institution with which the agreement on cooperation is being concluded. Major fields of cooperation are teaching, work on the theses, scientific-research work (projects, etc.), consultative services, as well as the work on programmes and health promotion activities.

Discussion and conclusion

The C-SPH has excellent chances to become a major centre of Public Health training and research.

Keywords: School of Public Health, Serbia

SIX UNIVERSITIES UNDER ONE ROOF. SSPH+

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Purpose

In Switzerland there are several postgraduate programmes in Public Health training. Currently the Swiss School of Public Health (SSPH+) is being founded. We propose presenting an informative poster on the current status of the development of the SSPH+.

Introduction

In the past decades many developments have occurred in the Swiss Public Health area. After professorships of Social and Preventive Medicine were first introduced at the Swiss universities in the 1960s, the following two decades showed a trend towards a comprehensive Public Health approach. Multidisciplinary contacts were increasingly maintained beyond the narrower field of Social and Preventive Medicine, in particular with the Social Sciences (Health Psychology, Medical Sociology), as well as Health Economics, and other fields of study. In 1990, the first postgraduate training programmes in Public Health began in Switzerland. During 2002-2004 the Network of Public Health and the Network of Health Economics were financed by the Swiss University Conference (CUS) with the aim of strengthening the position of Public Health as a research and training area. The networks developed the concept for a Swiss School of Public Health (SSPH+). Financially, the initiating process is being supported by the CUS during 2005 - 2007.

Methods and materials

The vision is to develop an organisation that will serve as a model for a successful national collaboration in Public Health and related areas in research as well as in scientific and professional training.

The goals of the SSPH+ include

- promoting and developing highest quality of postgraduate training for Public Health scientists, practitioners and leaders
- creating and developing a platform to support discussions, reflection and the diffusion of knowledge
- promoting a stimulating academic environment
- establishing new and strengthening existing collaborative partnerships
- positioning the SSPH+ as a resource to organisations that work on health issues
- organising events that promote the development of a Public Health culture in Switzerland

Keywords: Public Health training, postgraduate, partnerships

THE IMPORTANCE OF SUSTAINABLE PARTNERSHIPS

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Purpose

Cooperation among people and among countries is of utmost importance, especially in public health. Partnerships are the foundation for planning, delivering and evaluating public health. Therefore sustainable partnerships should be created (and maintained)

Introduction

The health research capacity will be enlarged by the strengthening of these international networks. Cooperation on a national level will increase the possibility of evidenced based practice and research capacity but by far not as much as cooperation on an international level will do. Combined knowledge and methodologies could lead to new outcomes and innovative new insights.

Second, health science is a broad field of study. The fields of mental health, social studies and biological research, these subjects are too extensive for one university. With the right partnerships a large field can be covered in an experiment and each university can become more specialized in a specific area.

Besides having the advantage of the best surroundings for the experiment, new ideas, opinions and different methods can be exchanged. These additional perspectives on a subject can be very helpful. The more perspectives and the more opportunities, the larger the number of experimental designs that can be researched.

The current international bachelor/master structure and the promoted mobility of students by the European Credit Transfer System (ECTS), enhances the possibilities for specialization. The bachelor is a more general study. To become more specialized in a field, the master is a perfect opportunity to focus on a smaller more detailed subject. With the right partnerships this research internship can be done at any most specialized university and the introduction of the ECTS made it easier for students to become mobile. The promotion of mobility will be profitable, for scientific research as well as for the students as for universities all over Europe.

The international community is more focused on well-trained and well-educated people working in the different departments of health science. Well-educated and well-trained health science students are necessary for the national and international community. Partnerships for educational purposes among international universities can provide a more diverse program for future employees. This increases the effective exercise of movement. More access to courses, training, teaching, and research possibilities. These extras can strengthen the position of students on the labour market.

Discussion and conclusion

How to reach these profitable outcomes? This will not be easy; it takes a lot of effort and time. That is why this conference is so important, new relations and new networks can be created and can evolve from the opportunity to discuss all the different views. With the help of modern technology communication becomes easier, faster and reaching a larger target group. On the internet different working approaches can be discussed, solutions found and more transparency created. It's in all our interest to work together.

Keywords: Students, Partnership

INTERNATIONAL COLLABORATION AS A SUCCESSFUL APPROACH IN MEETING CHALLENGES IN PUBLIC HEALTH

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Purpose

Application of knowledge and experience of Health Care professionals in community education and consequently increased awareness of Preventions as a crucial step in building healthy community in Balkan countries.

Introduction

Public Health in South East of Europe faces many challenges. In order to be able to follow modern requirements the whole health system in Serbia and Kosovo is changing rapidly. In this trend of changes, the role of Public Health sector is becoming even more important. Ability to meet and solve efficiently practical challenges such as reduction of smoking, prevention of AIDS and other diseases or environment protection is constantly requested.

Methods and materials

Cooperation with relevant institutions, interviews with health professionals, community members and comprehensive data analysis during period 2003.-2004.year.

Results

Several awareness campaigns were organized by matching the knowledge of local professionals and expertise of international organizations such UNICEF. Evaluation of the input Public Health awareness shared increased interest of community members in problems addressed in campaigns. This resulted in several discussions and questions raised seemed to be positive feed back for Public Health professionals and decision makers.

Discussion and conclusion

Balkan countries are passing through the period of fast changes and more than ever there is a need to use health prevention as effective tool in maintaining general community health.
What Public Health sector can do in transition period?

First of all, constant education of community on all levels is necessary. But besides traditional may such lectures, leaflets, more interactive approach is needed. This approach requires active involvement of each community member in discussions, workshops, trainings, in another words constant presence of Public Health sector in community life.

For successful realization of this approach world-wide experience is necessary. Therefore cooperation with relevant international organizations such as UNICEF, WHO etc. showed good results.

In conclusion, combination of local knowledge and international experience is efficient way to meet and solve the challenges in Public Health.

Keywords: cooperation, education, challenges

THE EFFECT OF THE STUDENT HEALTH EDUCATION ON THEIR FAMILY KNOWLEDGE AND PERFORMANCE

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Purpose

Determining the effect of the students health education on their family knowledge and performance.

Introduction

One of the most important issues in the educational system in the developing countries is health education and the role of the involvement and participation of individual and group in this matter and it is basic responsibility of community health nurses in the family health.

Methods and materials

This research is a quasi- experimental research with 80 pair parents whose children were guidance school students. The participants were selected in a random sampling manner and were divided into two groups as case and control groups. A community health nurse executed health education program for them. Then the knowledge and performance of the parents of the participants in the two groups were examined.

Results

The parents knowledge and performance in the case group was better than the control group ($p < .001$ in knowledge and $p < .04$ in performance)

Discussion and conclusion

Students health education can affect parents knowledge and performance. Community health nurses have a specific responsibility for performing this task.

Keywords: Family health, Health education, community health nurse

EXPERIENCE WITH UTILIZING E-LEARNING IN THE IMPLEMENTATION OF THE NATIONAL DRG SYSTEM

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Purpose

The Institute is an organisation that provides post-graduate education for doctors, pharmacologists and dentists. One of its 85 professional institutes is the School of Public Health. That, besides teaching the health care managers, also solves research assignments, implements projects, conducts health care analyses and develops conceptual materials.

In 2002 the Institute became responsible for the performance of the DRG Pilot project in the Czech Republic. The success of the entire project was preconditioned by educating a wide range of health care staff. The method of e-learning programmes in combination with classic classroom education was selected. The establishment of the project team and education of its members has become a crucial moment for the performance of a national e-learning project. The heterogenous nature of the team members' professional orientation is confirmed by their composition (authors, methodologist, graphics expert, executive editors, reviewers, editing board, administrator and course manager).

The execution of the project, naturally, encountered problems. Only during the performance of the project did the need for changes in the project team become obvious. Some of its members were external co-operators and their availability was restricted. Also, motivational problems occurred in the functioning of the team. Motivation was far from being merely associated with financial rewards and therefore it was necessary to find other motivational factors (social recognition, possibilities to communicate with domestic and foreign experts, formation of an independent department, retreats, etc.).

Despite the aforementioned problems, the project can be judged as being positive in hindsight. The main contributions can be assessed to be the possibility to individually select the programme, time and place of study, self-evaluation in the form of review tests and the possibility of electronic communication with the lecturers with a faster response rate than with classic personal consultations involving appointments.

Our experience with the national e-learning education system, then, is positive and yields the assumption that the method will be used more and more often, in other areas of postgraduate and life-long learning also (for example, in the area of urgent medicine, catastrophe medicine, medical law or when teaching practitioners, etc.).

Keywords: education, e-learning, Diagnosis Related Groups

TWO DAY TRAINING COURSES FOR THE VILLAGE AMBULATORY NURSES

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American University of Armenia (AUA)

Introduction

The courses were organized by the Garo Meghriyan Eye Institute For Preventive Ophthalmology (GMEIPO) within the Center of Health Services Research and Development (CHSR) of the American University of Armenia (AUA) and were sponsored by the Jinishian Memorial Foundation (JMF) and the World Vision (WV/Armenia). The courses were held in Gegharkunik, Taush and Lori marzes.

Aim

Improve the knowledge and practical skills of the primary eye care personnel in marzes.

Background

The primary eye care in marzes is in a poor level and in some places it is not yet developed. In many marzes there are neither primary nor secondary eye care specialists, in others the responsibilities of nurses are accomplished by not competent individuals (accountants, school teachers, etc.). Besides, in some regional units there are ophthalmic equipment (slit-lamps, ophthalmoscopes, etc.), which are not used due to lack of appropriate knowledge and practical skills of the medical personnel.

Due to all abovementioned the incidence of eye diseases and the blindness rate are very high in marzes. The 3.7% of blindness estimated in marzes exceeds the numbers reported for European countries. Cataract constitutes the major cause of blindness (69.7%) and is responsible for 76.1% of severe visual impairments. Absence of trained medical personnel, limited options on continuing medical education, financial constrains and lack of public awareness are the main barriers to reduction of blindness.

Taking into account all these, the GMEIPO organized trainings for the primary eye care personnel. Trainees were chosen from different villages according to the following criteria: distance of the village from the regional hospital and size of the population served by the nurse.

Course description

During the training course the nurses were acquainted with the basics of ophthalmology and learned practical skills to detect eye diseases in early stages of development. The theoretical part was presented by means of lectures and interactive sessions. Lectures on the visual organ anatomy, physiology and the main blinding diseases were covered. Different visual aids (colour atlases, charts, etc.) were used to assist the learning process.

The importance of the eye disorders early diagnostics and the role of the primary eye care personnel in blindness prevention were emphasized.

Handouts on blindness prevention activities in the scope of "VISION 2020 THE RIGHT TO SIGHT" were distributed to nurses. The handouts contained important data on global blindness and the main blinding diseases.

A separate session was dedicated to the patient referral systems and the role of primary, secondary and tertiary levels of eye care.

The practical skills were demonstrated during the lectures, thereafter, the nurses practiced the skills on each other.

By the end of the training, the nurses were provided with necessary supplies and medications, as well as received eyeglasses, to distribute among the village population.

One of the main constrains in the courses organization was transportation. There were villages far from the RP and nurses were late for the sessions. Some nurses did not participate in courses because their husbands did not allow them to participate.

Lack of basic knowledge in nursing was the third constrain. In many villages the responsibilities of nurses were accomplished by a school teacher or an accountant.

Conclusions

1. The active participation of nurses and their interest proved the importance of training courses.
2. The assessment test held on the second day of the course revealed that the knowledge and practical skills of nurses improved.
3. To improve the quality of primary eye care in marzes the trainings should be organized repeatedly and their duration be longer.

ORGANIZATION OF PEDIATRIC OPHTHALMIC SERVICE IN ARMENIA

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Kamo Ter Petrosyan

“Howard Karagheusian” medical benevolent social organization

Purpose

The purpose of the “Howard Karagheusian” medical benevolent social organization is to insure that the future of children of Armenia is in good physical and spiritual health.

Introduction

The organization was established in 1992 in Armenia. The initial focus was on dental care, then the board of directors of HKCC in New York decided to expand our efforts to cover other medical fields.

Methods and materials

In 2000, the foundation introduced a pilot program in Gyumri to provide basic eye examinations to all school children. Our foundation has established pediatric regional units to develop pediatric eye services in regions affected by the earthquake. Regional ophthalmic units were established in 2000 in Gyumri, 2001 in Vanadzor, 2003 in Stepanakert, 2004 in Yerevan (Nork Center, 2 units). In each of these units there is an ophthalmologist, nurse, examination room, room for treatment of refractive errors. We have developed special ambulatory record forms for patients as well as special daily, monthly and annual reporting forms regarding the activities performed by doctors and nurses.

Results

The activities of our foundation include:

- . Screening among children from 7 to 15 years of age in schools, colleges and boarding schools to reveal visual disorders (over 43000 schoolchildren).
- . Detailed eye examination of children with visual disorders. The examination includes anamnesis, visometria, skiascopy with wide pupils, cycloplegia, skiascopy with narrow pupils, biomicroscopy, ophthalmoscopy, ophthalmometry, cover test, observation of binocular function
- . Monitoring and dispensation (11000 patients)
- . Prescription of eyeglasses (over 4500 patients)
- . Medical treatment (over 2500 patients)
- . Treatment of amblyopia with special equipment
- . Correction with contact lens for the patients with anisometropia and severe myopia (45 patients)
- . Artificial eyes for patients with anophthalmia (10 patients)
- . Surgical treatment in special hospitals (150 patients).

Discussion and conclusion

The organization also supports educational, cultural, and social programs. Since 2001 HKCC provides capital improvement services in existing children facilities like boarding schools and orphanages; it also provides hearing devices and wheel-chairs to children in need.

Keywords: Health care, children

NEW COURSES ON DRUG MANAGEMENT TO MEET NEEDS OF PROFESSIONALS IN ARMENIA

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Purpose

Years of experiences through the world prove that the effective drug management allows to reach better public health outcomes and reduce expenditures. Rising pharmaceutical spending, an increasing number of counterfeit medicines and numerous reports on adverse drug reactions, as well as other challenges confirm that rational management of medicines is becoming increasingly valuable for public health. Nevertheless, the experience and knowledge in this area are often not available to many professionals. In Armenia policy-makers and decision-makers in the pharmaceutical sector are mainly pharmacists and physicians without a special training on managing drug supply and, correspondingly, appropriate knowledge. In addition, there are a lack of own experience in drug management under the conditions of a capitalist system and a poor access to information about world practice and current knowledge in this field.

The purpose of this work was to design Curricula for Courses on Drug Management for professional development of pharmacists corresponding to both current world approaches to education in this area and needs of Armenian professionals.

Methods and materials

Review of existing local and foreign programs in the area of drug management, publications and WHO recommendations has been implemented for designing curricula and teaching materials. Questionnaire has been developed and distributed in order to assess needs of post-graduate students (interns and residents) and public health specialists in the area of drug management and drug policy as well as their perception of the drug management situation in Armenia and the role of knowledge in its improvement.

Results

Some important gaps were defined in local undergraduate programs after comparing with content of training for Courses on drug management and drug policy in International Health offered by European and US institutions. The results of analyzing questionnaires show that the majority of respondents have been not familiar with or have a little knowledge on some important drug management issues. Key competencies have been developed on a publications review. Curriculum for post-graduate education Course (duration – 6 weeks) has been designed on the basis of needs identification and assessments. It has been discussed and approved by the Educational-Methodological Commission at the National Institute of Health (NIH). Some training materials have been developed for this Course. Another Curriculum has been designed for a short in-service training (duration – 1 week) for civil servants working in the area of public health. This Curriculum has been approved by the Commission on Education at the Drug Utilization Research Group (DURG). For the first time this training Course will be organized by DURG for selected professionals in autumn 2005.

Discussion and conclusion

There is a clear need in expanding and improving knowledge of local professionals in the area of drug management. Curricula designed for new Courses at NIH and DURG will provide the opportunity for pharmacists and other public health specialists to get an access to information on

world practice and gain knowledge necessary for effective drug management.

This work was supported by OSI, New York, USA and NISPAcee, Bratislava, Slovak Republic.

Keywords: Medicines Management Courses

WORKSHOP 1

Workshop 1

Saturday, 17 September

OSI REGIONAL COOPERATION: EXPLORING PARTNERSHIPS WITH SCHOOLS OF PUBLIC HEALTH TO ADDRESS HIV/AIDS in PARTNERSHIP WITH OSI AND THE GLOBAL FUND TO FIGHT AIDS, TB, MALARIA (GFATM) IN AFRICA, EURASIA, EUROPE & THE MIDDLE EAST

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Overview

In collaboration with ASPHER, Open Society Institute has supported since 2001 the development of graduate-level public health teaching programs in the European region and Central Asia. As the program winds down in 2005, OSI is interested in exploring potential collaboration with schools of public health to advance its public health agenda, which centers on protecting and promoting the health rights of vulnerable populations through civil society mobilization. HIV/AIDS, which is primarily transmitted by intravenous drug use and sex work in the Eurasian region, has been a particular focus of OSI funding. OSI is also interested in working in Sub Saharan Africa to address the generalized HIV/AIDS epidemic, and in understanding what are issues around illicit drug use and HIV/AIDS in parts of the Middle East. OSI supports through advocacy, technical assistance and grants the efforts of the Global Fund to Fight AIDS, TB, Malaria and is interested in forging partnerships with schools of public health to abet this effort.

The goal of this workshop is to gain insights into how schools of public health in Sub-Saharan Africa, the Middle East, and Eurasia interface with governmental policies, particularly PH workforce policies and ones designed to address HIV/AIDS & TB and implemented in collaboration with the GFATM. A subsidiary question is how schools of public health engage in community outreach programs, through research or otherwise.

How might OSI work with SPHs, government, civil society and international funding agencies, particularly the GFATM, to address the tremendous public health threat of HIV/AIDS?

Aim

To explore the interface of schools of public health, government, and civil society in Africa, the Middle East, and Eurasia in the context of the HIV/AIDS epidemic and to distill a number of recommendations of concrete use for the program planning process of potential international funders, including OSI and the GFATM

Objectives

- Analyze the relationship between PH short-term and diploma-track training and ministerial public health workforce policies as well the impact of training demand from the non-governmental sector in representative countries in the context of the HIV/AIDS epidemic
- Discuss representative career tracks of SPH graduates in each country and what this reveals about the demand for higher education in public health
- Describe existing models for the interface of SPHs and civil society whether through faculty/student research or other community outreach programs
- Describe any existing collaborative programs or activities between SPHs and the Global Fund to Fight AIDS, TB, Malaria

- Distill a number of recommendations of concrete utility for the program planning process of funders, including OSI, particularly with respect to HIV/AIDS and TB and to the access to health care of vulnerable populations

Intended Audience

Academic program directors and deans of schools/faculties of public health, from countries of Central and Eastern Europe, Africa, the Middle East, and Central Asia

**ASPHER XXVII ANNUAL CONFERENCE
17-20 September, 2005, Yerevan, Armenia**

**OSI REGIONAL COOPERATION:
EXPLORING PARTNERSHIPS WITH SCHOOLS
OF PUBLIC HEALTH TO ADDRESS HIV/AIDS in
PARTNERSHIP WITH OSI AND THE GLOBAL
FUND TO FIGHT AIDS, TB, MALARIA (GFATM)
IN AFRICA, EURASIA, EUROPE & THE
MIDDLE EAST**

Part 1: September 17, Saturday

Part 2: September 19, Monday

WORKSHOP PROGRAM

Yerevan, Armenia, September 17 and 19, 2005

**ASPHER XXVII ANNUAL CONFERENCE
17-20 September, 2005, Yerevan, Armenia**

WORKSHOP ANNOTATION

Workshop title	WORKSHOP: OSI REGIONAL COOPERATION: EXPLORING PARTNERSHIPS WITH SCHOOLS OF PUBLIC HEALTH TO ADDRESS HIV/AIDS in PARTNERSHIP WITH OSI AND THE GLOBAL FUND TO FIGHT AIDS, TB, MALARIA (GFATM) IN AFRICA, EURASIA, EUROPE & THE MIDDLE EAST
Venue	American University of Armenia, 40 Marshall Baghramian, Yerevan, Armenia American University of Armenia Business Center, 9 Alex Manoogian
Moderators	Ara Tekian, PhD, MHPE, Univerisity of Illinois at Chicago Assoc. Professor Linas Sumskas MD, PhD, Kaunas University of Medicine, School of Public Health, Kaunas. Lithuania Dr. Michael Borowitz, Director, OSI Public Health Programs
Date, time	<u>Part 1. Saturday, September 17, 2005:</u> Session 1: 10.30-12.00, Session 2: 13.30-15.30, Session 3: 16.00-17.30 <u>Part 2. Monday, September 19, 2005:</u> Session 1: 14.00-15.30 Session 2: 16.00-17.30
Maximum registration	50
Overview	<p>In collaboration with ASPHER, Open Society Institute has supported since 2001 the development of graduate-level public health teaching programs in the European region and Central Asia. As the program winds down in 2005, OSI is interested in exploring potential collaboration with schools of public health to advance its public health agenda, which centers on protecting and promoting the health rights of vulnerable populations through civil society mobilization. HIV/AIDS, which is primarily transmitted by intravenous drug use and sex work in the Eurasian region, has been a particular focus of OSI funding. OSI is also interested in working in Sub Saharan Africa to address the generalized HIV/AIDS epidemic, and in understanding what are issues around illicit drug use and HIV/AIDS in parts of the Middle East. OSI supports through advocacy, technical assistance and grants the efforts of the Global Fund to Fight AIDS, TB, Malaria and is interested in forging partnerships with schools of public health to abet this effort.</p> <p>The goal of this workshop is to gain insights into how schools of public health in Sub-Saharan Africa, the Middle East, and Eurasia interface with governmental policies, particularly PH workforce policies and ones designed to address HIV/AIDS & TB and implemented in collaboration with the GFATM. A subsidiary question</p>

	<p>is how schools of public health engage in community outreach programs, through research or otherwise.</p> <p>How might OSI work with SPHs, government, civil society and international funding agencies, particularly the GFATM, to address the tremendous public health threat of HIV/AIDS?</p>
Aim	<ul style="list-style-type: none"> • To explore the interface of schools of public health, government, and civil society in Africa, the Middle East, and Eurasia in the context of the HIV/AIDS epidemic and to distill a number of recommendations of concrete use for the program planning process of potential international funders, including OSI and the GFATM
Objectives	<ul style="list-style-type: none"> • Analyze the relationship between PH short-term and diploma-track training and ministerial public health workforce policies as well the impact of training demand from the non-governmental sector in representative countries in the context of the HIV/AIDS epidemic • Discuss representative career tracks of SPH graduates in each country and what this reveals about the demand for higher education in public health • Describe existing models for the interface of SPHs and civil society whether through faculty/student research or other community outreach programs • Describe any existing collaborative programs or activities between SPHs and the Global Fund to Fight AIDS, TB, Malaria • Distill a number of recommendations of concrete utility for the program planning process of funders, including OSI, particularly with respect to HIV/AIDS and TB and to the access to health care of vulnerable populations
Intended audience	Academic program directors and deans of schools/faculties of public health, from countries of Central and Eastern Europe, Africa, the Middle East, and Central Asia

PROGRAM

Part 1: Saturday, September 17, 2005

Venue: AUA

Session 1: 10.30-12.00 PLENARY: PANEL DISCUSSION

Title of presentation	Presenter
Welcome and description of Workshop's goals (5 mns)	Prof. Ara Tekian, University of Illinois at Chicago, USA
OSI priorities, HIV/AIDS, the GFATM and the role of SPHs (10 mns)	Dr. Michael Borowitz, OSI, New York
Governmental human resource policies, civil society, and SPH training programs in the Egypt/Middle East in the context of the HIV/AIDS epidemic and the GFATM (15 mns)	Hassan K. Bassiouny, Dean, High Institute of Public Health, Alexandria, Egypt
Governmental human resource policies, civil society, and SPH training programs in Africa in the context of the HIV/AIDS epidemic and the GFATM "(15 mns)	Prof. Frederic Wurapa, Dean, SPH, University of Ghana, Accra, Ghana
Developing a coherent and holistic response to the fundamental needs of South African Health Care System in the light of the HIV (10 mns)	Prof. Sharon Fonn, Dean, SPH Witwaterswand, South Africa
The experience of CHS/AUA in Armenia: the interface of training programs, government policy, and private sector demand (10 mns)	Dr. Haroutune Armenian Dean, College of Health Sciences, President, American University of Armenia, Yerevan, Armenia
Discussion (35mns)	

Participants. Participants from African and Middle Eastern schools of public health, moderators, and speakers.

Background. Over the past five years, OSI has funded, in collaboration with ASPHER and other organizations, faculty training, peer review, and program development in two dozen graduate-level teaching programs in Europe, Russia, and Central Asia. While direct institutional support for curriculum reform in schools of public health ends in 2005, OSI is interested in exploring work with schools of public health in areas particularly germane to its public health agenda and outside of its traditional region, the former socialist bloc. Foremost among OSI interests is the question of the access to health care of vulnerable groups afflicted by HIV/AIDS and TB, whether intravenous drug users or sex workers in countries with concentrated epidemics, or impoverished rural populations in countries with generalized epidemics. OSI is a supporter of the GFATM and is exploring ways to increase its effectiveness.

Aims. The plenary will introduce the discussion of how governmental human resource policies and the demands of the private sector impact the content and nature of the training offered by SPHs. What is the relationship between curriculum and diploma-track changes and governmental public health workforce policy? Does the private, non-governmental sector constitute a sizeable career track for future graduates? Does it impact the content of training programs? What is the role of the HIV/AIDS epidemic in driving educational programs and public health workforce government policies?

Members of the Session 1 will introduce the general issue of workforce training and public policy in the Middle East and Africa and the context of HIV/AIDS concentrated or generalized epidemics. The example of the conference host country, Armenia will also be discussed.

SESSION 2: 13.30-15.30 WORK IN TWO GROUPS

Workshop participants will be divided into 2 groups, one composed of African countries, the other Middle Eastern. Facilitators will be appointed for each working group.

TOPIC 1 (1 hour):

Discuss and document the interface of schools of public health, government, and civil society in Africa or the Middle East in the context of the HIV/AIDS epidemic

Questions to be addressed:

- Analyze the relationship between PH short-term and diploma-track training and ministerial public health workforce policies as well the impact of training demand from the non-governmental sector in representative countries in the context of the HIV/AIDS epidemic
- Discuss representative career tracks of SPH graduates in each country and what this reveals about the demand for higher education in public health
- Describe existing models for the interface of SPHs and the community whether through faculty/student research or other community outreach programs
- Describe any existing collaborative programs or activities between SPHs and the Global Fund to Fight AIDS, TB, Malaria

Task for the group:

The reporter for the work group should prepare the following conclusions from discussion:

- Findings per country
- Define general lessons learned on human resource planning for PH in the countries involved in the group work and in the context of the HIV/AIDS epidemic and any existing collaboration with the GFATM

TOPIC 2 (1 hour):

Distill a number of recommendations for the program planning process of potential funders, including OSI and the GFATM, involving the contributions of SPHs to the fight against HIV/AIDS and TB

Task for the group:

- Formulate your suggestions for a SPH/OSI partnership in collaboration with the GFATM to fight HIV/AIDS and TB, per country.
- Make recommendations for cross-country initiatives

Session 3: 16.00-17.30. PLENARY: DISCUSSION AND CONCLUSIONS

Participating countries:

All representatives involved in our Workshop, Part 1.

Presentations by 2 work groups (20 mns each)

Discussion (40 mns)

Conclusions with concrete recommendations to OSI (30 mns)

Suggestions for discussion

Reporters will present summaries of the discussions carried out in a workgroups. Members of the panel will be asked to make comments.

Workgroups also will be asked to present written summary with the conclusions and recommendations

The reporters and representatives of African and Middle East countries will be then invited to make presentations in Part 2 of this Workshop, which will be held on Monday, September 19.

Part 2: September 19, Monday, 2005

Venue: AUA

Session 1: 14.00-15.30. PLENARY: PANEL DISCUSSION
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Title of presentation	Presenter
Opening address to the participants of the Workshop (5 mns)	Prof. Martin McKee, London School of Hygiene and Tropical Medicine, UK. Member of the OSI Global Health Advisory Committee
Welcome and description of Workshop's goals (5-10 mns)	Linus Sumskas, SPH, Kaunas University of Medicine, Kaunas, Lithuania
The Afri Health project and SPHs in Africa (15mns)	Carel IJsselmuiden Council on Health Research and Development (COHRED), Geneva, Switzerland
Kyiv Mohyla Academy SPH in partnerships to tackle HIV/AIDS: beyond the Global Fund Grant Programme to Fight HIV/AIDS in Ukraine".(10mns)	Paola Pavlenko, SPH, Mohyla Academy, Kyiv, Ukraine
Report on Workshop, Part 1 and presenting the situation in PH education in African Countries (10 mns)	To be identified
Report on Workshop, Part 1 and presenting the situation in PH education in Middle East Countries (10 mns)	To be identified
Discussion 30mns	

Participants. Participants from schools of public health from Europe, Eurasia, Africa, Middle East.

Aims. Part 2 of the workshop will introduce and continue the discussion begun in Part 1 concerning the interface of schools of public health, government and civil society in the context of HIV/AIDS and TB, this time focusing on schools of public health in Europe and Eurasia. Findings from Part 1 will be reported in the opening plenary.

Session 2: 16.00-17.30. WORK IN TWO GROUPS AND CONCLUSIONS

Group work 16.00-17.00

Workshop participants will be selected into 2 groups. Facilitators will be appointed for each working group. African and Middle Eastern participants may join in either group and

The first group will include: Latvia, Lithuania, Estonia, Kazakhstan, Tajikistan, Ukraine, Russia, Armenia

The second group will include: Albania, Bulgaria, Croatia, Macedonia, Serbia, Hungary, Romania, Poland

Topic 1 (30 mns):

Discuss and document the interface of schools of public health, government, and civil society in Europe or Eurasia in the context of the HIV/AIDS epidemic

Questions to be addressed:

- Analyze the relationship between PH short-term and diploma-track training and ministerial public health workforce policies as well the impact of training demand from the non-governmental sector in representative countries in the context of the HIV/AIDS epidemic
- Discuss representative career tracks of SPH graduates in each country and what this reveals about the demand for higher education in public health
- Describe existing models for the interface of SPHs and the community whether through faculty/student research or other community outreach programs
- Describe any existing collaborative programs or activities between SPHs and the Global Fund to Fight AIDS, TB, Malaria

Task for the group:

The reporter for the work group should prepare the following conclusions from discussion:

- Findings per country
- Define general lessons learned on human resource planning for PH in the countries involved in the group work and in the context of the HIV/AIDS epidemic and any existing collaboration with the GFATM

TOPIC 2 (30 mns):

Distill a number of recommendations for the program planning process of potential funders, including OSI and the GFATM, involving the contributions of SPHs to the fight against HIV/AIDS and TB

Task for the group:

- Formulate your suggestions for a SPH/OSI/GFATM partnership to fight HIV/AIDS and TB, specifically per country. Include recommendations for cross-country initiatives.

Conclude in plenary 17.00-17.30

Presentations by 2 work groups (10 mns each)

Discussion and Conclusion (10 mns)

Suggestions for discussion

Reporters will present summaries of the discussions carried out in a workgroups. Members of the panel will be asked to make comments.

Workgroups also will be asked to present written summary with the conclusions and recommendations

The reporters and representatives of African and Middle East countries will be then invited to make presentations in Part 2 of this Workshop, which will be held on Monday, September 19.

**Part 1: Saturday, September 17, Saturday
Yerevan, Armenia**

List of OSI Workshop Part 1 participants

1. Adib Salim, Lebanon
2. Armenian Haroutune, Armenia
3. Bhatti Tufail, Pakistan
4. Borowitz Michael, UK
5. Bozorgzad Ahmad, Iran
6. Fonn Sharon, Witwaterswand, SA
7. Haddad Nadim, lebanon
8. Jalali Abdolarasool, Iran
9. Knight Stephen, SA
10. Odero Wilson, Kenya
11. Papikyan Anahit, Armenia
12. Papiyeva Irina, Armenia
13. Pavlekovic Gordana, Croatia
14. Shayesteh Salehi, Iran
15. Sumskas Linas, Lithuania
16. Tekian Ara, USA
17. Tusgdelger Sovd, Mongolia
18. Wurapa Frederick, Ghana
19. Zahraei Roshanak, Iran
20. Zurayk Huda, Lebanon

Part 2: Monday, September 19, 2005
Yerevan, Armenia

List of OSI Workshop Part 2 participants

1. Armenian Haroutune, AUA, Armenia
2. Bhatti Tufal Ahmed, Pakistan
3. Bozorgzad Ahmad, Iran
4. Berry Elliot, Israel
5. Bino Silvia, Albania
6. Birt Chrristopher, UK
7. Fonn Sharon, South Africa
8. Georgijeva Lora, Bulgaria
9. Gray Selena, UK
10. Hudaykulov Umid, Uzbekistan
11. Ijsalmuiden Carell, Switzerland
12. Isjanovska Rosalinda, Macedonia
13. Kauhanen Jusi, Finland
14. Kosa Karolina, Hungary
15. Kulshanov Maksut, Kazakhstan
16. Maksudova Zumrat, Tajikistan
17. McKee Martin, UK
18. Papiyeva Irina, Armenia
19. Pavlekovic Gordana, Croatia
20. Pavlenko Paola, Ukraine
21. Polluste Kaja, Estonia
22. Roshi Enver, Albania
23. Salim Adib, Lebanon
24. Sumskas Linas, Lithuania
25. Szosland Dorote, Poland
26. Takenova Madina, Kazakhstan
27. Tekian Ara, USA
28. Tudsgdelger Sovd, Mongolia
29. Villerusa Anita, Latvia
30. Wilson Odero, Kenya
31. Wurapa Frederick, Ghana
32. Zurayk Huda, Lebanon

CURRENT PROGRAMS

- MASTER'S DEGREES IN
 - Business Administration
 - Industrial Engineering
 - Political Science and Public Administration
 - Public Health
 - LLM and Comparative Legal Studies
 - Computer and Information Sciences
 - Teaching of English as a Foreign Language

CURRENT PROGRAMS

- CERTIFICATE PROGRAMS
 - Teaching of English
 - Environment and Conservation Studies
- EXTENSION PROGRAMS
- SCHOOL OF HEALTH CARE MANAGEMENT & ADMINISTRATION-with the Ministry of Health

RESEARCH AND DEVELOPMENT

- CENTER FOR BUSINESS RESEARCH AND DEVELOPMENT
- ENGINEERING RESEARCH CENTER
- ENVIRONMENTAL CONSERVATION RESEARCH CENTER
- CENTER FOR POLICY ANALYSIS
- CENTER FOR HEALTH SERVICES RESEARCH AND DEVELOPMENT
- LEGAL RESEARCH CENTER

OTHER FACILITIES

- AUA BUSINESS CENTER
- GARO MEGHRIGIAN EYE INSTITUTE FOR PREVENTIVE OPHTHALMOLOGY
- ALICE OHANASIAN DIGITAL LIBRARY OF ARMENIAN CLASSICS

UNIQUENESS OF AUA

- Historical circumstances
- Synergy of institutions
- American model in the Soviet and Russian cultural environment
- Graduate university geared to development and research
- Most efficient operation
- Vision for the future

Unique Features of the Public Health Program -1

1. Competency based curriculum
 - a. Problem Solving
 - b. Problem Investigation
 - c. Program Development
2. Block Course Teaching
3. JHU/BSPH Affiliation

Unique Features of the Public Health Program -2

4. Center for Health Services Research:
 - Engaged in the community – Tb, blindness
 - School of Health Care Management
 - Response to a donor base – GMEIPO
5. Geography and History of building a new public health on the vestiges of the Soviet system:
 1. “we have had public health for 70 years”.
 2. anatomy and physiology

Government Interface

- Consultation with Ministries of Health and Education.
- Steering Committee with MOH and alumni.
- Partnership with MOH on SHCMA.
- System of post-graduate education and its challenges.

Situation Analysis

- 1. Growing Enrollment
- 2. Growth in size and scope of projects
- 3. Armenia – Yerevan centered students
- 4. University-wide financial crisis
- 5. The imperative to expand as a regional program and institution

Why a Private Delivery Sector in Health Services?

- Country is trying to move towards a market economy.
- A large proportion of the health services delivery in Armenia is financed by direct fee for service payments that are part of the shadow economy. How to integrate these resources in a well organized delivery system?

Why a Private Delivery Sector in Health Services?

- In its current mode, the very meager government resources in Armenia, are unable to finance more than a small fraction of the operation of the health services.
- Private sector possibly more efficient.
- The need for an evolution of processes, systems and interactions.

Why a Private Delivery Sector in Health Services?

- Private sector will create a **competitive** environment for quality health services as it has already occurred with dentistry and pharmacy in Armenia.

A Program to Train Health Services Entrepreneurs & Models

- OBJECTIVES:
 - Train leaders for the private sector health care.
 - Develop new models of health services delivery.
- Young physicians and health care workers.
- Assessment of need and market research.
- Development of projects and business plans.
- Identify sources of funding and implement.

Future Perspectives

- A University for the whole region
- Priority for Quality Graduate Education
- Premier Research institution
- A Bridge and a source of Synergy
- A program of Universal value and significance



AfriHealth

Mapping Public Health Education Capacity *in and for* Africa: Preliminary Results & Update

Yerevan, Armenia
19 September 2005



<http://afrihealth.up.ac.za>



AfriHealth

Mapping Public Health Education Capacity *in and for* Africa:

Core Working Group in Africa

Abdallah Behir
Eric Buch
Lola Dare
Hassen Ghannem
Carel IJsselmuiden (Project Director)
Marian Jacobs
Adetokunbo Lucas
Reginald Matchaba-Hove
Bronwyn Moffett
Mary Mwaka
Thomas Nchinda
Augusto Paulo
Anne Strehler
Steven Tollman

Core Working Group outside Africa

Robert Beaglehole
Tim Evans
Paulo Ferrinho
Wade Hamma
Fadel Kane
Robert Lawrence
David Mowat
Vic Neufeld
KR Thankappan
Jeroen van Ginneken

<http://afrihealth.up.ac.za>



A definition:

- **Public Health Capacity** as ‘the ability (*of the health sector, a nation, a continent*) to identify and effectively address ongoing and emerging health problems;
 - it is **inclusive**: human resources at all levels; infrastructure; other sectors; etc



Core Objectives - short term, and in first instance:

- **Mapping of Public Health Capacity *in and for* Africa**
 - existing public health education institutions and programs (university or equivalent) *in Africa*
 - public health training programs *in the ‘north’* that have a major focus on public health education *for or in* Africa
 - existing **research networks** focussing on the improvement of public health capacity
- **Assess capacity for ‘technology-supported distance learning’ *in and for* Africa**



Core Objectives - medium term

- **Create opportunities for Network Development and Dissemination of the information**
 - prepare for a Pan African Public Health conference in 2004, and to
 - engage other networks, and to
 - explore opportunities and propose a plan for offering sustainable leadership training for public health, and to
 - Widen AfriHealth ownership / structure / organisation



Core Objective - long term

- Start / re-start of an ‘African Association of Schools of Public Health’
 - *Accreditation, networking, critical mass, clearing house, ...*
- or
- An/the voice of Africa in terms of public health
 - (*‘African Public Health Association’*)



Core Objectives – added:

- How to satisfy training needs of **countries too small** to set up own ‘schools of public health’ ?
- **Gender** and public health education capacity in Africa

– For each, a position paper was added to the work of AfriHealth;
(and PhD project)



Premises underlying AfriHealth (1)

- a **continental approach** to improving public health in line with new socio-political realities
- strengthening public health capacity by **networking**, and
- exploiting **information technology** to optimise learning and teaching;
- A **comprehensive, “wide” definition** of public health;



Premises underlying AfriHealth (2)

- **Public Health**, as an integrative effort, is essential to achieving health and equity in health and health care access;
- **“Essential Public Health Functions”** approach is example of more pragmatic and ‘narrow’ approach;
- **Outcomes from AfriHealth ... can be anything**, not just schools – education – research; may include advocacy, linkage, infrastructure, health systems engagement,



Sources of Information

- **Africa** : divided into manageable, geographical clusters, except lusophone countries
- **Europe** : access through “TropEd”
- **USA** : access through ASPH, CDC, and NIH
- **Canada** : Identification of groups and individuals within universities with relationship with Africa
- **Australasia** : anecdotal



Sources of ICT Information

- Web-based scan of current initiatives
- Review of major recent reports and surveys
- Visits to Tulane University’s Payson Center, and the Johns Hopkins University’s Bloomberg School of Public Health



AfriHealth – timeline (1)

- Project Approval by RF in January 2002
- First meeting: Geneva, May 2002
- Second, report back, meeting: Arusha, Nov 2002
- Current phase: re-starting ...
- This meeting:
 - **Communicate the findings,**
 - **Reconnect,**
 - **And develop the future of AfriHealth with your help**



AfriHealth – timeline (2)

- Started as ‘project’ in a School of Public Health in 2001;
- Was supposed to become an independent, African initiative by 2004 (intended conference as focus)
- Was ‘rudely interrupted’ in 2003/2004
- But did not ‘fizzle out’ ...
 - *It had outputs and consequences (next slide)*
 - *It is now again being resourced*
 - *Aiming for a conference in Oct/Nov 2006*



AfriHealth – outputs (1)

... early outputs

- **Presentations:**
 - Global Forum for Health Research, Arusha, Nov 2002
 - Joint Learning Initiative (JLI), Cape Town, March 2003
 - Institute of Medicine (IOM), Washington, June 2003
 - Accra, NEPAD & ACOSHED meeting, September 2003
 - USAID, Washington, November 2003
 - JLI, New York, November 2003
 - USAID ‘partnership consultation’, Pretoria, April 2004
 - ASPHER, Yerevan, September 2005



AfriHealth – outputs (2)

... early outputs

- **Capacity building:**
 - **PhD** in Gender and public health education (Mwaka)
 - Also received Ford Foundation scholarship for this
 - **USAID Public Health Leadership program:**
 - 2.5 million US / pa / 5 years / at least
 - 2 consortia in Africa selected (with substantial local ownership)
 - 2 ‘runners up in USA’ currently being further examined
 - Award expected later this year



Results ... in Africa (1)

– Programs (1)

(provisional only)

- **Graduate public health training in 53 countries in Africa:**

– No training:	27	(51%)
– 1 program:	16	(31 %)
– > 1 program:	10	(19 %)



Results ... in Africa (2)

– Programs (2)

(provisional only)

- Most programmes are still ‘**traditional**’, ‘**narrow**’, **medical – health access only**
- Many ‘**short courses**’ ... also through research and service institutions, NGOs, foreign institutions
- **Distance learning:** rare; ‘**on job – on campus**’ learning (some: e.g PHSWOW)



Results ... in Africa (3)

– Programs (3)

(provisional only)

- **Language is still an important divider of education available**, but is losing importance;
 - Lusophone countries in Africa (PSAC) rely on Portugal for all training. Mozambique is gearing up. Few francophone countries have ‘public health’ ... mostly ‘components’ of health, as in France.
- **Few** have substantive ‘**north-south**’ links, and even **fewer** ‘**south-to-south**’ links; ‘**institution-building**’ tends NOT to be included
- **Little regionalisation:** East Africa, SADC, West Africa perhaps



Results ... in Africa (4)

- Students

(provisional only)

- **Annual intake** of post-graduate degree students in Africa: **(600+)** (but: i) *unconfirmed, and ii) missing most of Egypt and Nigeria, many others*) and **rapidly increasing**; especially MPH
- **Accepting foreign students:** three countries (5 institutions) do; most do not or only incidentally
- (*Can not yet split between M and D*)



Results ... in Africa (5)

- Size of units

(provisional only)

Unit Size FT & PT FT only

1 – 5	5	4
6 – 10	13	20
11 – 15	14	10
16 – 20	4	1
21 – 25	2	2
26+	2	2

* In total (so far) 511 staff members in all of Africa



Results ... in Africa (6)

- Staff

(provisional only)

- **Male staff dominates:** **64% vs 36%**
- Ratio increases in terms of seniority of degrees – for those with doctoral degrees: **74% men vs 26% women**
- Low numbers of **international staff** (*except ...*)
- ‘Strange’ age distribution:

Yrs	Survey		“Expected”	
	N	%	N	%
< 35	85	17	10	25.0
36-50	337	66	15	37.5
51+	89	17	15	37.5



Results ... in Africa (7)

- Research

(provisional only)

- **Low research output** – *with exceptions*
- Public Health is taught with **little, if any, research linkage**, even if ‘centers of excellence’ are available
 - *E.g. almost no links with AfHRF, INDEPTH, AAVP, MRCs, Wellcome, ENHR, WHO-TDR, others*



Results ... for Africa (1)

(provisional only)

- **Europe :** 900 - 1000 graduate students from Africa pa; Of these, it is estimated that just over 500 are in degree programmes - 25% of which at doctoral level (TropEd members only)
- **USA :** unfortunately, no information yet (*but if similar to Europe ...*)
- **Ratio Africans trained IN / OUTSIDE Africa likely to be 50 % (40% - 60%) or less**until now



Results ... ICT in and for Africa (1)

- **Community training centers** operative in in South Africa, Mozambique, Uganda, Ghana, and Mali
- **‘web-education-ready’ countries :** Côte d’Ivoire, Mauritius, Rwanda, and South Africa
- **Successful cases:** IDRC from 1996-2001 in Benin, Côte d’Ivoire, Senegal and Morocco linked to McGill University
- **Private sector interest :** CISCO systems setting up ‘distance education laboratories’ at the Universidade Jean Piaget de Cabo Verde



Results ... ICT *in and for* Africa (2)

- **costs of satellite television and radio** is down dramatically and decreasing;
- **costs of satellite-based internet access** to halve in the next 5 years, while access will dramatically increase;
- **African Virtual University's** new status and infrastructure can be re-focused on public health
- **CD-ROM based** distance learning can be used
- **BUT: ICT capacity !**



Where is this leading to (1) ?

- **Africa needs a PLAN** for PH/HRH
 - NEPAD ? / African Union ? / WHO ? / RF ?
- **Major investment in public health capacity: individual, but especially institutional**
 - Magnitude of 5 – 10 times
 - Longterm (25 – 50 years ?)
 - Requires 'multi-donor --- multi-panel' format



Where is this leading to (2) ?

- **“Clustering” / Regionalisation of Public Health:**
 - 6 – 7 regional / supra-national consortia
 - Include **language:** 1 lusophone, 1 francophone
 - **Match teaching excellence with research excellence** (Mali with Senegal ? / Navrongo with Accra ? / Makerere has it all in-house)
 - **Increase critical mass** (> 50 ?)
 - **Increase independence** from political/economic instability
 - Enhances **staff exchange**
 - **Attract ex-patriate African expertise**
 - Can provide for **small countries**



Where is this leading to (3) ?

- **ECTS → African Credit Transfer System**
- **Open up / de-monopolize ‘public health’ :**
 - Disciplines
 - Sectors
 - Stakeholders / target audiences
- Substantial investment in **ICT and Educational Technology**
- African PH to look for **key partners in the north**



Where is this leading to (4) ?

- **Gender** and Public Health
- **Small countries** capacity building interests
- **Modernizing SPH financing and orientation:**
 - **Internationalize training** (like research)
 - Linkages to **policy / policy research**
 - SPHs as separate **‘business units’**
 - Focus on **‘narrow’ programs** for income
 - Change **training for Africa** into **training in Africa**



Link ?



- **Our business is to enable countries to invest in ‘research for health’**
 - *focussing on equity, health systems, development ...*
 - *we help build national health research management capacity*
- **In Africa in particular, this is likely to happen mostly through Schools of Public Health**
- **There is a ‘de-link’ between public health research and SPHs**



In brief ... (1)

- **Re-starting the initiative: finalise, update, clean data**
 - Current link is Makerere IPH & COHRED
 - Intention is to widen across Africa
- **Re-connect with interested SPHs**
- **Target the Global Forum for Health Research in Cairo (29 Oct – 1 Nov 2006)**
 - To fit with the global HRH agenda



In brief ... (2)

- Outcome 1: **African Association of SPHs ?**
 - Interest among donors is high
 - Interest among SPHs is ?
- Outcome 2: **African voice for African Public Health ?**
 - Why wait for the north to flag African public health problems & emergencies
- Outcome 3 etc: ...



In brief ... (3)

In relation to OSI / Global Forum

- **Possibility 1: 'health systems research' training**
 - COHRED/AHSPR/GFHR module
 - Focus on joint curriculum setting, methods, clearing house
 - One possible action of an African Association of SPH's
- **Possibility 2: 'responsible vertical programming'**
 - Global Fund: link HIV/TB/Malaria (10% for 'operational research')
 - COHRED main drive
- **Possibility 3: enabling: fund the SPH association**
 - and many of the activities listed here

Global Fund in Estonia

Kaja Põlluste, MD, MPH

Department of Public Health & Department of Internal Diseases
University of Tartu
Estonia

Global Fund Programme (GFP) in Estonia

- First stage of the programme
 - Oct 1st, 2003 – Sep 30th, 2005
- Second stage of the programme
 - 2005-2007
- Responsible institution
 - National Institute for Health Development

<http://www.tai.ee/?id=2401>

2

Target groups of GFP

- HIV/ AIDS prevention in risk groups
 - Young people aged 15–24
 - Injecting drug users
 - Commercial sex workers
 - Prisoners
 - Men who have sex with men
 - People living with HIV/AIDS

3

Strategic objectives of GFP (1)

- To reduce risk behaviour among children and young people aged 10–24 and to increase their knowledge of HIV related issues
- To reduce risk behaviour among injecting drug users aged under 25
- To reduce risk behaviour among sex workers and reduce vertical transmission of HIV

4

Strategic objectives of GFP (2)

- To prevent HIV transmission in prisons
- To reduce risk behaviour among men who have sex with men (MSM) and increase their knowledge of HIV related issues
- To improve the quality of life of people living with HIV by improving access to health care and social support services

5

Strategic objectives of GFP (3)

- To increase the institutional capacity and build cooperation amongst organisations involved in the programme to effectively meet the objectives of this programme
 - process objectives related to reaching the target group, informing the target group and terminating the process
 - objectives concerning the direct effect of actions related to changes in knowledge and attitude
 - objectives related to changes in behaviour
 - objectives related to the spread of infection

6

Partners

- NGOs
 - Training of trainers in health education
 - Health education
 - Media campaigns
 - Counselling and support
 - Needle exchange
 - Condom distribution
- National programme for HIV prevention
- Department of Public Health
 - Research

ASPHER XXVII ANNUAL CONFERENCE
17-20 September, 2005, Yerevan, Armenia

OSI REGIONAL COOPERATION:

EXPLORING PARTNERSHIPS WITH SCHOOLS OF PUBLIC HEALTH TO ADDRESS HIV/AIDS in PARTNERSHIP WITH OSI AND THE GLOBAL FUND TO FIGHT AIDS, TB, MALARIA (GFATM) IN AFRICA, EURASIA, EUROPE & THE MIDDLE EAST

INTRODUCTION TO WORKSHOP GOALS

*Linas Sumskas, Associate Professor,
School of Public Health of Kaunas University of Medicine, Kaunas,
Lithuania*

Yerevan, Armenia, September 17 and 19, 2005

WORKSHOP IN CONTEXT OF ASPHER CONFERENCE

CONFERENCE TOPICS:

- **Regional collaboration**
- **Creating sustainable partnerships**
- **Public health training and global problems**

WORKSHOP SCOPE IS BROADER

- **Covers Africa, Middle East Region and also East, South and Eastern Europe, Central Asia**
- **Expands discussion on newly emerging threat of AIDS, TB, Malaria**
- **Focus on a workforce development dimension and future roles of SPH**

OSI PRIORITIES AND FOCUS

- Since 2001 OSI has supported the development of public health teaching programs in the European region and Central Asia.
- After year 2005, OSI continue the efforts on protecting and promoting the health rights of vulnerable populations.
- HIV/AIDS, which is primarily transmitted by intravenous drug use.
- Sex work, drug abuse in the Eurasian region, has been a particular focus of OSI funding.
- OSI is also interested in working in Sub Saharan Africa to address the generalized HIV/AIDS epidemic, and in understand what are issues around illicit drug use and HIV/AIDS in parts of the Middle East.
- OSI supports through Global Fund to fight AIDS, TB, Malaria and is interested in widening partnerships with the schools of public health.

WORKSHOP FORMAT

Part 1. Saturday, September 17, 2005:

Session 1: 10.30-12.00

Session 2: 13.30-15.30

Session 3: 16.00-17.30

Part 2. Monday, September 19, 2005:

Session 1: 14.00-15.30

Session 2: 16.00-17.30

GOAL OF THIS WORKSHOP

To gain insights into how schools of public health interface with governmental policies

How PH workforce policies are designed to address HIV/AIDS & TB prevention and implemented in collaboration with the GFATM

How community based programs could be engaged and collaborate through research of SPH

UTILITARIAN GOAL

How might OSI work with SPHs, government, civil society and international funding agencies, particularly the GFATM, to address the tremendous public health threat of HIV/AIDS?

OBJECTIVES OF OSI WORKSHOP

- **Analyze** the relationship between PH short-term and diploma-track training and national health workforce policies, also training demand from the non-governmental sector in the context of the HIV/AIDS epidemic
- **Discuss** career tracks of SPH graduates in each country and describe the demand for public health education
- **Describe** existing models for the interface of SPHs and civil society whether through faculty/student research or other community outreach programs
- **Analyze** existing collaborative programs between SPHs and the Global Fund to Fight AIDS, TB, Malaria
- **Distill** a number of practical recommendations for the program planning process of funders, including OSI, with respect to HIV/AIDS and TB and to the access to health care of vulnerable populations

WORKSHOP Part 1 FORMAT

for African and Middle East Countries

Saturday, Sept. 17

Session 1: 10.30-12.00. PLENARY: PANEL DISCUSSION

Session 2: 13.30-15.30. WORK IN TWO GROUPS

Session 3: 16.00-17.30. PLENARY: DISCUSSION AND CONCLUSIONS

WORK IN GROUPS

Group 1: African Countries

Group 2: Middle east Countries

TOPIC 1: Discuss and document the interface of schools of public health, government, and civil society in Europe or Eurasia in the context of the HIV/AIDS epidemic

TOPIC 2: Distill a number of recommendations for the program planning process of potential funders, including OSI and the GFATM, involving the contributions of SPHs to the fight against HIV/AIDS and TB

WORKSHOP Part 2 FORMAT

for Euro Asia countries

Monday, Sept. 19

Session 1: 14.00-15.30. PLENARY: PANEL DISCUSSION

Session 2: 16.00-17.30. WORK IN TWO GROUPS AND CONCLUSIONS

WORK IN GROUPS

Group 1: Latvia, Lithuania, Estonia, Kazakhstan, Tajikistan, Ukraine, Russia, Armenia

Group 2: Albania, Bulgaria, Croatia, Macedonia, Serbia, Hungary, Romania, Poland

TOPIC 1: Discuss and document the interface of schools of public health, government, and civil society in Europe or Eurasia in the context of the HIV/AIDS epidemic

TOPIC 2: Distill a number of recommendations for the program planning process of potential funders, including OSI and the GFATM, involving the contributions of SPHs to the fight against HIV/AIDS and TB

Open Society Institute

Strategy for the Network Public Health Program (NPHP)

September, 2005
Yerevan, Armenia

Martin McKee
OSI Global Health Advisory Committee

Key OSI themes

Marginalization

- Drug users
- Sex workers
- Prisoners
- Roma
- Dying
- Mentally ill
- Mentally disabled
- MSM

Monitoring

- Public health watch
- Budget transparency
- “Law on the streets” implementation monitoring
- Civil society capacity building

The three dimensions

- **Marginalized Groups and specific health issues**
 - Marginalization
 - Institutionalization: *loss of freedom*
- **Capacity building and monitoring units**
 - Elements of civil society
 - Advocacy organizations, human rights organizations, media, professions, academia, foundations, and service providers
 - Capacity building programs: law, media, civil society
- **Geography: *Beyond the Soviet zone***
 - Traditional region
 - Africa, Asia, and Middle East

Network Matrix: Two Dimensions

Marginalized groups and specific health issues

- HIV/AIDS
 - IHRD
 - SHARP
 - IPCA
 - TB
- TB
- Roma
- Palliative Care
- Mental Health and Intellectual Disability

Capacity building and monitoring

- **Public Health Watch**
 - Law on books
 - Law on streets
 - Budget transparency
- **Law and Health**
(Justice Initiative)
- **Media and Health**
(Network Media program)
- **Civil Society Capacity**
 - Schools of public health
 - Policy Centers
 - Professional development

Horizontal approach:

Monitoring and Accountability

- Human Rights model: “Watch”
 - Civil society is watching what the government is doing
- Democratic accountability
 - Budget transparency (Caspian Revenue Watch)
 - Policy dialogue: EU-MAP and Afri-MAP
- Monitoring and Accountability in a Global Environment
 - UN system
 - New global health initiatives (GAVI, GFATM)

Development Assistance:

the resource curse

- **Architecture of International Development Assistance**
 - **AIDS in Africa**
 - PEPFAR
 - GFATM
 - WB MAP/PRSP
 - Human resources (IJJ)
 - **AIDS in Central Asia**
 - DFID
 - GFATM
 - USAID: capacity, DDRP
 - WB IDA grant
 - **Health in Eastern Europe:**
 - Balkans, Caucasus, Eastern Europe, Russia, Ukraine
- Monitoring of large-scale assistance

HIV/AIDS

- Harm reduction in Eastern Europe and the former Soviet Union, and more broadly (IHRD)
- SHARP: other aspects of concentrated epidemics- sex work, MSM (more focused on Asia/Africa) **New strategy**
- HIV/AIDS outside the traditional region:
 - GFATM
 - Accountability: public health watch
 - Development assistance
 - Resource transparency

Controlling an Epidemic: an evidence-based approach

- What you do depends on where you are on the epidemic curve
- Focus on incidence
- Focus on key determinants of reproductive rate
- Take into account changing pattern of exit and implications for palliation
- The relative cost-effectiveness of interventions

Evidence-based approach to HIV interventions

Concentrated *in high risk groups*

Injecting Drug Use
Sex Work
Prisoners
MSM

Generalized

Interventions

Needle-syringe exchange (NSE)
Substitution Therapy (ST)
100% condom policy

- Condom distribution
- Regular testing and treatment for STIs
- Client reduction

 Condoms, NSE, ST
Partner reduction
Age of sexual debut
STI treatment
Condoms?
Circumcision??

Public Health and Human Rights

Epidemiological approach

Injecting Drug Use
60% coverage of NES
High-level coverage ST

Sex Work
100% condom policy

MSM
Behavior change
closure of bath houses

Human Rights approach

Rights of drug users
Drug policy
Overdose treatment, hepatitis C

Sex Work legality and police harassment
Right to organize SW

Gay Rights
Access to treatment (ACTUP)

Public Health approach to treatment

Continuum of Care (remembering all people eventually die)

- Aspects of Treatment
 - ARV
 - ARV + Methadone for IDUs
 - ARV + TB
 - ARV plus (nutrition, cognitive support, and palliative care)
- ARVs and health systems
 - ARV + DOTS
 - ARV and primary care
 - Human resources
- AIDS and society
 - Orphans
 - Teachers/doctors
 - Social capital

Tuberculosis

- TB in Russian Prisons
 - Mdr-TB: DOTS-plus, Green light committee
 - Review of OSI/Global assistance
- TB/HIV intersection:
 - Advocacy: small grants uptake by Gates
 - Service delivery
- Public Health Watch: TB commitments
 - First Global activity

Other marginalized groups or specific health issues

- Roma
 - Decade of the Roma: Health key pillar
- Palliative Care
 - Major program in Africa on AIDS (IPCA)
 - Consolidation in traditional region
 - Key to PEPFAR and other global health initiatives
- Mental Health and Intellectual disability
 - Focus on traditional region

Strengthening Civil Society

- **Law and health**
 - Each marginalized group and disease-specific program has legal issues
 - Capacity in law and health
 - Public health legal clinics
 - Public health law courses (e.g. HIV/AIDS)
 - Public health law profession (e.g. bar associations)
 - Public health law scholarship and networking
 - Link of the justice initiative
 - International public health law (e.g. Framework Convention on Tobacco Control)
- **Media and health**
 - Each vertical program has media issues
 - Link with the network media program who are doing media capacity building
- **Public Health Watch**
 - Budget monitoring—sin taxes
 - Implementation monitoring (law on the books and law on the streets)
 - Tobacco corruption.
- **Schools of public health**
- **Policy Centers**
- **Salzburg training program**
 - Increased relevance to OSI vertical programs
 - Link to horizontal programs: public health, law and health, etc
 - GDLN network

What is policy?

- From policy to service delivery
- Elements of policy:
 - Public policy: formal laws and regulations
 - “Law on the books” versus “law on the streets”
 - Budgets: allocation and execution
 - Extra-budgetary funding: external assistance, out-of-pocket spending (OSI?)
 - Civil society engagement:
 - Governance: CCM, PRSP, etc
 - Implementation (e.g. service delivery) public versus private provision

Getting from A to B

- Global policies
 - UN organizations: UNODC, UNAIDS, WHO
 - Other key IO: World Bank, IMF, regional Development Banks
 - Bilaterals: USAID, DFID
 - International civil society: foundations
- Westphalian governance
- Nodal governance
- National models of policy change
 - Legislation
 - Administrative rules
 - Money: domestic and development assistance
- OSI model
 - Civil society champion

Modes of work

- Local Foundations: representatives
 - Is Public Health a priority of NF?
- Grants to international partners
 - Level of engagement, size of grant
 - Strategic partners: long-standing
- Grants to in-country NGOs
 - Schools of Public Health
- OSI staff activities
 - Conferences/convening role
 - Training
 - Direct technical assistance/indirect TA
 - International Organizations (e.g. panels, reviews)

Niche of OSI

- **WHO**
- **World Bank**
- **EU**
 - European bilaterals
 - DFID
- **USG/USAID**
- **New global partnerships:**
 - GFATM
 - STOP-TB
- **Foundations**
 - Gates
 - Other foundations
- Civil Society representative
 - Technical representative: eg harm reduction
- Local monitor
 - Collaborate on analytic work
 - Add sub-components to projects
- Advocacy on concentrated epidemics
 - Encouraging work in traditional region
 - Implement programs (New DFID HIV/AIDS project in Central Asia)
- Monitor
 - Stop from doing bad things
 - Implement programs (DDRP, unlikely to continue).
- Technical panels
 - Civil society representative/CCMs
 - Technical assistance in-country
- Gates is the 100 pound gorilla

OSI Comparative Advantage

- Local foundations provide on the ground presence with connection to local partners including oversight and budget transfer
- Relative small funder, but in some areas large
 - Roma, mental health, specific countries
- Influencing agenda:
 - Able to catalyze work with standard-setting organizations.
(large bureaucratic organizations like WHO and WB can be influenced with small amounts of money).
- Can fund start-up and recurrent costs of service delivery
- Can fund directly to NGOs without government intermediary
- Can work on sustained capacity-building including higher education, scholarships, policy centers, etc.
- East-East partnerships: Kaunas-Tadjikistan



Kyiv Mohyla Academy School of Public Health in partnerships responding to HIV/AIDS: beyond support to the Global Fund Grant Programme

'Overcoming HIV/AIDS Epidemic in Ukraine'

Presentation by Paola Pavlenko at the ASPHER-OSI *Exploring partnerships with SPHs to address HIV/AIDS in collaboration with OSI and GFATM in Africa, Asia, Europe and Middle East Workshop*, Yerevan 17-20 September 2005:



State of HIV/AIDS epidemic in Ukraine:

- 1987→1995→2005: 91,918 HIV+ 81,240 /AIDS 10,678/ D 20,081 (1/3): Dnipro, Odessa, Nikolayev, Donetsk (60-50x100,000)
- New HIV+: 2002: **8, 756**/ 2003: **10,009**/ 2004: **12, 491**
- Everyday 2004: **34 HIV+, 8 AIDS, 5 D**
- Prevalence (est. UNAIDS): 360,000 /700,000 HIV+
- TB, 2004: +4,4% 81x100,000; Dtb +5% 23x100,000
- TB in AIDS: 58% (2003), 55% (2004)



Transmission routes dynamics

	1997	2004
IDUs	84%	46%
Sexual	11%	32%
MtC	2%	18% (27% 2003)



Response

- GF Grant I, Mar04-Mar05: \$15,737,000 (2003/Sep05- \$24mln*)
- WB TB-HIV Loan, 2003*/06: \$60mln (\$30mln HIV:disburse 2%)
- State budget, 2004: \$3,5mln (incl WB)
- Ext sources, 2004: \$4,8mln

GF HIV Grant:

- **ART**, bef Mar04: 268/ 137 Apr05: 1,382 (100+165/1,647 ~32% need)

5 Components:

- Treatment & care: 64% 5,000 PLWHA
 - Prevention: 9% 45,000 IDUs, 4,500 CSWs, 3,500 prisoners
 - Info/Educ/Com: 14,5%
 - M&E: 4,3%
 - Prog M-nt: 15%
- Training & CB:** 24 % - \$3,8 mln (WB \$3,17mln)



UKMA School of Public Health

Date of birth: 2003

Courses: MSc M-nt in PH (I - 2004/5: 12; II - 2005/6: 20)
13 + 3 three-week modules

Parent: National Un-ty of Kyiv Mohyla Academy

Co-parents: Maastricht Un-ty and OSI

Relations: Illinois Un-ty

Sibling: UKMA School of Social Work (1995)



School of SW + School of PH =



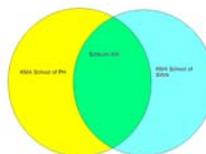
'Sotsium-XXI' NGO, 1998
Youth Centre for Problems of Transforming Social Sphere

Where: UKMA campus – Soc Sciences Dep.
Who: graduates, students and teachers (22+ volunteers)

Why: introduce modern technologies of social work with vulnerable groups of people

What: training and consultancy, search of social partners, collection, analysis and dissemination of information re social protection issues

2003: Co-founder of All-Ukrainian Network of HIV-service NGOs (19)





Projects 2003-2005

- Feb-Apr03 Creation of day-care centre for people with drug addiction (DFID)
- Apr03 Training for HIV/AIDS & Drug addiction telephone hotline workers (SAAPF)
- Dec03 Applied SocPolicy & SocWork training for USIF staff
- Oct 04-Jan05 'Practical SocWork' training for PLWHA Ukr Network
- Oct 04 – now **Set up & running Kyiv Regional Info-Resource Centre on HIV/AIDS (GF/ Alliance)**
- Mar-Jul05 Media Images of HIV/AIDS in Ukraine Survey (GF/Alliance)
- Jul-Sep ...2005 **Development of and running a new training programme "Social work for people living with HIV/AIDS" (GF/Alliance)**



Kyiv Regional Resource Centre for HIV/AIDS

- Based at KMA SSW/Sotsium XXI: Mon-Fri/9-6
- Oct04-Sep05*: \$185,000
- Kyiv + 6 oblasts: Kyiv, Zhytomyr, Vinnitsa, Sumy, Cherkassy, Chernigiv
- 13 staff + 10 experts + 10 volunteers
- Services: library, info support (incl web), consultations, running of seminars & courses for GO & NGOs, work with media, advocacy of HR/ PLWHA
- 8 months – 327 clients (regist)
- 2 most positive results: real resource – 'more than a base for training'; 'friendly/safe, non-stigmatising place'
- Big challenge: contacting local media



Social Work with People living with HIV/AIDS Course Development

- Start: July 05/ three months +
- Course development/ best practice of SW in HIV training (3day, 5day, longer course: 144 hrs)
- Target: HIV-service NGOs staff, HIV-sector trainers and supervisors, SWers
- 3 days training piloted for the SWers of 9 regions
- 5 days training course – 22 SWers of HIV-service NGOs
- Project partners: KMA SSW/SPH, AFEW, Connect Plus-Berlin, Institut fur angewandte Forschungen, Freiburg



Partnerships & participation

- 1) Part of HIV Sector NGO Association: Representation
 - GoU-Donor-NGO Consolidation Group on submission of application for the GF HIV Grant II
 - National Coordination Council of Ukraine for prevention of HIV/AIDS spread (May 2005, 6 cmmttes):
 - Strategic Planning, Budgeting, M&E
 - Healthy Lifestyles
 - Treatment, Care and Support
 - Work with Vulnerable Groups
 - Regional Policy (co-chair*)
 - PLWHA Rights
- 2) KMA SPH/SSW: Consultation with GoU/MoH, MLSP, MFY
 - Civic Advisory Council of the Ministry of Health
 - CabMin Supervisory Board of the Social Investment Fund (WB Loan)
- 3) Project implementation: training/ courses for go/ngo non-medical practitioners



Thank you!

UKMA SPH contacts

- e-mail: pmsph@ukma.kiev.ua
- web page: www.ssw.ukma.kiev.ua
- tel. (+38 044) 238 2569
- info source: www.aidsalliance.kiev.ua

HIV/AIDS IN LEBANON

Salim M. Adib, MD, DrPH



NATIONAL AIDS CONTROL PROGRAM
As of June 2004

HISTORY

- ∩ Early cases in 1981-82:
 - hemophiliacs, returning homosexuals
- ∩ AIDS control program started 1984
- ∩ First national consensus 1995
- ∩ Drugs available through MOPH clinics 2003
- ∩ Second national consensus 2003

STATISTICS

Cumulative number HIV/AIDS	765
Full-blown AIDS	(35.9%)
(Full-blown in 2001)	(45%)
Total new reports in 2004	≈20
Total number worldwide	40 M
New HIV reports in 2003	5 M
MENA in 2001	440,000
Demographics in Lebanon	
Age 30-50	58.8%
Women	18.5%

POTENTIAL TRANSMISSION

N = 650 CASES (%)

SEXUAL	77.3
Heterosexual	52.7
Homosexual	10.0
Bisexual	5.6
Unspecified	31.7
BLOOD PRODUCTS	6.8 (7.8)*
IV DRUG USE	5.8 (8.3)*
TRANSPLENTAL	2.8 (3.8)*
UNDETERMINED	7.5 (14.8)*
* Data in 2001	
LIFE OUTSIDE LEBANON	48.3

DYNAMICS OF THE EPIDEMIC

- ∩ First wave: hemophiliacs, homosexuals
- ∩ No IV transmission of importance
- ∩ After 1990: heterosexual, transplental leading to marriage license in 1994
- ∩ Epidemic under control...almost low endemic



THANK YOU

School of Public Health

University of Witwatersrand,
Johannesburg, South Africa



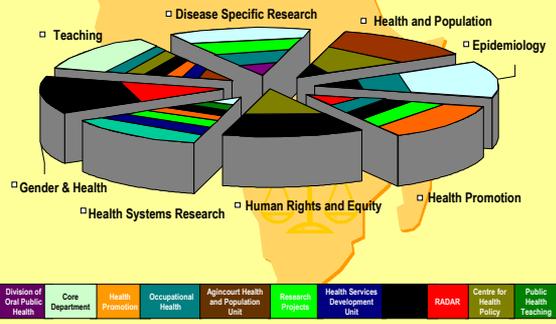
MISSION

- The Wits School of Public Health promotes public health through relevant, appropriate and excellent teaching, research and service, based on the principles of equity, the promotion of human rights and a coherent and comprehensive response to the needs of the peoples of South and Sub-Saharan Africa in their various living and working conditions

Entities within the School of Public Health

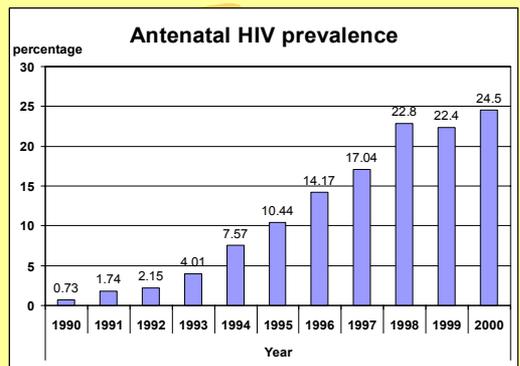


Synergy

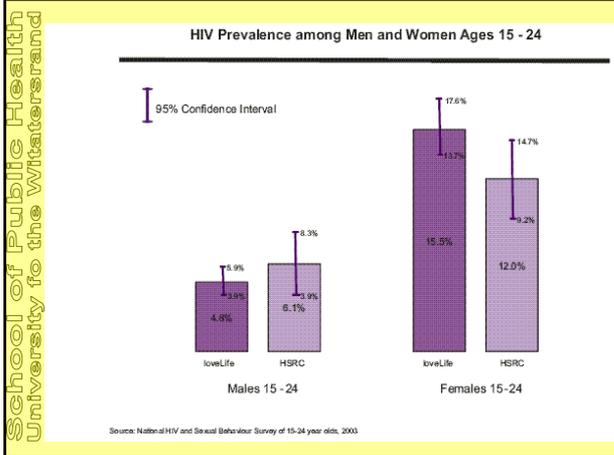


Role of Schools of Public Health

To respond to the big questions that vex the development and delivery of health services and related interventions that will impact positively on population health



2003 rate is 27.9%



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Context of HIV in South Africa

- Human Sciences Research Council – 11.5% national prevalence
- Eastern Cape Rhodes University Centre for Aids Development Research and Evaluation:
 - 1 in 10 HIV positive;
 - 96 000 people need ARVs and 15 169 enrolled in treatment programmes;
 - need to increase 20x the number of people by end of 2006 to meet needs;
 - 69 accredited Rx sites ,16 operational;
 - 27% of HIV funds (2002-2003) were unspent;
 - 7 million residents in the ECape will die if there no effective intervention

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Context HIV in Africa

- Prevalence high
- Impact on individual infected
- Impact on affected, individual (care often women, children); family; community; economy
- On the health service
- Must provide treatment – to decrease the various impacts, to decrease stigma and most importantly to draw people into prevention efforts
- Real need is to create the social conditions which decrease the risk of infection – education; employment; housing; poverty reduction; gender equity

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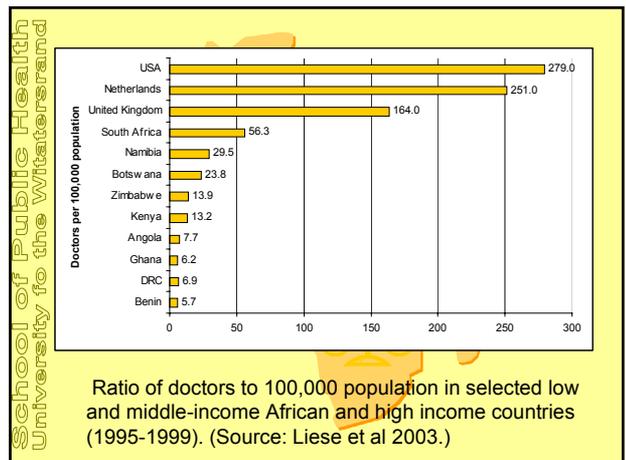
Obstacles to providing treatment

- Access
- Continuity of care
- Reliable drug supplies
- Reliable lab service
- Reliable record keeping
- Trusting relationship with health care provider
- Able and willing staff

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Looking just at the issue of staffing

- Despite the conventional view of African public health sectors as bloated (USAID 2003), the health worker: population ratios of developing country health systems remain vastly inferior to those of industrialised nations.



- Kurowski and Mills (2004) estimated the human resource requirements necessary to meet the recommendations of WHO's Commission on Macroeconomics and Health.
- Their case studies of two countries, Tanzania and Chad, indicated a 2.7 and 5.4-fold gap, respectively, in the necessary size of the health sector workforce

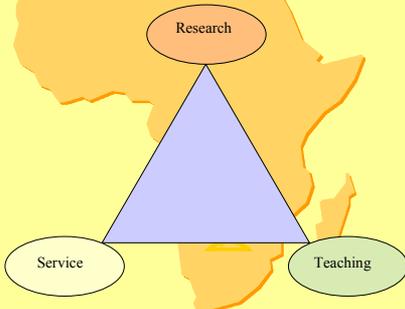
- HIV has heightened our understanding of the need for a functional health care system and there is increasing international agreement on the need to strengthen health systems, in particular in Africa.
- A unique opportunity and **obligation** to use the investments that are being made available for interventions on HIV to strengthen health system functioning.

Schools of Public Health must

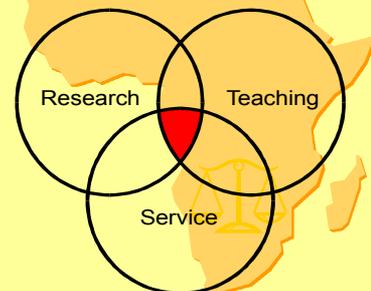
- understand the fundamental skills that are required
- build a cadre of health care workers at various levels
- simultaneously develop coherent and effective and appropriate responses to HIV and to build functional health care systems
- Appropriate curriculum
- Taught by a faculty that is multi disciplinary and rooted in health services and real day-to-day issues of health service delivery through practice and research

- Further, fundamental to the generation of appropriate solutions for health and development in Africa is research - conceptualised, conducted, analysed and published by Africans. In order to do this, research capacity in Africa must be developed.
- The immediate need in Africa is to considerably expand the base of masters-level research scientists with the vital skills and qualities necessary to contribute to research and leadership focused on promoting health and development on the continent.
- Longer term pipeline for PhD

Functions



More efficient approach



Essential to link research to teaching

- Relevant to the issues of the day
- Keep researchers grounded
- Student exposed to the current issues in all their complexity
- Appropriate to local realities
- More efficient for supervision of student projects

What research is currently underway?

- Large intervention study to assess the impact of poverty alleviation and HIV education on the prevalence of HIV in a rural area
- Impact of HIV through demographic surveillance
- Impact of HIV on the health system through a sentinel surveillance system
- Integrating TB and HIV care at hospital and district level
- Economic impact of HIV in Swaziland
- Evaluation of HBC programmes
- Impact of HIV on hospital admissions
- Research to improve chronic disease care capacity
- Research on factors influencing quality of care

Current teaching programme

- Undergraduate teaching – medical doctors
- Post graduate
 - Masters in Public Health
 - MSc Epidemiology and biostats
 - MSc Field based epidemiology
 - MA Demography
 - MMed
 - PhD

All courses geared to offer “in-service” training

- Block release system
- Part time and full time options
- Promote research skills
- Significant proportion of international students from the Africa
- All began with seed funding
- All oversubscribed

Our students

- Significant number from the public sector
- Some from NGO's
- Usually people who have been promoted into management roles in the DHS
- From all over Africa –

COUNTRIES from which students have come

Botswana; Burkino Faso; DRC; Cameroon;
Ghana; Congo; Ethiopia; Lesotho; Nigeria;
Kenya; Swaziland; Malawi; Rwanda; Uganda;
Namibia; Sudan; Zambia; Zimbabwe;

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Master of Public Health (MPH) aimed at preparing professionals to play leadership roles in the management, improvement and evaluation of health and the health care system.

The objectives of the course are to

- Promote equity in health
- Play a leadership role in public health.
- Attain a broad understanding of the core disciplines of public health.
- Develop expertise in at least one area within the broad field of public health.
- Develop a comprehensive understanding of health, the health care system, public health problems and of measures that can be taken to address these problems and to promote and maintain health.
- Develop skills of critical and analytical thinking.

Areas of specialisation (fields of study) include: health measurement, policy and management and occupational hygiene (the only one in Sub Saharan Africa). In development are fields of study in HIV; Gender and Health and Hospital Management.

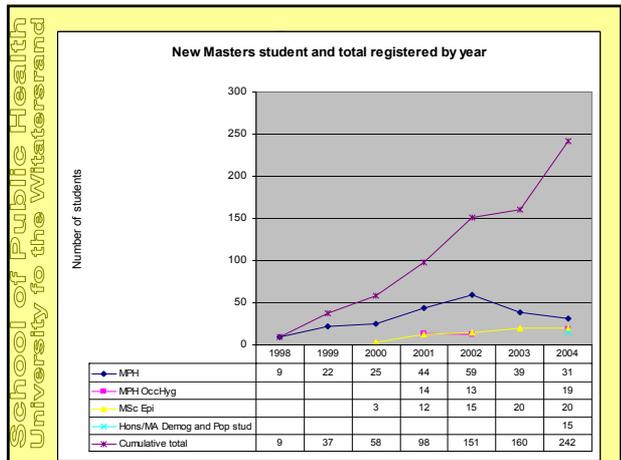
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MSc(Med) in Epidemiology and Biostatistics

- To develop the epidemiology, biostatistics and associated computing skills necessary to investigate health problems and evaluate interventions.
- To develop knowledge and skills in the identification, monitoring, implementation and evaluation of interventions (preventive and curative) to decrease diseases prevalent in Africa.
- To promote high quality protocol development, data collection, analysis, interpretation, report writing and presentation skills to address questions of public health importance.

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- **MSc in Population-based Field Epidemiology**
- This differs from other programs by its focus on:
 - health and demographic surveillance sites
 - development of scientific leadership and research management skills in addition to excellence in research methods
 - a substantial field-based component with a guided internship and associated mentoring and coaching
 - a combination of epidemiology, biostatistics & demography in one degree
 - strong links to the social sciences and a solid introduction to qualitative research methods
 - database design and management, with a focus on relational databases
 - a combination of contact, distance-based, and real-time video teaching methods
 - a continuing learning program.



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Requirements

- Sufficiently well funded faculty staff posts to allow staff to do both research and teaching
- To ensure staff can spend time on course development/upgrading
- Scholarships for students
- Sufficient funds to bring in international faculty, post docs to supplement student learning and give regional flavour
- Funding to allow for external evaluation process
- Sufficient investment in infrastructure to allow for optimal size classes and facilities to impart state of the art teaching
- Sufficient funding to allow some field based teaching where appropriate

ROLE OF THE TERTIARY HEALTH CARE CENTRE IN AIDS SURVEILLANCE, HYDERABAD

PAKISTAN

XXVII ANNUAL CONFERENCE

17-20 September 2005, Yerevan, Armenia

"Educating the Public Health Workforce: Development Perspectives
for the European and Mediterranean Regions"

Dr. Tufail Ahmed Bhatti MBBS, MPH, (Ph D)
Research Medical Centre, LUMHS, Hyderabad Sindh

Dr. A.H Jokhio, Research Coordinator, Research Medical Centre, LUMHS, Hyderabad Sindh.

Siraj Muhammad Pandhiani, Assistance Prof: Isra University, Hyderabad

HIV/AIDS

- A global view of HIV infection is 33 million adults living with HIV/AIDS as of end 1999.
- Pakistan had remained sheltered from the HIV for at least the first decade of the existence of AIDS.
- The graph of the newly discovered HIV positive patients continues to rise by the year, if unreported cases are recognized, we may be taken by surprise.
- In Pakistan HIV prevalence in adults 15-49, end 1999 is 0.10 %

Source: UNAIDS, WHO

Introduction: Hepatitis B

- Despite the discovery of the virus more than 30 years ago, the efficacy of hepatitis B (HBV) vaccine and the advances in therapy, hepatitis B still remains an important public health problem.
- According to the WHO one third of the world's population (2 billion people) have been infected with HBV, and about 5 % are chronically infected (more than 350 000 million people).

- These individuals are at risk of developing hepatologic and nonhepatologic manifestation.
- Between one-third and one quarter of people infected chronically with HBV are expected to develop progressive liver disease (Cirrhosis and primary liver cancer, digestive hemorrhage, liver failure).
- Areas of low prevalence are High-risk sexual behavior, multiple partners, HIV, genital herpes, injection drug users, frequent exposure to blood products, health care workers, blood transfusion before 1970

- Transfusion-related hepatitis B is rare, since screening for hepatitis B has been a routine in transfusion centers for at least two decades.

Can a healthy carrier state be defined?

- Most longitudinal or cross-sectional studies in HBV have distinguished a "healthy" carrier state, a phase of chronic hepatitis and cirrhosis.
- The definition of "healthy HBV Carrier" is not clear and therefore could be dangerous for patients.

- If the definition is the absence of symptoms the absence of transaminase elevation and the absence of abnormalities in the liver, these negative findings should have been observed at least twice.

- Even in patients with the absence of hepatitis B surface antigen (HBsAg) and the presence of anti-HB liver complications may occur.
- Chronic hepatitis B is a serious clinical problem in Pakistan and is also an important cause of hepatocellular carcinoma.
- In our country it remains in the intermediate HBV prevalence area with a carrier rate of 3-4 %.
- The HBs Ag carrier rate in different groups viz. Voluntary blood donors, college students and pregnant women ranges from 2.2 to 3.3 %.

Hepatitis C

- Hepatitis C virus (HCV) is a blood-borne, previously the major etiologic agent of non-A, non-B hepatitis worldwide.
- Presently, approximately 170 million people are infected by HCV.
- The global prevalence of HCV infection averages 3% according to estimation of World Health Organization.
- The incidence of (HCC) hepatocellular carcinoma in cirrhotic patients due to Hepatitis C is now increasing up to 40-50 % in Pakistan.

Objectives:

General Objective:

- To evaluate the screening program in Blood bank and surveillance system of HIV in tertiary care hospital LUMHS, Hyderabad, Sindh Pakistan

Specific Objectives

- To determine the healthy blood donors in screening program during 2001 to 2004 in Research blood bank of LUMHS, Hyderabad
- To determine the Hepatitis B,C and HIV among in healthy donors in screening program during 2001 to 2004.
- To evaluate the Surveillance system and Screening Program in LUMHS, Hyderabad
- To provide recommendations of our study to the concerned department of LUMHS.

Methods:

Study Design:

- Retrospective Study

Study Site:-

- Research Diagnostic Laboratory and Blood Bank of City branch LUMHS, Hospital Hyderabad .

Study Participants:

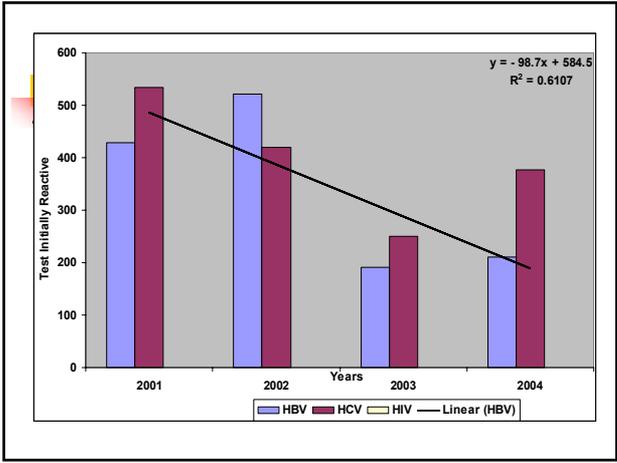
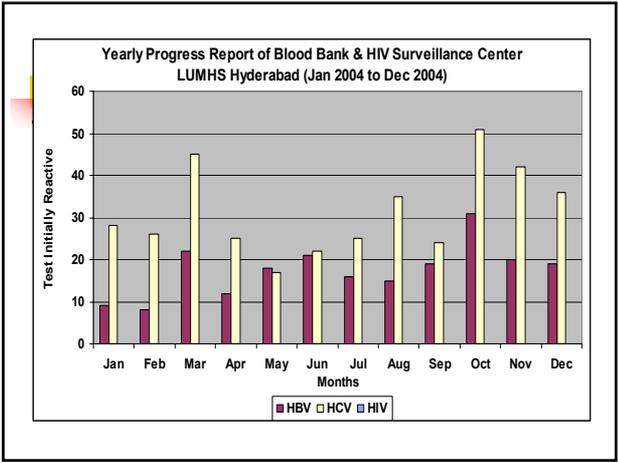
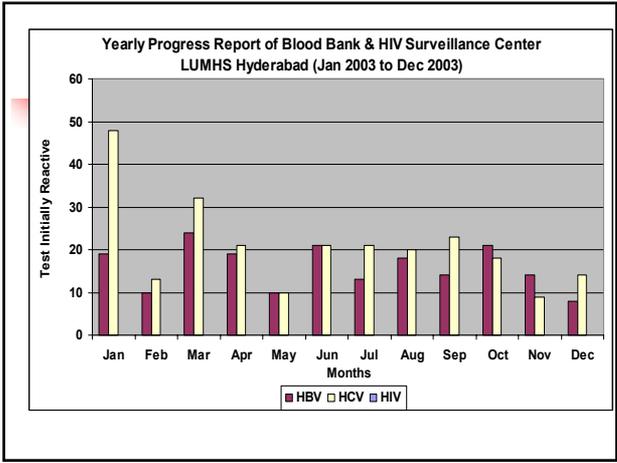
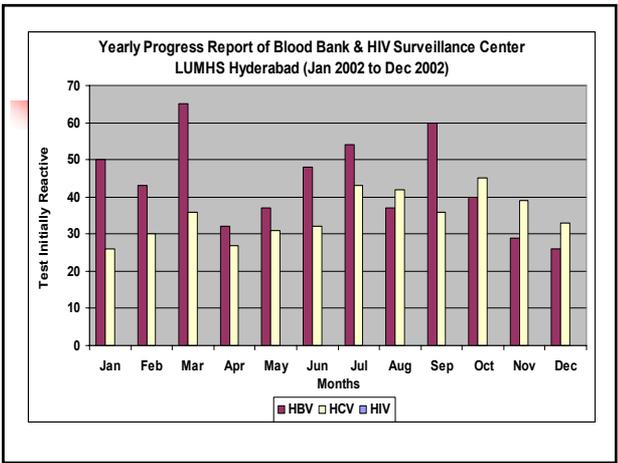
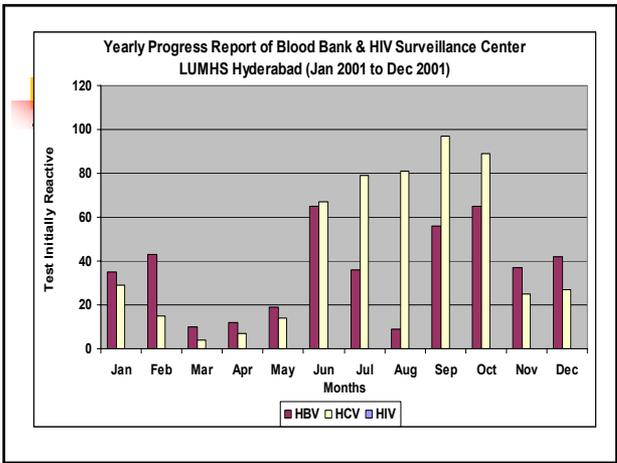
- **64720** All blood donors, who have donated their blood for donation from 2001 to 2004

Results:

- In screening program we observed the HIV, HBV and HCV.
- If HIV found positive we sent them for further confirmation to NIH (National Institute of Health Islamabad) Pakistan.
- Our study shows that with in 4 years, average 16180 people per year were screened in LUMHS Medical Research Laboratory Hyderabad.

LIAQUAT UNIVERSITY HOSPITAL HYDERABAD & JAMSHORO
January 2001 To December 2004

4 years	Total Donor Bleed	HIV	HBV	HCV
2001	19932	0	429	534
2002	17841	0	521	420
2003	13403	0	191	250
2004	13544	0	210	376
Sum	64720		1351	1580
Avg	16180.00		337.75	395.00
S.D	3240.20		163.06	117.38
C.V	0.20		0.48	0.30
Min	13403.00		191.00	250.00
Max	19932.00		521.00	534.00
Range	6529.00		330.00	284.00



- We found HBV (2.0%), HCV (2.4%) and no HIV as carrier with in last four years.
- By verbal autopsy it was found that only 5 cases of HIV were screened out positive in last four years.
- The five samples were sent to NIH but they were found negative, although the five people who were presumptively declared positive, were not followed.
- The carrier of HBV and HCV were also not advised for any preventive measures and further follow-ups.

- 
-
- In the records of screening forms of Medical Research laboratory their were no any age, sex, address, professions and no any risk identification for HIV,HBV,HCV etc.
 - So that there is no any epidemiological and demographical picture available at in tertiary health care center.



Conclusion:

- The Medical Research Center of LUMHS is doing only screening of Blood donors.
- Under reporting found
- Surveillance System found deficient.

Recommendations:

- Blood Donors found reactive in HBV,HCV or HIV in healthy donors should be advised for further advanced confirmatory investigations.
- The questionnaires of proper record keeping should be include for epidemiological and demographical events.

GOVERNMENTAL HUMAN RESOURCE POLICIES, CIVIL SOCIETY AND PUBLIC HEALTH TRAINING IN AFRICA IN THE CONTEXT OF A GLOBAL CRISIS IN HEALTH CARE INEQUITY

INTRODUCTION

- Heavy disease burden
 - Very high IMR
 - Very high MMR
 - Tens of millions suffer from
Malaria, TB and HIV/AIDS/STD
-

CONDITIONS OF IMPROVED HEALTH

- A strong political commitment to improve health
 - An intersectoral perspective in planning and operating systems of health care
 - An appropriate organizational framework and managerial process
-

CONDITIONS OF IMPROVED HEALTH

- An equitable distribution of health resources
 - Community involvement at all levels
-

CHARACTERISTICS OF NATIONAL HEALTH CARE SYSTEMS

- Undersupply as well as under-use of human resource
 - The contrast is more in public health care systems
 - Low wages, morale and motivation is common
 - Lack of standard managerial procedures
 - Practical training in supervisory skills is lacking
-

CHARACTERISTICS OF NATIONAL HEALTH CARE SYSTEMS

- Poor transportation and communication facilities
 - Curricula of training institutions advocate primary health care but in practice emphasize clinical care
 - Result is a mismatch between content of training and actual health needs
 - Great need for trained persons in policy analysis, planning and budgeting
-

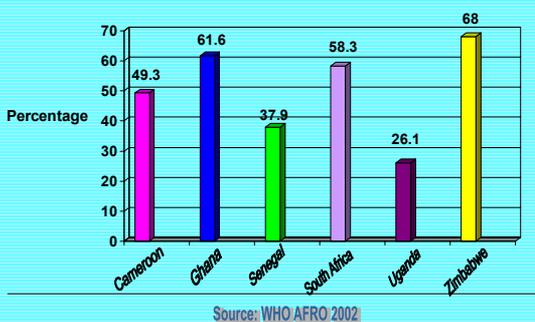
THE PHILOSOPHY OF PUBLIC HEALTH TRAINING IN AFRICA

- Prevent, monitor, respond and control priority disease threats
- Strengthen the major public health sectors within the system
- Improve the quality, availability, exchange and dissemination of information
- Rocker Feller Foundation, WHO, CDC and USAID have been supporting the four SPH to develop competency-based epidemiology training

THE PHILOSOPHY OF PUBLIC HEALTH TRAINING IN AFRICA

- These training programs belong to the International Training Programs in Epidemiology and Public Health Intervention Network (TEPHINET)

Proportion of Health Workers who intend to migrate, 2002



REASONS FOR MASSIVE BRAIN DRAIN

- Unsatisfactory work environment
- Low remuneration and poor benefit package
- Lack of opportunities for upgrading skill and career
- Poor infrastructure and facilities
- Lack of schools for dependent children
- Poor housing and other social amenities

FACTORS AFFECTING HEALTH WORKFORCE PERFORMANCE IN AFRICA

- Education and Training (Pre-service and continuing professional development)
- Motivation
- Human Resource Planning Management

THE OBJECTIVES OF THE REGIONAL PROGRAMME

- Strengthen Public Health Capacity
- Enhance national surveillance
- Strengthen monitoring and evaluation
- Develop Centers of Excellence

ROLE OF THE TERTIARY HEALTH CARE CENTRE IN AIDS SURVEILLANCE, HYDERABAD SINDH, PAKISTAN

**TUFAIL AHMED BHATTI, A.H.JOKHIO AND SIRAJ MUHAMMED
PANDHIANI**

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Assistance Professor, Department of Computer Science, Isra University Hyderabad,
Pakistan*

Background:

Pakistan had remained sheltered from the virus for at least the first decade of the existence of AIDS. However, the graph of newly discovered HIV positive patients continues to rise by the year, if unreported cases are recognized, we may be taken by surprise. We were also detecting the viruses of HBV and HCV in screening program. One of transmissions is through blood; this study was designed to profile the laboratory screening test of family healthy donor in LUMHS, Hyderabad.

Objective:

The objective of this study was to evaluate the surveillance system of blood bank of LUMHS, Hyderabad. This study was designed to profile the laboratory screening tests of family healthy donors.

Methods:

Design: Retrospective study in which we evaluated the medical records of **64720** healthy family donors from 2001 to 2004.

Results:

In screening program we were observing the HIV/HBV and HCV virus, if HIV/AIDS found positive we were sent them for further confirmation to NIH institute Islamabad, Pakistan. Our study shows that with in 4 years, average **16180** people per year were screened, non were found HIV positive, but we found HBV (2.0 %) and HCV (2.4 %) as carrier. By verbal autopsy it was observed that only 5 cases of HIV were detected positive in last four years, for further confirmation sera were sent, but found negative by NIH. Moreover the five people who were positive declared they were not properly followed. No epidemiological and demographical picture available at Tertiary Health Care Centre which we expect in Surveillance system.

Conclusion:

- The center was not working proper Surveillance, avoid under reporting and improve the laboratory testes.

DRUGS USE: HOW TO RELATE POLICY MAKING WITH RESEARCH IN ROMANIA

*Authors: Silvia Florescu, Luminita Barbu, Carmen Sasu,
Marius Ciutan, Claudia Bara, Raluca Iupcianu,
Mihaela Stoican, Cipriana Mihaescu Pintia*

PURPOSE AND BACKGROUND

The goals of the study are:

- reviewing the history of drugs policy and research in Romania, in order to explain the evolution of phenomenon
- consulting the experts in the field to get their insight, understanding and perspective about the process itself
- demonstrating that the policy and decision making has to be an evidenced based process; thus, a strong awareness about the benefits of this approach, together with an active, continuous effort made by bringing together various types of professionals and financing their research accordingly, are needed.

This purpose can be reached through: institutional capacity building for creating and motivating professional teams, improving the training process besides its technical aspects, understanding how global, deeply interconnected are currently the different levels of society.

It is the public health role to facilitate and strengthen this perspective, by knowledge driving, problem solving and social interaction.

It is assumed that the quality of policy-making is improved while research based, through its appropriate mechanisms and networks.

METHODS AND MATERIALS

Case study including:

- analysis of the main laws, policies and strategy papers regarding drugs, as issued in Romania;
- interview in depth with key-informants: decision makers, researchers, service provider, journalists, opinion leaders
- focus group with researchers and public health trainers
- review of scientific reports elaborated in this area.

MAIN LAWS ON DRUG POLICY IN ROMANIA, 2000-2005

FIGHTING AGAINST TRAFFIC AND ILLICIT CONSUMPTION OF DRUGS

regarding Romanian participation as a member of the Group Fighting against drugs traffic and illicit consumption

- Fighting against traffic and illicit consumption of drugs (law, July 26, 2000)
- Application norms for the Law concerning fighting against drugs traffic and illicit consumption (December 20, 2000)
- Approval for the List of human and veterinary pharmaceutical products containing forbidden substances (April 8, 2000)
- Legal regime for precursors used to produce illicit drugs (law, May 17, 2002)
- Application rules for the Low concerning legal regime of precursors used to produce illicit drugs (October 10, 2002)
- Modification and completion of the List of human and veterinary pharmaceutical products containing forbidden substances (September 12, 2000)
- Modification and completion of application norms for the law concerning fighting against drugs traffic and illicit consumption (April 15, 2004)
- Participation of Romania as a member of the group Fighting against drugs traffic and illicit consumption (law, March 23, 2005)

ORGANIZING AND FINANCING THE PREVENTION OF ILLICIT DRUGS CONSUMPTION; ANTI-DRUG NATIONAL STRATEGY

- Financing the detoxification treatment, medical observation and forensic examination for the drug addicts (October 19, 2000)
- Organizing the prevention of illicit drugs consumption (September 5, 2001)
- Establishing the Anti-Drug National Agency (ANA) (December 18, 2002)
- The approval of National Strategy Anti-Drug (February 6, 2003)
- Health care facilities providing medical assistance to drug addicts as well as NGOs preventing the transfer of pathogenic microorganisms among the intravenous drug users (March 19, 2002)

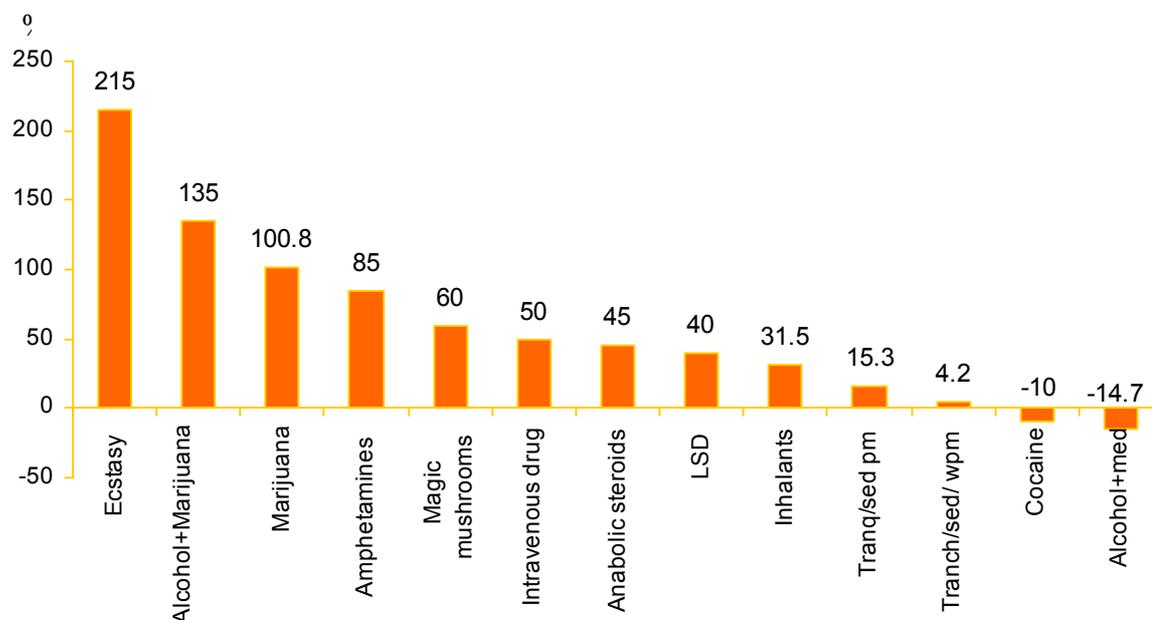
Institutions in charge

- National Anti-Drug Agency (under the Ministry of Internal Affairs) - currently
- Evaluation Committee (before the creation of the National Anti-Drug Agency), formed by representatives of state departments mainly involved (Internal Affairs, Health, Justice, Public Finance, Education and Research, Youth and Sport, Work and Social Solidarity)
- National Focal Point
- Drug use prevention: the Interministerial Commission for the Prevention of Illegal Drug Use (representatives of Internal Affairs, Health and Family, Public Administration, Education and Research, Youth and Sports)
- Almost 50 Centers for Counseling and Fight Anti-Drug

Research - quantitative and qualitative studies

- The European School Survey Project on Alcohol and Other Drugs (1999 and 2003)

**Percentage increase on drug use among teenagers of 16
in Romania, 2003 in comparison with 1999**



Source: NIHRD Bucharest, 2004

- The Rapid Situation Assessment of Intravenous Drug Users (1997 and 2002)

Distribution of intravenous drug use on age groups

Age group	Group code	Percentage	Cumulative percentage
<19	1	12.1	12.1
20-24	2	40.5	52.5
25-29	3	29.9	82.4
30-34	4	11.7	94.2
35-39	5	3.6	97.8
40-44	6	1.0	98.8
45-49	7	0.7	99.5
>50	8	0.5	100.0
Total		100.0	

Source: National Anti-drug Agency, Report for the European Centre of Drugs and Drug Addiction

Specific interventions on drug use:

- Drug demand reduction: preventing drug use and social assistance and integration
- Drug supply reduction: legal framework, evaluation of internal and international risk factors, international cooperation

The national strategy

- The National Program for preventing and fighting against drug use
- The National Anti-Drug Strategy –Government responsibility (funds from the budget of ministries involved, state budget)

Elaborated mainly in order:

- to initiate and support a political debate at the national level, with the goal of decreasing drug abuse and improving the situation of drug users.
- to increase society awareness about the danger of drug use and to promote the participation of private institutions, support groups, associations and individuals to public campaigns
- to stimulate a public health network of services, integrated and standardized, in order to pull and better use resources
- to encourage the control of drug delivery by promoting actions directed against drug smuggling, money laundering and other associated crimes
- to encourage international cooperation both as a part of competent international organization with bilateral and multilateral relationships with other countries or regions.
- to guarantee the evaluation of actions for fight against drugs.

RESULTS

Existing legislation focus more on institutional building and illicit aspects ruling but less on drug users rights and services.

Initially, scientific and managerial expertise on fight against drugs has been internationally provided and a number of institutions became stable partners and acquired substantial knowledge and *know how*.

Visible aspects in mass media were focused more on the criminal aspects, less on the existing structures able to provide counseling and support.

Romanian approach drugs in a narrative style, not debatable.

Population awareness is limited to the presence of a general drug problem at society level, not informed about the availability of specialized services, including prevention.

Drug addict behavior is blamed, not understood and the users are rejected as criminals or losers.

Drugs research at national level is limited to the school population; when relied on pilot study, the low power of inference makes it seem not accurate or reliable enough.

Research findings have been slightly disseminated at population level, scientific world and services providers.

There is a lack of reliable data related to the real number, characteristics and the subgroups at risk of drug users and intravenous drug users. Study results do not match with official statistics...

Decision makers are reluctant to introduce methodological knowledge about sampling or estimation in drugs area in the curricula of public health and social assistance training, considering that as too specific.

Specific interventions are not necessarily based on needs assessment.

Community diagnosis and research is poor developed and the interventions performed are not evaluated. Multidisciplinary working teams deal with communication problems.

Research on drugs use was performed after specialized structures were in place.

Dominant theories and models for interventions were imported and the training and expertise were mostly provided by international agencies.

Funds allocated for research were limited and received with delay accordingly with data collection requirements; research organizations have involved in studies with in-kind efforts in terms of human technical and financial resources. Dissemination of findings remained limited.

Policy making is still characterized by: lack of continuity, influenced by election and professional dynamic dislike the delay till the launching of final reports, hermetic style of presenting the data, information not translated into answers to main policy questions.

Scientific world appeared to be reluctance to the attempts of providing study results in a "friendly" manner, by accusing a diminished accuracy.

Researchers experienced process-related difficulties, such as lack of appropriate software, human resources, attitude of indifference, hostility and methodological prejudices. Some findings were not accepted from political or social point of view. There is a perceived need for scientific and analysis of the drugs phenomenon in Romania, for the purpose of predicting the trends, proposing appropriate interventions and reducing consequences. In this way, difference between formal and informal data will also decrease.

CONCLUSIONS

In order to increase the national research input on policy development, clarifying the roles and improving the collaboration between stakeholders are required.

**ABSTRACT OF THE PRESENTATION DURING THE OSI WORKSHOP
7 AT THE 27TH ASPHER CONFERENCE IN YEREVAN, ARMENIA.**

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The School of Public Health and Social Sciences in Dar Es Salaam is one of the five schools of the college and has five academic departments. It currently runs a one year MPH program but has two other postgraduate programs which are not running at the moment. In addition it has its own undergraduate program of B.Sc. in Environmental Health Sciences. The school is also heavily involved in teaching in the undergraduate and postgraduate programs of the other schools of the college. Research, including collaborative research between the faculty members and colleagues from universities in other countries, is an important activity of the school as is involvement in professional activities, especially consulting and facilitation for different organizations.

The school interfaces with government policies in different ways, foremost among these are carrying out the formative research and writing of background documents as well as participation the actual policy and strategy formulation processes. The school has a teaching district in which much of the outreach activities, especially involving students in learning by doing in the health facilities and communities at large. Perhaps a unique venue for outreach has been the school's involvement in running the Tanzania Public Health Association and active participation by the faculty in the annual conferences of the association which are well attended by members, many of whom are middle and lower level cadres in various health programs and related sectors. Another important aspect of outreach has come up following the formulation of the National HIV/AIDS Policy and the National Multisectoral HIV/AIDS Control Strategy. All the sectors are required to formulate sector specific HIV/AIDS control strategies. Members of the faculty provide technical assistance to these sectors for the formulation of their strategy. In addition the school runs two short courses for Research Methodology and Health Care Financing and these are very popular.

The school recently conducted a Tracer Study with a view to documenting the career paths of the graduates and establishing the basis for curricular review aimed at enhancing their relevance to changing situation in the country. The study established the fact that our graduate are working in diverse context both in the public and private sector, and especially with international NGOs, Bilateral and Multilateral Organizations which support health and related programs.

The school has not had the opportunity for formal collaboration with the Global Fund to Fight AIDS, TB and Malaria, but its research has informed the preparation of proposals submitted to it from this country.

The school hopes that participation in the ASPHER conference and in the OSI Workshop 7 will lead to the opening up of opportunities for collaboration with the Fund, and with other schools of public health for collaborative research and exchanges of experience.

**UNIVERSITY OF CAPE TOWN SCHOOL OF PUBLIC HEALTH AND FAMILY
MEDICINE: RECENT DEVELOPMENTS AT THE SCHOOL IN RELATION TO
GFATM AND SOME IDEAS ON THE WORKSHOP THEME**

Andrew Boulle, Rodney Ehrlich

School of Public Health and Family Medicine, University of Cape Town, South Africa

1. Training: Our qualifications menu includes a diploma in management for senior health sector personnel, an MPH and four year residency for medical graduates. There is a large demand from the NGO sector and from other African countries for increased postgraduate training relevant to HIV/AIDS and TB. Tension between breadths (overview) versus depth (specific skills) arises in such training. Our disciplinary strength lies in quantitative skills, including epidemiology, biostatistics and economic evaluation, which are needed to complement clinical and behavioural/social science approaches. There is potential for short courses on projecting costs, resource tracking, demographic modelling, household surveys, as well as district health HIV burden assessments and district expenditure reviews.

2. Career paths: Public health graduates compete well for management jobs in government, but demands of operational management and working in large bureaucracy are unattractive to some. Alternative model is for professionals employed by schools of public health to be contracted to carry out technical work for government. Ways need to be sought for funding of this technical work, with clearly defined role of sponsor and executor, or funding the machinery to maintain this collaborative mechanism, e.g. via specialized units.

3. Civil society interface: AIDS and AIDS treatment are contested areas in South Africa, with very vigorous civil society response in form of advocacy campaigns and donor funded service programmes. The School has partnered NGOs in advocating for treatment, in the setting up one of the first public sector PMTCT programmes, and, later, one of the first public sector antiretroviral treatment services, as well as sitting on a Monitoring Forum which reviews HIV service delivery from perspective of civil society. These activities carry some risk of alienating government – a point for discussion.

4. Collaborative programmes following the successful round three Western Cape applications to the GFATM, the School worked with WHO and GFATM to develop an antiretroviral treatment costing methodology and software tool for next round proposal development. This tool was used by WHO field staff to assist countries preparing round four and round five applications. Have since been commissioned by WHO to extend the methodology to cover all HIV service interventions, not just treatment. The School has also been involved in the planning of palliative care programmes for persons with AIDS within the provincial health services.

5. Some idea on what schools of public health can offer GFATM funded programmes:

a) Training support (as above)

b) Planning support

- Resource planning – projecting need, including human resource needs, coverage, and (in broader context) demographic implications of service programmes;

- Service planning, in context particularly of Primary Health Care (PHC) services – e.g. in asking critical questions about integration versus vertical services, and implications of each, in context of large infusions of donor funding.
- b) Monitoring and evaluation:
- Use of systems principles to develop sustainable information and monitoring systems - e.g. appropriate IT plus paper based systems and minimum but sustainable datasets versus highly capitalized IT systems;
 - Regular whole programme evaluations, to determine impact of service programmes on the health system, good and bad.
 - Enhancement of surveillance systems generally, including TB, antenatal surveys, population-based HIV surveys, etc.
- c) Health promotion/Behavioural sciences:
- Use of evidence based approaches to health promotion and linkage of health promotion messages and channels to emerging treatment programmes;
 - Critical self-examination of failure to achieve effective preventive interventions (other than PMTCT). Promoting greater depth in social sciences within schools of public health and linkage of these disciplines to traditional public health disciplines such as epidemiology.
- d) Critical evaluation of impact of GFATM (and other large initiatives such as PEPFAR):
- E.g. for their development of indigenous capacity in schools of public health and other institutions versus reliance on expatriate skills.

THE WITS SCHOOL OF PUBLIC HEALTH – DEVELOPING A COHERENT AND HOLISTIC RESPONSE TO THE FUNDAMENTAL NEEDS OF SOUTH AFRICAN HEALTH CARE SYSTEM IN THE LIGHT OF THE HIV EPIDEMIC.

Sharon Fonn

The HIV epidemic in Africa is having a devastating impact on health and on the social fabric in South Africa. Life expectancy is decreasing and families and social networks infected and affected by AIDS are dealing with illness, loss, and bearing the burden of care for the people who are ill and children who are left behind once parents have died. Poor families are being drawn into a vortex of increasing poverty. The Aids epidemic has also seen the development of a vibrant civil society organising around issues of access to treatment, challenging international norms on trade and intellectual property and in South Africa sometimes working in conjunction with the Government and often forming a pressure group to demand services from Government.

The HIV epidemic has exposed, in an even more graphic way, the inadequacy of health systems in Africa, South Africa included. Health systems, while making some advances, have overall been unable to provide the kind of care that should have seen a decrease (for example) in maternal mortality in the 25 years that this has been a focus of international attention and advocacy. Dysfunctional health care systems have been at the root of disappointing outcomes of DOTS for TB, Integrated Management of Childhood Illnesses and integration of reproductive health services. Research has shown that health system inadequacy has contributed to poor morale of health care providers.

The HIV epidemic has heightened our understanding of the need for a functional health care system and there is increasing international agreement on the need to strengthen health system, in particular in Africa. From this point of view the HIV epidemic offers a unique opportunity and a specific challenge to use the investments that are being made available for interventions on HIV to strengthen health system functioning.

However “socially complex health intervention such as ART requires not only that health systems manage their current functions better, but also demands new kinds of performance from these systems, a reoriented from acute to chronic care, ensuring uninterrupted supplies of treatment and high levels of adherence.” We have to ask if it is possible to structure investments in ART so that they do not divert scarce resources from other essential activities and instead benefit the health system for delivery of all health programmes? “HIV treatment, as with interventions such as IMCI and TB care, and in contrast to polio immunisation or social marketing of bed nets and condoms, cannot be provided in a separate vertical programme without re-creating a whole new parallel health system infrastructure. If ART is to reach the huge numbers who need it and in an organised and regulated manner (required to ensure adherence to protocols and to avoid treatment failure and development of multi drug resistance), the existing health care infrastructure will have to be called upon. The private-for-profit sector and workplace health services may have a role to play, but cannot substitute for the core function of the

public health sector, both as provider of services and as a manager of roll-out.”¹ The inadequate supply of skilled and motivated health care workers is now generally recognised as a key systems constraint to scaling up of HIV treatment. Not only is the absolute number of health care workers in Africa inadequate but the skill mix and managerial capacity is inadequate.

The role of Schools of Public Health is to respond to the big questions that vex the development and delivery of health services and related interventions that will impact positively on population health. It is essential that Schools of Public Health understand the fundamental skills that are required to build a cadre of health care workers at various levels who are able to simultaneously to develop a coherent and effective and appropriate responses to HIV and to build functional health care systems. Thus an appropriate curriculum, taught by a faculty that is multi disciplinary and rooted in health services and real day to day issues of health service delivery, through practice and research is essential. Schools of Public Health must therefore respond to this issue - take on the responsibility of training managers at mid and senior level and develop an understanding of health systems development.

Further, fundamental to the generation of appropriate solutions for health and development in Africa is research - conceptualized, conducted, analyzed and published by Africans. In order to do this, research capacity in Africa must be developed. The immediate need in Africa is to considerably expand the base of masters-level research scientists with the vital skills and qualities necessary to contribute to research and leadership focused on promoting health and development on the continent.

In this presentation I will describe the responses that the Wits School of Public Health has developed in order to train health care workers to begin to fill the skill gaps required to build the South African health care system, the programmes, the number of graduates and where they work. The Wits School of Public Health has integrating the three functions of universities: service; teaching; and research in an attempt to be more efficient in producing appropriate graduates. Examples of this will be presented. The paper will end by describing the kind of investments needed to make such an approach feasible and sustainable.

¹ This paragraph is drawn from, and a significant part of this paper is informed by a publication by Schneider et al “Health systems strengthening and ART scaling up: challenges and opportunities.” 2004 Centre for Health Policy, School of Public Health, University of the Witwatersrand which has been placed on the web (ref required) and people are encouraged to read it.

Preliminary summary of discussion from Africa (1) group.

SUMMARY

1. Each School of Public Health is context specific and broad generalizations do not hold.
2. African Schools need to develop a public health workforce who are able to understand, develop and implement interventions that impact on population health – they need adequate resources to do this
3. Advocacy as a tool of public health can/should be included in the teaching programmes
4. The network of public health professionals is weak

RECOMMENDATIONS

1. A network of Schools of public health and or public health professionals and or Public health associations is desirable.
2. The network would focus on a range of issues:–
 - a. training,
 - b. around a specific issue (topical and important now is the documentation of the impact of issue (disease) specific international funding and to motivate for the need for integration and synergy of funding so that while specific health issues are addressed a focus on building the health care system overall is also achieved
 - c. advocacy on the above issue to both national governments and to international donors
 - d. advocacy for public health as a discipline and for the role of public health professionals both nationally and internationally
3. increase the capacity of schools of public health to train so as to increase the critical mass of public health professionals

ACTION PLAN

1. Immediate – the host a workshop/meeting in conjunction with the Public Health Association of Southern Africa (PHASSA) meeting in May 2006 to develop this idea.
2. To build a consensus for a presentation at the Global forum meeting in November

Preliminary summary of discussion from MENA (2) group.

Colleagues present from Iran, Lebanon and Pakistan

1. IMPORTANCE OF THE PROBLEM

- Absence of reliable data due to organizational defects and denial/ religious stigma attitudes, and the absence of national control programs in most MENA countries.
- Evolving epidemic of unknown dimensions in Iran and Pakistan, low endemic problem in Lebanon (about 1 new case/100,000 per year).
- In Lebanon, it has helped to confront the religious establishment with their responsibility for the “preservation of the family” and to include them in the decision-making for preventive activities. Thus the “silence” was broken.
- The perceived financial helplessness of governments facing the issue of HIV is a disincentive to further investigate/control the problem
- There is an opportunity for surveillance of HIV in Iran when drivers are tested for drugs every 5 years to renew their license
- Important role of anonymous hotlines to provide a venue for HIV-related information

2. RESPONSES TO SPECIFIC QUESTIONS

- In some areas, government employees are sent to SPH to obtain diplomas in infectious surveillance and control, but not specifically for HIV/AIDS control.
- Training offered by SPH is often affected by agendas set by the funding agencies rather than by NGO groups. Consequently, the impact of such “unrequited” training remains limited.
- There are no identified career tracks in HIV issues now.
- Not much programmatic involvement from SPH in MENA area with public infectious control agencies.
- There are opportunities for students’ research on these issues in several SPH.
- Individual consultations from academic staff with governmental agencies on HIV/AIDS have occurred.

3. MAIN RECOMMENDATIONS FOR POTENTIAL ROLE OF PH SCHOOLS

- a. Promoting epidemiological research to generate reliable data on the profile of the epidemic which would then orient the recommendations for prevention. All sources of data can be used, especially data from situations where blood is tested for one reason or the other.
- b. Conducting needs assessments to discover real programmatic training demands from governmental and NGO sectors.
- c. Creating educational modules/programs for attitudinal change in youth; opinion-makers: political, religious; etc...
- d. Effecting university curricular changes in health/medicine to include more awareness on HIV/AIDS, thus provoking a demand to care for HIV-related issues
- e. Engaging with government and playing an advocacy role for better control or prevention of HIV and protection of the rights of HIV sufferers
- f. Building support networks for HIV-related research, training, community services and academic programs, in collaboration with international organizations such as OSI and others.

CONCLUSIONS AND RECOMMENDATIONS
OF THE WORKING GROUP
FROM
AFRICAN COUNTRIES

September 17, 2005, OSI Workshop Part 1

ASPHER XXVII ANNUAL CONFERENCE
17-20 September, 2005, Yerevan, Armenia

**WORKSHOP: OSI REGIONAL COOPERATION:
EXPLORING PARTNERSHIPS WITH SCHOOLS OF PUBLIC HEALTH TO
ADDRESS HIV/AIDS in PARTNERSHIP WITH OSI AND THE GLOBAL FUND TO
FIGHT AIDS, TB, MALARIA (GFATM) IN AFRICA, EURASIA, EUROPE & THE
MIDDLE EAST**

Participants of Workshop from Ghana, Tanzania, Kenya, South Africa had discussed the situation of public health training and the role of schools of public health in context of OSI and the Global Fund initiatives to fight Aids, TB, Malaria.

The problems to be solved and some recommendations of this workgroup are presented below.

1. IMPORTANCE OF THE PROBLEM

- Each School of Public Health is context specific and broad generalizations do not hold.
- African Schools need to develop a public health workforce who are able to understand, develop and implement interventions that impact on population health – they need adequate resources to do this
- Advocacy as a tool of public health can/should be included in the teaching programs
- The network of public health professionals is weak

2. RECOMMENDATIONS

- A network of Schools of public health and or public health professionals and or Public health associations is desirable.
- The network would focus on a range of issues:
 - a. training,
 - b. around a specific issue (topical and important now is the documentation of the impact of issue (disease) specific international funding and to motivate for the need for integration and synergy of funding so that while specific health issues

are addressed a focus on building the health care system overall is also achieved

- c. advocacy on the above issue to both national governments and to international donors
- d. advocacy for public health as a discipline and for the role of public health professionals both nationally and internationally
- Increase the capacity of schools of public health to train so as to increase the critical mass of public health professionals

3. ACTION PLAN

- Immediate – the host a workshop/meeting in conjunction with the Public Health Association of Southern Africa (PHASSA) meeting in May 2006 to develop this idea.
- To build a consensus for a presentation at the Global forum meeting in November.

**CONCLUSIONS AND RECOMMENDATIONS
OF THE WORKING GROUP
FROM
THE MIDDLE EAST REGION AND SOUTH ASIA**

September 17, 2005, OSI Workshop Part 1

ASPHER XXVII ANNUAL CONFERENCE
17-20 September, 2005, Yerevan, Armenia

**WORKSHOP: OSI REGIONAL COOPERATION:
EXPLORING PARTNERSHIPS WITH SCHOOLS OF PUBLIC HEALTH TO
ADDRESS HIV/AIDS in PARTNERSHIP WITH OSI AND THE GLOBAL FUND TO
FIGHT AIDS, TB, MALARIA (GFATM) IN AFRICA, EURASIA, EUROPE & THE
MIDDLE EAST**

Participants, which represented Iran, Lebanon, Pakistan, Mongolia had discussed the situation of public health training and the role of schools of public health in context of OSI and the Global Fund initiatives to fight Aids, TB, Malaria.

The problems to be solved and some recommendations of this workgroup are presented below.

1. IMPORTANCE OF THE PROBLEM

- Absence of reliable data due to organizational defects and denial/ religious stigma attitudes, and the absence of national control programs in most of the countries.
- Evolving epidemic of unknown dimensions in Iran and Pakistan, low endemic problem in Lebanon (about 1 new case/100,000 per year).
- In Lebanon, it has helped to confront the religious establishment with their responsibility for the “preservation of the family” and to include them in the decision-making for preventive activities. Thus the “silence” was broken.
- The perceived financial helplessness of governments facing the issue of HIV is a disincentive to further investigate/control the problem
- There is an opportunity for surveillance of HIV in Iran when drivers are tested for drugs every 5 years to renew their license
- Important role of anonymous hotlines to provide a venue for HIV-related information

2. RESPONSES TO SPECIFIC QUESTIONS

- In some areas, government employees are sent to SPH to obtain diplomas in infectious surveillance and control, but not specifically for HIV/AIDS control.

- Training offered by SPH is often affected by agendas set by the funding agencies rather than by NGO groups. Consequently, the impact of such “unrequited” training remains limited.
- There are no identified career tracks in HIV issues now.
- Not much programmatic involvement from SPH in the countries with public infectious control agencies.
- There are opportunities for students’ research on these issues in several SPH.
- Individual consultations from academic staff with governmental agencies on HIV/AIDS have occurred.

4. MAIN RECOMMENDATIONS FOR POTENTIAL ROLE OF SPH

- Promoting epidemiological research to generate reliable data on the profile of the epidemic which would then orient the recommendations for prevention. All sources of data can be used, especially data from situations where blood is tested for one reason or the other.
- Conducting needs assessments to discover real programmatic training demands from governmental and NGO sectors.
- Creating educational modules/programs for attitudinal change in youth; opinion-makers: political, religious; etc.
- Effecting university curricular changes in health/medicine to include more awareness on HIV/AIDS, thus provoking a demand to care for HIV-related issues
- Engaging with government and playing an advocacy role for better control or prevention of HIV and protection of the rights of HIV sufferers
- Building support networks for HIV-related research, training, community services and academic programs, in collaboration with international organizations such as OSI and others.

**CONCLUSIONS AND RECOMMENDATIONS
OF THE WORKING GROUP
FROM
EUROASIA REGIONS**

September 19, 2005, OSI Workshop Part 2

ASPHER XXVII ANNUAL CONFERENCE
17-20 September, 2005, Yerevan, Armenia

**WORKSHOP: OSI REGIONAL COOPERATION:
EXPLORING PARTNERSHIPS WITH SCHOOLS OF PUBLIC HEALTH TO
ADDRESS HIV/AIDS in PARTNERSHIP WITH OSI AND THE GLOBAL FUND TO
FIGHT AIDS, TB, MALARIA (GFATM) IN AFRICA, EURASIA, EUROPE & THE
MIDDLE EAST**

Participants of Workshop from Albania, Armenia, Bulgaria, Croatia, Estonia, Hungary, Poland, Latvia, Lithuania, Macedonia, Kazakhstan, Uzbekistan, Tajikistan, Mongolia had discussed the situation of public health training and the role of schools of public health in context of OSI and the Global Fund initiatives to fight Aids, TB, Malaria.

The problems to be solved and some recommendations how these issues to be tackled are presented below.

1. IMPORTANCE OF THE PROBLEM

- Majority of countries have a low-prevalence of HIV/AIDS, with low absolute number of cases, but rapid increase rates of disease spread in most of the places.
- Public health agenda had been dominated by the problems of high mortality and morbidity from CVD/CHD, cancers. Evidence on health effects of smoking, alcohol abuse also was well presented but less covered by the prevention measures in majority of these countries.
- Some countries (e.g. Latvia and Ukraine) locate the HIV/AIDS problem on the country health policy agenda. However lack of involvement of and relevant training at the Schools of Public Health was observed in the region.
- Most countries have well documented data on prevalence of HIV, TB, and malaria in populations. Some countries (Uzbekistan, Tajikistan) need more advanced monitoring system and resources allocated. Perception of the problem of HIV ranges from increasingly threatening (in Ukraine) to moderate or small (Macedonia, Lithuania).
- Concepts of harm reduction, protection of rights of marginalized groups still need to be more strongly communicated and discussed in majority of these countries.
- At the moment Schools of public health do not seem to play a meaningful role in the provision of training in the HIV/AIDS & TB prevention area, and in the development of projects on advocacy and tackling inequalities in health. Some

countries have only recently started (Macedonia, Albania, Uzbekistan etc) or going to start modern public health postgraduate training (Tajikistan, Mongolia).

2. RECOMMENDATIONS

- Assist partner countries in the region to establish and strengthen Schools' of Public Health teaching capacities in this area;
- Provide support for epidemiological research in the countries without resources and relevant experience to do it;
- Introduce HIV/AIDS prevention and control issues, incl. harm reduction, into the teaching agenda and research curriculum at the schools of public health
 - a. Encourage individuals and groups of students to conduct research in the HIV/AIDS area in a separate country and possibly, across several countries (for example, neighboring countries or united by a common specific topical interest);
 - b. Incorporate cases on HIV/AIDS within the modules of PH courses, (Epidemiology, Communicable diseases, Health Economics, Health Promotion and Disease Prevention, Health Policy.
 - c. Develop short re-training courses on HIV/AIDS/ HIV-TB at the request of the local government agencies/ MoH, and NGOs, HIV service providers.
 - d. Develop teaching courses on health advocacy and work with marginalized groups, on rights of patients.
- Extend collaboration of schools of Public health with NGOs, community groups, which are involved in HIV/AIDS and drug abuse control projects
- Schools of public health in the region should use the opportunity for networking in the framework of ASPHER or to create informal networks. Partners also are encouraged to develop joint applications (as the networks) for international funding organizations.
- Schools of public health in the Eurasia region in context of globalization are encouraged to take into account experiences of developed industrial countries as well as lessons learned from Africa, Middle East and South Asia about practices of tackling HIV, TB, malaria in these countries.

**ASPHER XXVII ANNUAL CONFERENCE
17-20 September 2005, Yerevan, Armenia**

WORKSHOP

**OSI REGIONAL COOPERATION:
EXPLORING PARTNERSHIPS WITH SCHOOLS OF
PUBLIC HEALTH TO ADDRESS HIV/AIDS in
PARTNERSHIP WITH OSI AND THE GLOBAL FUND
TO FIGHT AIDS, TB, MALARIA (GFATM) IN
AFRICA, EURASIA, EUROPE & THE MIDDLE EAST**

**Part 1: September 17, Saturday
Part 2: September 19, Monday**

FINAL REPORT

**Yerevan, Armenia,
2005**

Summary

Background. This Workshop was a result of collaboration of Network Public Health Programs of Open Society Institute, New York, and its projects aiming to strengthen teaching capacities at the schools of public health in Central and Eastern Europe. The discussions at the Workshop also projected the possible future activities in countries of Middle East and Africa in the context of global threat of such disease as Tuberculosis, AIDS, Malaria.

Initiative to hold a Workshop during ASPHER conference in Yerevan was launched by Noah Simmons and Michael Borowitz at the OSI New York in spring 2005. Kaunas School of Public Health, Kaunas, Lithuania and its representative Associate Professor Linas Sumskas was invited to lead the coordination of this Workshop together with the host of the Workshop – American University of Armenia (AUA). The AUA team - Tsovinar Haratyuinian, Ara Tekian, Irina Papieva and others – provided very strong professional contribution to this Workshop.

Main aim of the Workshop. To explore the interface of schools of public health, government, and civil society in Africa, Middle East, and Eurasia in the context of the HIV/AIDS epidemic and to distill a number of recommendations of concrete use for the program planning process of potential international funders, including OSI and the GFATM

Place, time and format. Workshop was organized at the premises of the American University of Armenia during the annual ASPHER conference in 2 parts. Part 1 was held on September 17, 2005 for Middle East and African countries (more than 20 participants were involved in this part); Part 2 was held on September 19, 2005 for Central and East European and Central Asian countries with participation of representatives from Part 1 (more than 32 persons were involved).

Participants. Workshop organizers invited directors, deans and key persons from the schools of public health from the following Middle East and Central Asia Countries: Lebanon – 3, Iran – 4, Pakistan 1, Mongolia – 1, Kazakhstan – 2, Tajikistan – 2, Uzbekistan – 1. Representatives from Eastern and South Eastern European countries were invited: Armenia – 4, Macedonia – 1, Croatia – 1, Bulgaria – ?, Estonia – 1, Latvia – 1, Lithuania – 1, Ukraine – 1, Poland – 1. African participants were represented at the Workshop by the following countries: Ghana – 1, Kenya – 1, South Africa – 2.

Plenary sessions and work in groups. Linas Sumskas and Ara Tekian were selected as the chairmen for this OSI Workshop.

Part 1. Linas Sumskas, Lithuania; Ara Tekian, US; Michael Borowitz, US; Anahit Papikyan, Armenia; Haroutune Armenian; Frederick Wurapa, Ghana; Sharon Fonn, South Africa; Tufail Bhatti, Pakistan; and Salim Adib, Lebanon, made their presentations during the plenary session. Later participants were selected to work in 2 groups: Middle East Group and African Group.

Part 2. Linas Sumskas, Lithuania; Martin McKee, UK; Carel Ijsamuiden, Switzerland; and Paola Pavlenko, Ukraine, made presentations at the plenary session. Participants continued their work in EuroAsia group. Middle East and African Groups had a possibility to finalize their reports and recommendations about public health training in context of collaboration and Global Fund to fight AIDS, TB, Malaria.

Conclusions and recommendations. The participants of this Workshop prepared three reports from Middle East Group, Africa Group and EuroAsia Group.

- African Group. The African group expressed the need for an initiative to provide stronger advocacy and support for public health training and professional field . It was recommended to strengthen collaboration between schools of public health and to continue attempts on establishing an international organization on the continent as the forum for discussing and planning joint public health training initiatives for Africa.
 - Middle East Group. Participants have emphasized the need for generating more reliable data on health situation in these countries. HIV/AIDS prevention issues were pointed out as very important and necessary to be included in the training curriculums.
 - EuroAsia Group. It was stated that the situations regarding the population health status and public health training were quite divers in this big geographic. The group emphasized the important role of Schools of public health in tackling HIV/AIDS issues and mentioned that international collaboration in the framework of the Global Fund initiatives provided more opportunities for receiving funding from international funding agencies.
-

Part 1: September 17, Saturday

Ara Tekian, PhD, MHPE, University of Illinois at Chicago

- Greeting remarks welcoming all participants; opening of the ASPHER conference;
- Introduction of all participants

List of the participants:

1. Adib Salim, Lebanon
2. Armenian Haroutune, Armenia
3. Bhatti Tufail, Pakistan
4. Borowitz Michael, US
5. Bozorgzad Ahmad, Iran
6. Fonn Sharon, Witwaterswand, SA
7. Haddad Nadim, Lebanon
8. Jalali Abdolarasool, Iran
9. Knight Stephen, SA
10. Odero Wilson, Kenya
11. Papikyan Anahit, Armenia
12. Papiyeva Irina, Armenia
13. Pavlekovic Gordana, Croatia
14. Shayesteh Salehi, Iran
15. Sumskas Linas, Lithuania
16. Tekian Ara, USA
17. Tusgdelger Sovd, Mongolia
18. Wurapa Frederick, Ghana
19. Zahraei Roshanak, Iran
20. Zurayk Huda, Lebanon

Ara Tekian, University of Illinois at Chicago, USA

- Description of workshop's general goals
- Introduction of Public Health as a science of great importance all over the world
- Emphasis was put on HIV/AIDS, TB and Malaria in Africa and Middle East regions and on the roles of Schools of Public Health (SPHs)

Linas Sumskas, Kaunas University of Medicine, School of Public Health, Lithuania

- Greetings/Opening remarks
- Introduction to workshop goals, objectives and format
- Emphasis on much broader scope of the workshop: coverage of Africa, Middle East Region and also East, South and Eastern Europe, Central Asia; expands discussion on newly emerging threat of AIDS, TB, Malaria; focus on a workforce development dimension and future roles of SPH
- Introduction to OSI priorities and focus
- Main goal of the workshop: to gain insights into how schools of public health interface with governmental policies; how PH workforce policies are designed to address HIV/AIDS & TB prevention and implemented in collaboration with the

GFATM; how community based programs could be engaged and collaborate through research of SPH

- Utilitarian goal of the workshop: to determine how might OSI work with SPHs, government, civil society and international funding agencies, particularly the GFATM, to address the tremendous public health threat of HIV/AIDS
- Objectives of the workshop: to analyze the relationship between PH short-term and diploma-track training and national health workforce policies, also training demand from the non-governmental sector in the context of the HIV/AIDS epidemic; discuss career tracks of SPH graduates in each country and describe the demand for public health education; describe existing models for the interface of SPHs and civil society whether through faculty/student research or other community outreach programs; analyze existing collaborative programs between SPHs and the Global Fund to Fight AIDS, TB, Malaria; distill a number of practical recommendations for the program planning process of funders, including OSI, with respect to HIV/AIDS and TB and to the access to health care of vulnerable populations

Michael Borowitz, OSI Public Health Programs

- Presentation of possible ways of collaboration between and inside countries
- Each country has to have its national independent foundation, its own executive board, which will be run not only by PH people
- Presentation of key OSI themes: marginalization and monitoring
- Description of civil society: it consists of governmental organizations, non-governmental organizations, media, schools of public health
- AIDS in Europe - elaboration on the issue: injected drug users, substitution therapy; controlling an epidemic - an evidence-based approach
- Strengthening civil society: law and health; media and health; public health watch schools of public health; policy centers

Anahit Papikyan, OSI, Armenia

- Short and precise presentation of scope of work of OSI Armenia: focus on drug users, smoking

Haroutune Armenian, American University of Armenia, Yerevan, Armenia

- Introduction to the AUA: western style; mission of AUA; its role in the society;
- current programs; research and development
- AUA Business Center; Garo Meghriyan eye institute for preventive ophthalmology;
- Alice Ohanasian digital library of Armenian classics
- Elaboration on Public Health Program at AUA
- Emphasis on importance of private delivery sector in health services in Armenia
- Collaboration with OSI

Frederick Wurapa, School of Public Health, University of Ghana, Ghana

- Presentation of government human resource policies, civil society and public health training in Africa in the context of a global crisis in health care inequity
- Introduction to the disease burden: high IMR; high MMR; tens of millions suffer from
- malaria, TB, HIV/AIDS/STD
- Elaboration on conditions of improved health: focus is on strong political

- commitment; intersectoral perspective in planning and operating of health care systems; organizational framework and managerial process; community involvement at all levels; equitable distribution of health resources
- Introduction to the main characteristics of national health care systems: emphasis is put on undersupply and under-use of human resources; poor communication facilities; need in trained professionals in policy analysis, planning and budgeting
- Public health training in Africa: main dimensions
- Factors affecting health workforce performance in Africa
- Objectives of the regional program: strengthening public health capacity; strengthening monitoring and evaluation; development of centers of excellence

Sharon Fonn, School of Public Health, Witwatersrand, SA

- Introduction to the University of Witwatersrand
- Elaboration on mission of the university: promotion of public health through relevant,
- appropriate and excellent teaching, research and service, based on the principles of equity; promotion of human rights and a coherent and comprehensive response to the needs of people of South and Sub-Saharan Africa in their various living and working conditions
- Main role of schools of public health: to respond to the big questions that aggravate the development and delivery of health services and related interventions that will have a positive impact on population health
- Introduction to HIV context in South Africa
- Roles of schools of public health: presentation of all current programs
- Elaboration on each program: Master of Public Health, MSc(Med) in Epidemiology and Biostatistics, MSc in Population-based Field Epidemiology
- Current research in the fields of public health regarding HIV/AIDS, TB and Malaria

Tufail Bhatti, Liaquat Medical Health University, Pakistan

- Presentation of the role of the tertiary health care center in AIDS surveillance in Pakistan: introduction to the study
- Elaboration on current situation with HIV/AIDS and Hepatitis B, Hepatitis C in Pakistan: presentation of available data
- Specific objectives of the study: to determine healthy blood donors in screening program during 2001 to 2004 in research blood bank of LUMHS, Hyderabad; to evaluate the Surveillance system and Screening Program in LUMHS, Hyderabad; to provide recommendations of our study to the concerned department of LUMHS.
- Results of the study: main emphasis is on the fact that there is no any epidemiological and demographical picture available at in tertiary health care center
- Recommendations: blood donors found reactive in HBV, HCV or HIV in healthy donors should be advised for further advanced confirmatory investigations; the questionnaires of proper record keeping should be included for epidemiological and demographical events.

Salim Adib, Lebanese University, Beirut

- Short presentation about situation on HIV/AIDS in Lebanon
- Introduction to the history of HIV/AIDS epidemic

- Presentation of available statistical data
- Possible ways of transmission
- Dynamics of the epidemic

Work in groups

Group 1: African Countries (Ghana, Tanzania, Kenya, South Africa)

Reporter – Sharon Fonn

Group 2: Middle East Countries (Iran, Lebanon and Pakistan)

Reporter – Salim Adib

TOPIC 1: Discuss and document the interface of schools of public health, government, and civil society in Europe or Eurasia in the context of the HIV/AIDS epidemic

TOPIC 2: Distill a number of recommendations for the program planning process of potential funders, including OSI and the GFATM, involving the contributions of SPHs to the fight against HIV/AIDS and TB

- Discussion of the topics
- Presentation of the results/preliminary reports

Final report of the discussion from the Group 1 (Africa group).

1. Importance of the problem

- Each School of Public Health is context specific and broad generalizations do not hold.
- African Schools need to develop a public health workforce who is able to understand, develop and implement interventions that impact on population health. African Schools need adequate resources to do this
- Advocacy as a tool of public health can/should be included in teaching programs
- The network of public health professionals is weak

2. Recommendations

- A network of Schools of public health and or public health professionals and or Public health associations is desirable.
- The network would focus on a range of issues:
 - training
 - specific and important issues now is the documentation of the impact of issue (disease)), specific international funding and to motivate for the need for integration and synergy of funding so that while specific health issues are addressed a focus on building the health care system overall is also achieved [this part is not clearly stated]
 - advocacy on the above issue among both national governments and international donors
 - advocacy for public health as a discipline and for the role of public health professionals both nationally and internationally
- Increase the capacity of schools of public health to train to create a critical mass of public health professionals

3. Action plan

- Immediate – to host a workshop/meeting in conjunction with the Public Health Association of Southern Africa (PHASSA) meeting in May 2006 to develop this idea.
- To build a consensus for a presentation at the Global forum meeting in November.

Final report of the discussion from the Group 2 (MENA).

The participants from Iran, Lebanon, Pakistan, and Mongolia had discussed the situation of public health training and the role of schools of public health in the context of OSI and Global Fund initiatives to fight Aids, TB, and Malaria.

The problems to be solved and some recommendations are presented below.

1. Importance of the problem

- Absence of reliable data due to organizational defects and denial/ religious stigma attitudes, and the absence of national control programs in most of the countries.
- Evolving epidemic of unknown dimensions in Iran and Pakistan, low endemic problem in Lebanon (about 1 new case/100,000 per year) [what condition is meant here? If the only focus is HIV/AIDS then it should be specified from the beginning.].
- In Lebanon, the religious establishments were confronted with their responsibility for the “preservation of the family” and they were included in the decision-making for preventive activities.
- The perceived financial helplessness of governments facing the issue of HIV is a disincentive to further investigate/control the problem
- There is an opportunity for surveillance of HIV in Iran when drivers are tested for drugs every 5 years to renew their license
- Important role of anonymous hotlines to provide a venue for HIV-related information

2. Responses to specific questions

- In some areas, government employees are sent to SPH to obtain diplomas in infectious surveillance and control, but not specifically for HIV/AIDS control.
- Training offered by SPH is often affected by agendas set by the funding agencies rather than by NGO groups. Consequently, the impact of such training remains limited.
- There are no identified career tracks in HIV issues now.
- Not much programmatic involvement from SPH in the countries with public infectious control agencies.
- There are opportunities for students’ research on these issues in several SPH.
- Individual consultations from academic staff with governmental agencies on HIV/AIDS have occurred.

3. Main recommendations for potential role of SPH

- Promoting epidemiological research to generate reliable data on the profile of the epidemic, which would then orient the recommendations for prevention. All sources of data can be used, especially data from special screenings where blood is tested for one reason or the other.
- Conducting needs assessments to discover real programmatic training demands from governmental and NGO sectors.
- Creating educational modules/programs for attitudinal change in youth; opinion-makers: political, religious; etc.
- Effecting university curricular changes in health/medicine to include more awareness on HIV/AIDS, thus provoking a demand to care for HIV-related issues

- Engaging with government and playing an advocacy role for better control or prevention of HIV and protection of the rights of HIV sufferers
- Building support networks for HIV-related research, training, community services and academic programs, in collaboration with international organizations such as OSI and others.

Part 2: Monday, September 19, 2005
Yerevan, Armenia

List of OSI Workshop Part 2 participants

1. Armenian Haroutune, AUA, Armenia
2. Bhatti Tufal Ahmed, Pakistan
3. Bozorgzad Ahmad, Iran
4. Berry Elliot, Israel
5. Bino Silvia, Albania
6. Birt Chrristopher, UK
7. Fonn Sharon, South Africa
8. Georgijeva Lora, Bulgaria
9. Gray Selena, UK
10. Hudaykulov Umid, Uzbekistan
11. Ijsalmuiden Carell, Switzerland
12. Isjanovska Rosalinda, Macedonia
13. Kauhanen Jusi, Finland
14. Kosa Karolina, Hungary
15. Kulshanov Maksut, Kazakhstan
16. Maksudova Zumrat, Tajikistan
17. McKee Martin, UK
18. Papiyeva Irina, Armenia
19. Pavlekovic Gordana, Croatia
20. Pavlenko Paola, Ukraine
21. Polluste Kaja, Estonia
22. Roshi Enver, Albania
23. Salim Adib, Lebanon
24. Sumskas Linas, Lithuania
25. Szosland Dorote, Poland
26. Takenova Madina, Kazakhstan
27. Tekian Ara, USA
28. Tudsgdelger Sovd, Mongolia
29. Villerusa Anita, Latvia
30. Wilson Odero, Kenya
31. Wurapa Frederick, Ghana
32. Zurayk Huda, Lebanon

Linas Sumskas, SPH, Kaunas University of Medicine, Kaunas, Lithuania

- Opening remarks
- Introduction to the objectives of the second day of the workshop
- Introduction of the presenters

Prof. Martin McKee, London School of Hygiene and Tropical Medicine, UK. Member of the OSI Global Health Advisory Committee

- Elaboration on key OSI themes, presented by Michael Borowitz on the first day of the workshop: marginalization and monitoring
- Presentation of network matrix in two dimensions: marginalized groups and specific health issues; capacity building and monitoring

- Introduction to the horizontal approach: human rights model: “Watch”;
 - democratic accountability with the emphasis on budget transparency;
 - monitoring and accountability in a global environment (example from UN system)
- Introduction to key components of development assistance with the specific examples of AIDS in Africa, Central Asia
- Controlling an Epidemic: introduction to the evidence-based approach and focusing on its key components: incidence as being the most important component, understanding of the whole epidemic curve and assessment of current situation, cost-effectiveness of the interventions and implications for palliation (specification with AIDS example)
- Elaboration on Tuberculosis issue
- Strengthening civil society
- Introduction to policy concept: its elements and links to service delivery
- Modes of work with the emphasis on OSI activities and Public Health Schools

Carel Ijsselmuiden, Council on Health Research and Development (COHRED), Geneva, Switzerland

- Introduction to the mapping public health education capacity in and for Africa
- Explanation of the term - public health capacity. Introduction to core objectives: mapping of public health capacity in and for Africa. Assessment of capacity for technology-supported distance learning as a short-term objectives; creation of the opportunities for network development and dissemination of the information as a medium-term objectives; start or re-start of “African Association of Schools of Public Health” (accreditation, networking) and strengthening of African Public Health Association as long-term objectives
- Emphasis on a continental approach to improving public health in line with new socio-political realities
- Exploiting information technology to optimize learning and teaching
- approach of “Essential Public Health Functions” is an example of more pragmatic and narrow approach
- Possible outcomes from AfriHealth can be various not only related to schools,
 - Education and research; may include advocacy, linkage, infrastructure and health
 - Systems engagement
- Elaboration on current phase (re-starting) and particularly on this meeting:
- Communicate the findings, reconnect, and develop the future of AfriHealth with your help
- Introduction to the outputs AfriHealth (see presentations)
- Short introduction to the results and programs (see presentation) Summarizing all important points: Africa needs a plan for PH
- It is necessary to enable countries to invest in research for health

Paola Pavlenko, SPH, Mohyla Academy, Kyiv, Ukraine

- Introduction to HIV/AIDS epidemic in the Ukraine: statistics, transmission routes
- Responses that took place in the 2003-2005 time period
- Presentation of UKMA Public Health School
- Projects of 2003-2005 yy. with the emphasis on two of them: Set up and running “Kyiv Regional Info-Resource Centre on HIV/AIDS” (GF/ Alliance)

- Development of and running a new training programme “Social work for people living with HIV/AIDS” (GF/Alliance)
- Short introduction to the Kyiv Regional Resource Centre for HIV/AIDS
- Brief review of social work with people living with HIV/AIDS course development
- Introduction to partnerships and participation

Work in groups

Group 1: Latvia, Lithuania, Estonia, Kazakhstan, Tajikistan, Ukraine, and Armenia

Group 2: Albania, Bulgaria, Croatia, Macedonia, Hungary, Poland

TOPIC 1: Discuss and document the interface of schools of public health, government, and civil society in Europe or Eurasia in the context of the HIV/AIDS epidemic

TOPIC 2: Distill a number of recommendations for the program planning process of potential funders, including OSI and the GFATM, involving the contributions of SPHs to the fight against HIV/AIDS and TB

The participants from Albania, Armenia, Bulgaria, Croatia, Estonia, Hungary, Poland, Latvia, Lithuania, Macedonia, Kazakhstan, Uzbekistan, Tajikistan, and Mongolia discussed the situation of public health training and the role of schools of public health in the context of OSI and Global Fund initiatives to fight Aids, TB, and Malaria.

The problems to be solved and some recommendations how these issues to be tackled are presented below as a summary of the two groups’ discussion (EURASIA group).

1. Importance of the problem

- Majority of countries have a low-prevalence of HIV/AIDS, with low absolute number of cases, but rapid increase rates of disease spread in most of the places.
- Public health agenda had been dominated by the problems of high mortality and morbidity from CVD/CHD, cancers. Evidence on health effects of smoking, alcohol abuse also was well presented but less covered by the prevention measures in majority of these countries.
- Some countries (e.g. Latvia and Ukraine) locate the HIV/AIDS problem on the country health policy agenda. However lack of involvement of and relevant training at the Schools of Public Health was observed in the region.
- Most countries have well documented data on prevalence of HIV, TB, and malaria in populations. Some countries (Uzbekistan, Tajikistan) need more advanced monitoring system and resources allocated. Perception of the problem of HIV ranges from increasingly threatening (in Ukraine) to moderate or small (Macedonia, Lithuania).
- Concepts of harm reduction, protection of rights of marginalized groups still need to be more strongly communicated and discussed in majority of these countries.
- At the moment Schools of public health do not seem to play a meaningful role in the provision of training in the HIV/AIDS & TB prevention area, and in the development of projects on advocacy and tackling inequalities in health. Some countries have only

recently started (Macedonia, Albania, Uzbekistan etc) or going to start modern public health postgraduate training (Tajikistan, Mongolia).

2. Recommendations

- Assist partner countries in the region to establish and strengthen Schools' of Public Health teaching capacities in this area;
- Provide support for epidemiological research in the countries without resources and relevant experience to do it;
- Introduce HIV/AIDS prevention and control issues, including harm reduction, into the teaching agenda and research curriculum at the schools of public health
 - Encourage individuals and groups of students to conduct research in the HIV/AIDS area in a separate country and possibly, across several countries (for example, neighboring countries or united by a common specific topical interest);
 - Incorporate cases on HIV/AIDS within the modules of PH courses (Epidemiology, Communicable diseases, Health Economics, Health Promotion and Disease Prevention, Health Policy);
 - Develop short re-training courses on HIV/AIDS/ HIV-TB at the request of the local government agencies/ MoH, and NGOs, HIV service providers;
 - Develop teaching courses on health advocacy and work with marginalized groups on rights of patients.
- Extend collaboration of schools of Public health with NGOs, community groups, which are involved in HIV/AIDS and drug abuse control projects;
- Schools of public health in the region should use the opportunity for networking in the framework of ASPHER or to create informal networks. Partners also are encouraged to develop joint applications (as the networks) for international funding organizations.
- Schools of public health in the Eurasia region, in the context of globalization, are encouraged to take into account experiences of developed industrial countries as well as lessons learned from Africa, Middle East and South Asia about practices of tackling HIV, TB and Malaria in these countries.

WORKSHOP 2

Workshop 2

Sunday, 18 September 2005

PUBLIC HEALTH TRAINING IN THE CONTEXT OF AN ENLARGING EUROPE (PHETICE)

Thierry Louvet, thierry.louvet@aspher.ensp.fr
Executive Director, ASPHER

Purpose

The purpose of this workshop is to introduce and familiarise participants with the EU co-funded PHETICE project in which ASPHER is a partner.

Objectives

The objectives of this workshop are:

- to present the objectives and planned output of the PHETICE project;
- to ensure support and participation from European PH training programmes for this project by raising its visibility in the ASPHER community;
- to get some initial feedback from represented European SPHs and programmes on the project.

ASPHER Annual Conference, Yerevan, Armenia

Workshop 2: Public Health Training in the Context of an Enlarging Europe (PHETICE)

Sunday 18 September 2005 – 11.30 to 13.00

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Programme Outline:

Introduction

Thierry Louvet, Executive Director, ASPHER.

Background information on PHETICE project:

Emil Pettersson, Dpt of Public Health, Karolinska Institute, Stockholm, Sweden.

Work Package 3: Introduction of prioritised issues, networking and production of guidelines

Susanna Thulin, Dpt of Preventive Nutrition, Karolinska Institute, Stockholm, Sweden.

ASPHER's contribution.

Thierry Louvet, Executive Director, ASPHER

The workshop was introduced by Thierry Louvet, ASPHER Executive Director. The other presenters are:

- Susanna Thulin, Department of Preventive Nutrition, Karolinska Institute (Sweden);
- Emil Petersson, Department of Public Health, Karolinska Institute (Sweden);

The PHETICE project is funded under the EU Public Health programme (DG Sanco), the same funding programme as for the EMPH project. ASPHER is now one of the partners in the PHETICE project.

The purpose of this workshop is to present the overall objectives of the project which has only very recently started and also to enlist the support of ASPHER members to take part in the mapping of PH education in Europe.

TL hands over to Emil Petersson (EP) who presents the overall framework of the project.

Background to PHETICE

Four European Master programmes (see below) had received funding from DG Sanco and were told by DG Sanco that funding would be terminated unless those programmes were to start working together. They then started to establish this project with Karolinska Institute as a coordinator and ASPHER was later approached. The acronym (PHETICE) stands for Public Health training in the context of an enlarging Europe.

The contract was signed with DG Sanco in July of this year but started officially on 1 April with a budget of 2 Million Euros for 3 years.

The Partners are:

- at Karolinska Institute, Stockholm, Sweden: Dpt of Social Medicine and Dpt of Biosciences (where Preventive Nutrition is)
- University of Brighton UK (UoB)
- Free University Amsterdam Netherlands (VUA)
- Johannes Gutenberg University in Mainz Germany (JoGU)

Respectively, the Dpt of Biosciences has a European Master in Nutrition, UoB a European Master in Health Promotion, VUA a European Master in PH Gerontology and JoGU a European Master in Epidemiology.

The general objectives of this project are as follows:

- To contribute to a European strategy in public health (PH) specialist training, building on experiences and investments from existing training programmes, identifying commonalities and synergies;
- To identify and integrate educational institutions from acceding and candidate countries into existing European PH training programmes;
- To develop a common understanding of the core competencies of professionals within PH specialist areas, through networking and collaboration with relevant projects and institutions;
- To develop European professional and academic standards to enable uniform quality control processes and joint degrees on all levels;
- To further develop methods for PH training and integrate areas of inequality, health monitoring and best practice (EU prioritised areas) in PH training (e.g. in teaching modules);
- To publish and disseminate guidelines for public health specialist training in Europe;
- To increase access to evidence-based education and information to European PH specialists and thereby to European citizens.

The work is divided among partners in different Work Packages (WP) with KI Dpt of PH as the coordinator of the project. These are:

WP 3 "Introduction of prioritised issues, networking and production of guidelines" is done by KI Dpt of Preventive Nutrition;

WP 4 by UoB is "Professional and academic standards/Pedagogical strategies";

WP5 by VUA is "Programme linkage, curriculum and modules";

WP 6 is Website and Databases is done by ASPHER;

WP 7 by JoGU is about "Mapping PH programmes in Europe".

Jutta Lindert from JoGU (Mainz) was supposed to be here and it would have been useful because her WP is the first thing we will have to do in PHETICE i.e. to map what kind of PH training is out there in Europe.

Development of questionnaires for programme directors to be answered on-line (via internet) and this part is done by ASPHER.

A further aim of the project which is not explicitly in the objectives and was agreed in our first project committee meeting in April is to link between the networks and improve communication between those networks and also to contribute to the implementation of the Bologna process and this why we were granted money for this project. DG Sanco would like to see more harmonisation in PH training and to strengthen this area.

Following Emil's presentation, Susanna Thulin gives an overview of WP3 led by KI PrevNut (Agneta Yngve and Susanna Thulin). Attention here is focusing on curricula design and content with regards to surveillance of health indicators (what are the relevant determinants and indicators to include).

Also included are equality within countries, best practice and European dimension.

The main objective of WP3 is to integrate prioritised areas into the core curriculum either as full modules or as part of modules. A separate module will be produced on monitoring.

The deliverables of WP3 are:

- report on consensus regarding inclusion of prioritised issues in core curricula. To be finalised in June 2006.
- Introductory module in health monitoring (10-15 ECTS) to be completed by August 2006.
- Guidelines and dissemination to identified contacts. December 2006.

This was a short introduction to this WP as the work has not yet started.

In his presentation, TL stresses the following points:

- importance of the enlarging Europe concept which refers to both new entrants in the now EU25 and accessing countries such Bulgaria and Romania and beyond (Balkan countries in particular).
- Context in which ASPHER was approached by KI. ASPHER was not involved in the initial project write-up and the reason why ASPHER was approached is because one of the initial partner withdrew.
- Initial contact between KI and A. Foldspan and hence this opportunity arose and it made sense to join in view of the overall content and objectives of the project.

For instance content and deliverables of all WP were already all written up and ASPHER was not able to change these even if we hope to influence the process as we go along. ASPHER's role is limited to WP6 (Website and databases).

This is our core business as it deals with PH training in Europe and with Eastern Europe in particular. Even if our role is more technical on paper, we want to be able to influence positively the project by making our knowledge and experience available to all the partners.

The first step in the project is to map PH training in CEE countries in order to bring them into the project. ASPHER will create a tool which will allow to collect information (on-line web-based tool).

In terms of deliverables, ASPHER will have to produce:

- Web-based questionnaires;
- Database of information collected.

Opportunity for ASPHER to enlarge its knowledge of other existing training programmes.

Presentations are followed by Questions & Answers session:

Question from André Meijer (University of Maastricht) about the Bologna declaration.

Reply from EP and ST stressing the 3+2 model.

Question from Franco Cavallo (Turin University): Is ASPHER's role going to be limited to WP6 or will it be larger? What is the strategy behind all this as it is not apparent from the presentations made?

On the first question, TL hopes that by being now involved in PHETICE, the EMPH will become an integral part as this was not the case at the outset if we refer to all four other European Master programmes.

On the generalist versus more specialised European Masters, EP sees this as an area of reflexion. Should Europe follow a North American generalist approach or a specialised approach?

Question from Vesna Bjegovic (Belgrade) about modules and ECTS and scope of PH training to be mapped (will it include undergraduate as well as postgraduate?)

Reply from EP: Discussion on this already and even if undergraduate education was not initially part of the project it will now be included.

Future guidelines to be produced will be more of a benchmarking nature.

Comment from Roza Adany (SPH Debrecen): In the EMPH project very important questions were discussed with the participation of ASPHER member schools. It would be nice if the other partners in the PHETICE project would acknowledge the work already done by ASPHER in this area, as well as on accreditation. For RA, these should be the basis for the work to be done by this project. On Bologna, in the case of health sciences, of which Public Health is a part, the 3+2 model cannot be used for RA.

EP had no further comment to make on the point relating to ASPHER's role in the project. On Bologna, it will be up to individual governments to implement the Bologna declaration according to their own rules and regulations.

Gordana Pavlekovic (A. Stampar SPH, Zagreb, Croatia) supports all the other points made by other participants and has no further comment to make. Regarding the other partners, as they are part of academic circles, do you plan to have cooperation with EUPHA?

EP: The answer is yes and plans are made in order to be present at the EUPHA conference in Graz in November of this year (workshop with representatives of all the work packages).

Ted Tulchinsky (Hadassah-Braun SPH Jerusalem, Israel) has the impression listening to the presentations that people are trying to rediscover the wheel and realise that it may come out square. He wants to caution the partners in PHETICE and by doing so will only repeat what others already said but will say it more bluntly. A lot of efforts has been put in the creation and development of SPHs in Europe over the last 50 years. There is an experience and there is a momentum and there is a certain consensus towards the content.

But that is not what you are thinking about if we listen to your presentations. None of the members of your consortium have an MPH programme so TT is suggesting a very open door to ASPHER and all of the people in ASPHER in the decision-making process, so not simply on the web page aspect.

TT takes as an example the nutrition specialty in PH. The EU in this area is lagging behind on important issues of PH nutrition and he senses that this could happen with other specialties. He would that his comments are taken in a constructive and not regressive manner in a train already in motion.

Reply by EP: he is aware of the risk described by TT and mentions that each of the partners responsible for each WP has its own network. So it is not only a small group people but rather a series of networks and we would very much like to broaden.

Regarding the specialists Masters, EP would like to mention that his Dpt at KI has in fact its own MPH.

Allan Krasnik (IPH Copenhagen) is Glad that ASPHER is now represented in the project hence involving the PH training community. AK supports the acceptance of the project as it is by ASPHER and urges the coordinator and other partners, as other speakers already did, to give space to ASPHER and its experience and to establish a plan for communication to our mutual benefit.

EP perfectly agrees with what has just been said and thinks that it is important.

Anders Foldspang (University of Aarhus and ASPHER President) would like to give more details about the history. AF has close contacts with KI over many years and was asked if he would be interested to take part in this project. After discussion with KI, AF felt that this was more a job for ASPHER than for him as a local scientist even if Aarhus was to get some resources it would not be one of its core activity.

Then this was brought to the attention of ASPHER's EB and if ASPHER had decided against participating in PHETICE, then what would have come out of it may not be as well founded as we in ASPHER would wish it to be. So for AF, it seemed that ASPHER would be better off in rather than out and be represented by its Executive Director with his experience and his experience in PEER Reviews.

This was AF's consideration and the outcome could potentially have been negative if ASPHER had not been involved as it represents nearly 70 members and over 40 years of experience and expertise. Looking at the papers, there are a number of things that AF would have organised in a different way. There is a mapping exercise and AF is confident that TL will be able to put his expertise into that and that we should all sustain him.

EP thinks that the other partners are also aware of ASPHER as a contributor to this project and does not see this as a problem.

Chris Birt (Liverpool) understands the difficult position within the ASPHER Executive Board and believes that they made the right decision which CB supports. There is a long history behind all this and it is time that somebody reviews the whole scene.

The problem here is that there is no strategy and the important thing is what use is made of the information about to be collected. We need to see how we can make best use of what comes out of this project with ASPHER in the lead in the appropriate time.

Lidia Georgieva (FPH Sofia) asks if there are plans to cover all PH programme in accession countries or only to make a selection

Reply by EP: the project intends to cover all PH training programmes.

For Christoph Pammer (University of Graz), DG Sanco should have approached ASPHER first. ASPHER and EUPHA need to get closer to DG Sanco and inform it

For Martin McKee (LSHTM), there are in fact three accession countries at the minute and the post 2004 new MS, not to mention the wider European neighbourhood with Ukraine, Belarus, Armenia, and the Caucasus as well.

EP: recent MS and the 3 accession countries are included. We are free to include other parts of EE too but that is part of the mapping process to decide the targets and so on.

Charles Normand (Dublin and ASPHER past-president) thinks that it was useful to sketch the history of this project but to ignore it as history is not important for what we should be doing next. As a community we want to help this project as we have embedded in ASPHER a huge amount of knowledge. So CN is asking fellow ASPHER members to be tooled up to be as helpful as possible. The concerns that are being raised are very real, such as around the whole question of Bologna. Since then, we've tried to live with a framework which has only been partially thought through.

CN sees the OSI-ASPHER programme as a component to be fed into the thinking of this group because there is a lot of information and material which could be of use.

We had an opportunity to say this is not what we wanted but now we do want this to proceed and we need to have a very generous spirit.

Karolina Kosa (SPH Debrecen) mentions that she was recently invited to participate in the work of WP4 (UoB) during a conference in Lisbon and discovered how much in a precarious position she was.

But she will consider herself in this group as the ASPHER liaison because KK feels that her responsibility is to make sure that people involved in WP4 are aware of ASPHER.

KK asks for support in her role as ASPHER liaison with that group.

Ted Tulchinsky suggests that the steering group of the PHETICE project includes an ASPHER Executive Board person.

For Emil Petterson, this is fine with him but it is up to ASPHER to decide who it wants to send to PHETICE meetings.

Susanna Thulin gets the impression that people think that KI has the sole decision-making role in the PHETICE project which is not the case.

As there are no other questions, TL and the other presenters thank everyone for their participation and all their remarks.

- oOo -



Workshop 2

“Public Health training in the context of an Enlarging Europe – PHETICE”

XXVII ASPHER Annual Conference
Yerevan

Thierry Louvet
Executive Director
ASPHER

www.aspher.org



ASPHER & PHETICE project and partners

- Context in which ASPHER was approached.
- Initially contact made by Karolinska Institute (Stockholm) with A. Foldspang (Aarhus).
- First contact with ASPHER in January 2005 (In case of joining the project, ASPHER invited to take over work package 6 (website and databases)).

www.aspher.org



ASPHER & PHETICE project and partners

- Overall project lies with our core business, especially strengthening of information about PH training education.
- ASPHER interested in working collaboratively to look at the development of public health training in its widest sense across Europe (i.e. not simply limited to website and databases).

www.aspher.org



PHETICE - WP6

- To increase access to evidence-based education and information to European PH specialists and thereby to European citizens.
- Create a website for evidence-based information and educational resources.
- This WP will be closely linked to all the other WPs, creating the electronic format for all survey tools used to assess the five existing programmes and training of public health in ACC.

www.aspher.org



Deliverables:

- Production of web-based electronic questionnaires and instructions for use.
- Results of other WP's electronic questionnaires included in a database for common use.
- The draft Guidelines will be posted on an open website for downloading and commenting.
- After commenting, the finalised Guidelines for public health training in Europe will be posted as pdf-file.
- Further materials, tools, online modules, training packages for trainers and students will be published on the website.

www.aspher.org



Thank you for your attention.

www.aspher.org



Emil Pettersson

Coordinator
PHETICE

Public Health Training In The Context Of An Enlarging Europe

Acronym: PHETICE

Basic facts

- Contract signed with DG SANCO 1st of July 2005
- Official starting date 1st of April 2005
- Global budget: 2 milj €
- Duration: Three years from starting date

PHETICE Partners

- Karolinska Institutet, department of PH and department of biosciences
- University of Brighton
- Vrije University of Amsterdam
- Johannes Gutenberg university of Mainz
- ASPHER

PHETICE-General Objectives

- To contribute to a European strategy in PH training
- To integrate PH training programmes from acceding and candidate countries into existing European PH training programmes
- To develop a common understanding of the core competencies of professionals within PH specialist areas
- To develop European professional and academic standards to enable uniform quality control processes and joint degrees on all levels

PHETICE-General Objectives

- To further develop methods for PH training and integrate areas of inequality, health monitoring and best practice
- To publish and disseminate guidelines for public health specialist training in Europe
- To increase access to evidence-based education and information to European PH specialists

WP 1	Coordination of the project	KI-dep of PH
WP 2	Dissemination of the results	KI-dep of PH
WP 3	Introduction of prioritised issues, networking and production of Guidelines	KI-dep of BS
WP 4	Professional and academic Standards/Pedagogical Strategies	UoB
WP 5	Programme linkage, curriculum and modules	VUA
WP 6	Website and Databases	ASPHER
WP 7	Mapping public health programmes in Europe	JoGu

Further aims

- To be a link between networks in the PH area
- Contribute to the implementation of the Bologna process within PH education
- Strengthen the professional role of PH workers

Contact info

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 - WP 5 rtj.van.rijsselt@fsw.vu.nl VUA
 - WP 6 thierry.louvet@aspheer.ensp.fr ASPHER
 - WP 7 mail@ilindert.de JoGu
- Website: <http://phetice.kpm.ki.se/> (under construction!)

WORKSHOP 3

Workshop 3

Sunday, 18 September

OSI ASPHER: LESSONS LEARNT FROM THE OSI ASPHER PROGRAM

Julien Goodman, julien.goodman@aspher.ensp.fr
ASPHER, France

As the final stages of the joint OSI ASPHER program draw to a close, this workshop examines the lessons learnt from the perspective of the program clients – the schools themselves. The first objective is to understand what mechanisms took place and how they can be recognised, replicated and improved upon by schools seeking a similar developmental path. The second objective is to look at the publication of materials which encompass the lessons learnt from the program for use by future clients.

The structure of the workshop follows a sequential order from the activities that are conducted by newly established schools through to activities accomplished by schools in the later stages of development. The presentations are followed by a round table where delegates are invited to raise questions about what they have heard. The final part of the workshop is dedicated to an open discussion on the structure and contents of the publication to ensure it is of the greatest value to its prospective clients.



Introduction & Overview of OSI ASPHER Program

Yerevan, September 2005

Julien Goodman
Program Manager
ASPHER



<http://www.aspher.org>



“Quality Development of Public Health Training Programmes In Central and Eastern Europe”

Overall goal:

To enhance institutional teaching programs of public health in the region through curriculum development, the review of teaching programs by academic peers from the region, and partnerships with other European schools of public health.



<http://www.aspher.org>



TIMEFRAME

September 2000 to March 2001	LOI Stage
March 2001 to June 2001	Needs Assessment Stage
July 2001	Applications from CEE Schools to OSI
September 2001	CEE Schools in to ASPHER Membership*
October 15th 2001	Official ASPHER Application to OSI
November 19 th 2001	Formal Acceptance Letter (with conditions)
March 31 st 2002	Re-application date for Stream 2
June 30 th 2002	Re-application date for Stream 1
Summer 2005	Program Close



<http://www.aspher.org>



Applicants benefit from one of two program packages

Program Stream 1 <PEER Program>

Strengthening and deepening public health education and training.
Armenia, Bulgaria, Croatia, Estonia, Hungary, Lithuania, Poland

Program Stream 2 <PARTNERSHIP Program>

Building public health education and training capacity.
Albania, Georgia, Romania, Ukraine, Uzbekistan, Latvia.



<http://www.aspher.org>



STREAM 1 PEER Program

Three elements

P.A.D.	Preliminary Assessment Document Application July 2001
M.P.D.	Monitoring P.A.D. / PEER for Development
PEER	Public Health European Review



<http://www.aspher.org>



STREAM 2 Partnership Program

Three institutional partners

Partner A	Lead partner/ institution from western Europe, responsible for overseeing development plan
Partner B	Secondary partner/ institution from western Europe, responsible for technical support
Partner C	CEE Partner from Stream 1 School*

* does not include Ukraine



<http://www.aspher.org>



Thank you for your attention

Julien Goodman
Program Manager
ASPHER



<http://www.aspher.org>

Assessment of needs for public health training in Bulgaria

Lora Georgieva
Faculty of Public Health
Medical University of Varna
Bulgaria

Introduction

- The development of the public health education has solid basis both in the **modern trends** of the European health policy and in **national context**;
- Public health training is of great importance in dealing with the **growing population health problems** and in the development of **new public health policy**;
- The continuing assessment of the needs of the public health professionals is important not only for assuring the public health training but also for the **sustainability** of the MPH programme.

Aim

A **continuing study** has been undertaken by the Faculty of Public Health (Medical University of Varna). The aim of this study was to assess the need for public health professionals in Bulgaria on national and regional levels.

This is one of the activities of OSI ASPHER project
"Quality development of public health education
in Eastern and Central Europe".

Methods

Three stages of the study:

- **Before** the start of the MPH programme (2001);
- **During the first year** of the MPH programme (2001-2002);
- **Follow-up** assessment (2003-2004).

Three target groups

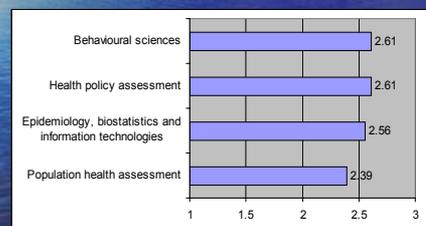
- **Experts:** 23 scientists and senior academic staff working in the field were interviewed for their opinion on public health training needs;
- **Employers:** 72 key persons from 16 regional centres in Bulgaria were interviewed for their perception of the changing needs for knowledge and skills of the staff working in the field of public health ;
- **Students:** 23 students in the first course of the MPH programme were asked what their expectations for the outcome of training are.

Results

First two stages of the study

Experts

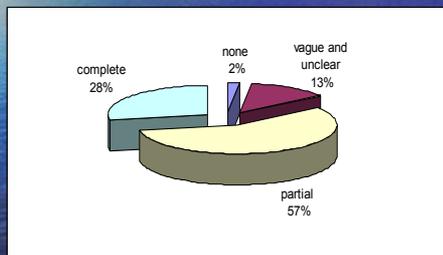
The experts' assessment (based on a 3-graded scale) of the mostly **lacking areas** of public health knowledge and skills:



Employers

During the last decades there were various definitions and different understandings of public health as a field.

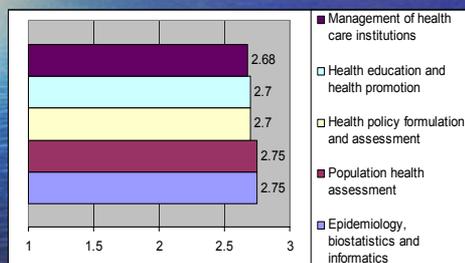
- **Understanding** of the essence of public health as a field:



- The need for public health education was **realized** by **all** (72) participants;
- **All** employers declared **willingness** to stimulate Public Health training of the staff (including financial support in 25% of the cases);
- **78%** of the employers saw **the training of available staff** in MPH programme as a solution of the public health professionals shortage problem;
- **75%** of the employers pointed out that a Master Degree in Public Health should become **legal requirement** for occupying high-level position in the field.

Students

Students' expectations of knowledge and competence acquisition in the framework of MPH programme (assessed on a 3-graded scale) :



Third stage of the study (2003 – 2004)

Respondent groups: 15 **experts** and 36 **employers**.

- **52%** of the respondents showed "**complete understanding**" of the essence of public health as a field;
- **All** employers continued to declare a **high level of willingness** to support training of the staff;
- **Legislative requirement** of a Master Degree in Public Health for occupying high-level positions in the field was defined as absolute necessity for the future development of public health training and to the sustainability of the MPH programme.

In order to manage the existing situation, the Faculty of Public Health **has lobbied** before representatives of the Ministry of Health for introducing **legislative requirement** of MPH-diploma to get high-level positions in the field of public health care.

According to the Health Act (2005), Hygiene and Epidemiology Inspectorates have been transformed into **Regional Inspectorates for Public Health Protection and Control (RIPHPC)**. **Departments of Public Health Protection** were newly established in RIPHPCs.

Major activities of the Departments:

- analyzing demographic indicators in the region;
- carrying out epidemiological studies;
- developing regional projects in the field of public health protection;
- studying the health knowledge and habits among different population groups;
- undertaking health education activities.

Conclusions

- **Shortage** of public health professionals;
- **Willingness** of the employers to stimulate Public Health training of the staff;
- Necessity for **legal requirements** for obtaining Public Health diplomas by the professionals practicing in the field;
- Necessity for **continuing** assessment of the needs for public health professionals;
- Necessity for **constant promotion** of the MPH programme;



THANK YOU FOR YOUR
ATTENTION!

Master of Public Health (MPH)
December 2004 – December 2005
Tirana

Dr Enver Roshi MPH & Dr Silvia Bino
Department of Public Health
National Institute of Public Health
University of Tirana
Albania

Master of Public Health (MPH), Tirana

- Under the auspices of the **Faculty of Medicine (FM – Dean: Prof. Kristo PANO) and the Institute of Public Health (IPH – Director: Dr.Silvia BINO)**

- *“The overall goal of the program is to strengthen the public health training capacities through developing a Master in Public Health.*
- *The aim of the course is to meet the increasing demand for well trained public health professionals.”*

- **Management Committee:**
FM , IPH Open Society Institute ,Minister of Health
- **Academic committee of the MPH Program**

General Features of the Curriculum development of the MPH Program

- The MPH is based on 60 credits according to the *European Credit Transfer System (ECTS)*. The ECTS is approximately 25-30 hours including up to 50% *frontal teaching or seminar format* and at least 50% *student independent self-study*.

Target Groups

- Coordinators responsible for writing the curricula of each subjects (particularly for core courses)
- Teachers where involved in Internal workshop from Department of Public Health & National Institute of Public Health
- Management Committee, Academic committee ,international experts.



Aim

- Curriculum development for our master courses in Public Health



Outcome

- Final designed curricula for each subject was produced based on Bologna ECT.



General Features of the Curriculum of the MPH Program (continue)

- The MPH is based on approximately 25 credits for *Core Courses* required for all students and 20 for *Elective Courses*, as well as 3 for *Research Forum* (required) and 12 for *Thesis*.
- Core curriculum is required for all students. Elective courses are chosen according to student specialization interests*



General Features of the Curriculum of the MPH Program (continue)

- The MPH program is run in a *modular* fashion over a period of 12 months (December 2004 – December 2005), with *three working days per week* (from 08.00 to 14.00).



How we developed MPH curricula

- Designed the obligatory course and elective courses with international experts.
- Coordinators of Epidemiology (for example) were for three week in the Belfield university developing epidemiology curricula.
- After the trained teacher in epidemiology had internal workshops, brainstorming, seminars with other staff from DPH and NIPH.
- On this workshop was introduced the content of subject.



- For Health Promotion (Belfield Germany, Health Environmental, Biostatistics (La Sapience Rome)
- A group of lectures from DPH and NIPH were selected to go in La Sapience Rome, Bielefeld, Bari.
- They studied the host university curricula preparing a draft of them at the end of their staying.
- Head of both institution had study tour in Italy, Germany, Israel and Varna Bulgaria.



International experts

- We also discussed all our curricula with our International experts Prof Ulrich Laaser and Prof Ted Tulchinsky going in detail for all our subjects (obligatory and elective courses)
- Their contribution were in whole development curricula process.



Continue

- At the end of internal workshops as we call (ToT) a draft curricula was designed.
- The designed drafts of curricula's was presented to the academic committee
- Management committee ,academic committee together with international experts Prof Ulrich Laaser , Prof Ted Tulchinsky all curricula's were presented and discussed again.
- After all this stages a final curricula for all Master Course subjects was produced.



- We would like to say many thanks to:
- Prof Ulrich Laaser, Faculty of Health Sciences, University of Bielefeld , Germany
- Prof Ted Tulchinsky, The Braun School of Public Health and Community Medicine, Hadassah Medical University, Jerusalem, Israel.
- OSI, Julien Goodman , Noah Simmons , Pina Frazzica and Stoyanka Popova.



Conclusion

- As we have now a Master course, a development curricula should not be see as a final stage but as a dynamic process according to global health, WHO health strategy and health strategy of the country.



Thank you for your attention!!!!

AND

Welcome to Albania

Capacity building - training staff at other schools

Experiences in training at the ASSPH

Luka Kovačić, MD, PhD, Professor in Public Health

ASPHER Conference, Yerevan, 2005

Capacity building - ASSPH

ASPHER/OSI - Stream 1

- ❑ Peer program for MPH program
- ❑ Support for quality development of public health teaching programs
- ❑ Train new training developers in the skills, knowledge, techniques
- ❑ Receive a packet of reference materials and lesson plans so when they return they can use it in practice

Types of educational activity:

- ❑ PhD and MPH program
- ❑ Short courses
- ❑ Conferences, congresses

PhD and MPH Programs

- ❑ LSHTM
- ❑ University of Nijmegen,
- ❑ Karoliska Institut, Stockholm

Short Courses:

- ❑ Ecole Nationale de la Sante Public, Rennes, France (4 members)
- ❑ Salzburg Weill Cornell Seminar
- ❑ University of Oxford
- ❑ University of Birmingham
- ❑ European Training Consortium in Public Health and Health Promotion (ETC/PHHP)- (2 members)
- ❑ Summer School in Perugia, Italia (2 members)
- ❑ University of Maastricht (2 members)
- ❑ Training Course on EC Project Management, Hungary (2 members)
- ❑ Training of Teachers in General/Family Practice", IUC, Dubrovnik, Croatia (4 members)
- ❑ School of Public Health, Tirana, Albania

Conferences, congresses:

- ❑ AMEE conference
- ❑ ASPHER Annual Conference
- ❑ American University of Armenia
- ❑ University of California (seminar in Cavtat, Croatia)
- ❑ EGPRN Spring Meeting Goettingen/Germany (4 participants)
- ❑ TTB Conference (2 participants)

Course and conference contents:

- ❑ EC Project Management
- ❑ Health Promotion
- ❑ Rational Pharmacotherapy in General Practice
- ❑ Teaching General/Family Practice
- ❑ Problem Based Learning
- ❑ Strategies for Health in Europe:
Rethinking Health Promotion in a
Changing Europe

Education's outcomes of the ASPHER/OSI project:

- ❑ New knowledge and skills in education's technology for teaching staff
- ❑ Positive impact on reform and development of new modular system
- ❑ Quality knowledge and skills for public health professionals trained at the ASSPH

Capacity building in framework of OSI ASPHER project “Development of Master of sciences in Public Health at Riga Stradins University”

Anita Villerusa
Dean, Faculty of Public Health
Riga Stradins University

The Faculty of Public Health

- Established in year 1997
- Studies for **the Bachelour degree** from year 1997/1998, lasts for 4 years.
- The study program consists of eight terms, 2 practice trainings and bachelour degree work
- The core of the program is common, but in the fourth year students have a possibility to chose selective course depending on future professional interests (health promotion and education, environmental health and health care administration).

Master of sciences in Public health

- Started to develop in year 2000
- Firsts enrolment in year 2001/2002
- 2 year study program,
- The program emphasises the importance of theory in research and evidence based public health practice

A Joint Program of Open Society Institute (OSI) & the Association of Schools of Public Health in the European Region (ASPHER) STREAM 2 PARTNERSHIP PROGRAM

- **The aim of the project** is development of the curriculum and the modules for training at the Master Sc. degrees in Public health and increasing the number of young public health researchers and teachers

Objectives

- to promote establishment of public health education system in Latvia, stressing research oriented approach;
- to train local academic staff to prepare and develop own modules and curricula;
- to develop and deepen co-operation among academic staff in Latvia and EEC countries to accumulate experience and education materials;
- to join credit transfers system in field of public health within Europe.

Crucial area for further development of the Master of sciences in Public health

- program development
- capacity building
- improvement basic resources

Increasing the numbers of the faculty and building their capacity by:

- Improving their theoretical knowledge and practical skills in teaching advance courses
- Introducing new problem oriented pedagogical methods
- Increasing the activity in research and the publishing practice

Project year 1

Two workshops for faculty members with guest professor Ilze Kalnins about Master theses supervision an new pedagogical approach in Masters training in Public Health

- the trainers instructed in the usage of the progressive interactive methods
- The requirements and standards of research projects of the students were synchronized

Project year 2

Series of Training seminars for trainers "Health and Health policy: research and practice interaction"

- "Health status monitoring. Determinantes of health. Health indicators." by Michael Rigby
- "Needs assessment. Priority setting in Public Health. Strategic planning." by Martin McKee and Ellen Nolte
- "Implementation and evaluation of Public Health interventions" by John Ovretveit

New knowledge obtained in development of various indicators for the evaluation of health status, assessment of the health care system and development, implementation and evaluation of health policy

Project year 3

Training seminar for trainers "*Methods and strategies in bridging the gap between research and practice in public health, with special emphasis on the situation in Latvia*", by Antony Morgan, Ilze Kalnins and Sandra Veinberga

- Knowledge and skills in policy setting process in different levels; presenting the evidence and getting evidence into practice; barriers to effective communication; community mobilization; leadership skills; PR, communication styles; role of mass media; press release, press conference.

Benefits

- Possibility to invite high class experts
- The new knowledge used for the existing module improvement and new development
- To broaden training approach with new training methods showed during seminars
- A lot of good materials, literature were disseminated among participants
- High number of participants were trained (17-21 in each seminar)

Indirect results

- Improvement of the collaboration among different departments
- Increased cooperation among different level institution
- Increase awareness among PH trainers and practitioners about role of evidence based approach
- Improvement of communication skills
- Better recognizing of the role of Master program in Public health

Summary from the questionnaire of the participants

- Good quality and high competence of the selected lecturers for the seminar
- Increase in the competences and the skills among the participants
- Confidence in use theories and research methods in communication with practitioners and policy makers
- New understanding of the need of communication and way of the communication between professionals and between professionals and the public
- Good atmosphere and friendliness during seminars

Evaluation of the Faculty of Public health in 2005

- A significant development has occurred in the Faculty of Public Health
- M.Sc. in Public Health in year 2004 was accredited till 2009 (for 6 years) by the National Accreditation Agency (under the Ministry of Education).
 - Two new staff members were employed
 - Four doctoral students enrolled in they doctoral studies

Gratitude

- OSI for financial support
- ASPHER for coordination
- Roza Adany, Lennart Kohler, Marc Mc Carthey for advising

PEER review at the Faculty of Public Health, Kaunas University of Medicine

Ramunė Kalėdienė
Dean of the Faculty of Public Health,
Kaunas University of Medicine

Historical perspectives

Faculty of Public Health established in 1994

Structure: 5 departments

- Preventive medicine
- Social medicine
- Family medicine
- Environmental and occupational health
- Philosophy and social sciences

Public Health training at Kaunas University of Medicine



Number of graduates from the Faculty of Public Health



PEER Review

Master Program in Management of Public Health

Faculty of Public Health

Kaunas University of Medicine

December 1 – 5, 2003

Name of team members:

Franco Cavallo, Turin
Allan Krasnik, Copenhagen
Stojgniew Sitko, Krakow

Thierry Louvet, ASPHER
Julien Goodman, ASPHER
Walter Burnett, Observer

Main reasons for conducting peer review

- Full range of public health training programs has been created at the FPH
- The critical mass of public health lecturers was trained
- The FPH was participating actively in the international public health training projects
- FPH has never been exposed before for review procedures, which are developed for public health training assessment.
- Important role of OSI and ASPHER

Aim of the project

To develop and implement systematic quality evaluation of public health training programs at the Master's level at the Faculty of Public Health of Kaunas University of Medicine

Objectives

- To assist in providing full procedure of ASPHER PEER review
- To promote broader collaboration of public health Master programs with professional organisations of health care professionals and student's alumni organisations
- To provide training and experience exchange for the KMU academic staff (program managers, lecturers) on the procedures and methods of quality evaluation and preparing academic reviews
- To provide support for public health Master programs at KMU in developing and updating curriculum, training resources

Major challenges in the process of preparation to Peer review

- Time consuming
- New, not familiar procedure
- National and international accreditation criteria were rather different

Major benefits

- Enabled to reassess programs critically
- Highlighted strengths and weaknesses
- Constructive criticism
- Initiated new activities
- Waking up the sense of team work and common aim
- Adding an external perspective from highly skilled experts
- International support
- Served as a basis for reaction and comments to the previous national review

Learning from experience

- Faculty of Public health was historically well placed to seize opportunities to reinforce its position in Lithuania through international collaboration.
- The Faculty has achieved respected and influential positions at both national and European levels considering the time and circumstances
- Constructive criticism according to the ASPHER criteria

Learning from experience

However...

- National review performed by the national Center for Quality of Studies presented somehow different and not so highly qualified recommendations
- Some recommendations differed considerably from the "national" review

Process of implementation of the changes

Improving the collaboration with professional organisations, NGOs, other universities, and creating Alumni organisation of SPH graduates was an important outcome of the project. Need of such enhanced collaboration now becomes essential and self-evident.

Process of implementation of the changes

One of major outcomes of the project is empowerment of faculty to provide step-by-step quality evaluation procedures based on self-assessment

Expectations

Review of other public health training programs and International accreditation

PEER review?



OSI/Soros Foundation: Quality Development Of Public Health Teaching Programs in Central and Eastern Europe

The School of Public Health in Hungary

Ádány, R. (project leader), Cseh, J., Kardos, L.,
Kósa, K., Pocsai Zs., Schaf, V., Széles, Gy., Szűcs.
S., Tóth, M., Vokó, Z.

School of Public Health
University of Debrecen, Hungary

- > f. Promoting your school/program - Debrecen
 - >
 - >
 - >
 - >
 - > a. What was the activity?
 - > b. Why was the activity undertaken and what were the expectations of the outcome?
 - > c. Were these expectations met and if not, why do you think that was?
 - > d. What were the "lessons learnt"? - (If you could change something what would you change i.e. if you were to advise someone)
 - > e. Did you get value for money and would you encourage other people to do the same?

What kind of activities were planned?

1. Further development of MSc Public Health course
2. Improvement of quality
3. Promotion of course and School

Why increase quality & develop marketing?

- No legal requirement for the diploma
- Funding is up to yearly negotiations
- High quality courses attract more students
- Promotion: increases visibility of School, applications & income

What kind of activities were planned?

1. Further development of MSc Public Health course
 - Restructuring the MSc in PH course:
 - Contact hours ↓
 - 2-year curriculum
 - Building in study units (TEMPUS)
 - Development of English MSc in PH
 - Development of undergraduate training + remodeling of MSc in line w/ Bologna declaration

What kind of activities were planned?

2. Improvement of quality
 1. Monitoring of dropouts
 2. Invitation of guest lecturers
 3. Establishment of institutional quality management system
 4. Implementation of PEER
 5. Development of field & culminating training
 6. Improvement of pedagogical methods
 7. Maintenance & strengthening of European contacts

What kind of activities were planned?

3. Promotion of course and School

- Contracting PR specialist
- Establishment of Alumni Association
- Road-shows
- Open day
- Career fair
- Summer school
- Conference on mission statement / PH functions

Promotion I.

1. PR-specialist:

- **Annual booklet of the School:** distributed within the NPHS, universities, local governments
- **Leaflets on courses:** mailed to every county and city office of the NPHS, to all medical graduates, and graduates of public health-disciplines

2. Alumni association

- Organized workshops, conferences
- Alumni participated in testing of new courses
- Alumni contribute to School projects as field representatives

Promotion II.

3. **Road-shows:** performed by staff of the SPH 2x annually in county offices of the NPHS
4. **Open day, career fair:** in conjunction w/ graduation ceremony
5. **Conferences**

Were expectations met?

Yes:

- Quality of training: increased
- No legal requirement for the diploma: no change
- Funding is up to yearly negotiations: partial change
- High quality courses attract more students: yes
- Marketing & visibility: improved

Were expectations met?

No:

- Field training, culminating experience:
 - Difficult to organize for field workers
 - Not sustainable without external funding
- Completion of studies in 2 years:
 - Non-compliers should not be punished

Lessons learned

Improving quality of training is good investment BUT

- Only in the long term
- Costs money
- Takes time
- Should start w/ assessing needs
- Should involve all stakeholders
- Prepare for delays & setbacks
- Political involvement inevitable
- Internal (institutional) feedback system helps development

Lesson for all

**‘If you are not improving,
you are getting worse.’**

WORKSHOP 4

Workshop 4

Monday, 19 September

COOPERATION IN THE FIELD OF PUBLIC HEALTH TRAINING FROM A GLOBAL PERSPECTIVE

Stojgniew Sitko, mxsitko@cyf-kr.edu.pl
Institute of Public Health, Poland

Purpose

To explore possible educational and research projects which could form the basis for cooperation between regional networks such as ASPHER, APACPH, ASPH, ALAESP.

Objectives

To reach a list of projects which could be developed with a view to seek funding from international agencies and a plan of action to apply for such projects.

Audience

ASPHER members and representatives of regional educational networks.

Keywords: global, training, public health

Cooperation in the field of Public Health training from a global perspective,

WS Overview

1. Introduction - Stojgniew J. Sitko, **ASPHER** EB
2. **Asian-Pacific Perspective** – Brian Oldenburg, **APACPH**, Brisbane, AUS
3. **Experiences** of global cooperation in PH education - discussion
 - What kind of common project/grants possible?
 - How to proceed to succeed?

Premises

- Many PH as well as education problems are **global**;
- **Added value** to exchange experiences on a wider scale (ie not limited to Europe);
- There are **growing contacts** and formal agreements with “sister” associations: such as ASPH, APACPH, ALAESP also with WFPHA;
- **Bilateral interest** towards common activities with WHO lately;
- Recent, **successful projects** on a larger-than-European scale (OSI-ASPHER-FIC) just ending.

Main questions

- Are the common „global” projects at all possible?
- Are there any successful examples?
- What are potential area of such cooperation?
- Where to apply for such projects?

Building regional academic capacity and engagement to improve global public health

Professor Brian Oldenburg
Regional Director, APACPH
&
School of Public Health,
Queensland University of
Technology



Building Capacity to improve Public Health in Australia

ANAPHI Case Studies Project

Professor Brian Oldenburg
Case Studies Coordinator



Case Studies

Four current, major public health challenges:

- **Case Study 1:** Emerging Infectious Diseases (SARS)
- **Case Study 2:** Management & prevention of chronic diseases
- **Case Study 3:** Aboriginal & Torres Strait Islander Health
- **Case Study 4:** Moving public health action upstream



Case Studies of Academic Engagement

Key questions/issues:

- **Response** of Australia's academic public health institutions to national/emerging public health challenges;
- **Judge** the efficacy of this response;
- **Examine the links** between research and workforce training & education capacity;



Asia-Pacific Academic Consortium for Public Health (APACPH)



APACPH Conference 2004

"Public Health Networks and Alliances: Building Capacity in the Asia-Pacific Region". Brisbane, Australia – 1-3 December 2004



Asia-Pacific Academic Consortium for Public Health

- Asian Pacific Regional Network of academic public health institutions (since 1984)
- 55 members in 18 countries
- International collaboration via linking of individuals and collaboration
- Member institutions from many countries (18):
Australia, Bangladesh, Indonesia, Japan, Kazakhstan, Korea, Laos, Malaysia, Mongolia, Nepal, People's Republic of China, Philippines, Singapore, Sri Lanka, Taiwan, Thailand, USA, Vietnam



Vision and Mission

Vision

To achieve the highest possible level of health of all the people of the nations of the Asia-Pacific region.

Mission

To improve regional and national capacity to address major public health challenges through the delivery of education, research and advocacy by APACPH member institutions.

Future

APACPH will become an incorporated not-for-profit organisation by December 2006

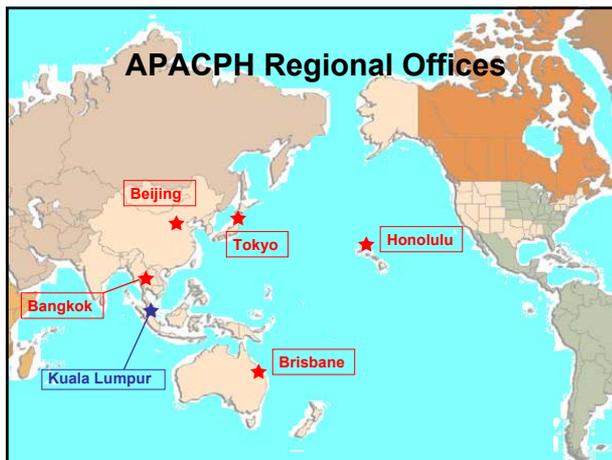


Objectives

- To enhance the quality and relevance of educational and training programs in public health – **workforce development**
- To expand knowledge, improve skills and demonstrate effective interventions – **research and evidence development**
- To raise awareness of current, emerging, and re-emerging public health issues and develop programs of action for their resolution – **advocacy and system engagement**
- To enhance the capacity and sustainability of public health systems – **capacity building and leadership**
- To assist in **policy and leadership development** for health within countries and throughout the Region.



APACPH Regional Offices



Partnerships

APACPH has/is currently establishing formalised partnerships with:

- WHO (SEAR/MPRO)
- United States AED (Academy for Educational Development)
- ASPHER (Association of Schools of Public Health in the European Region)
- ASPH (American Schools of Public Health)
- SEAPHEIN (South-East Asia Public Health Education Institutes Network)
- Globally active philanthropic organisations



Summary of Achievements (to date)

- Improved teaching, research and advocacy and established MPH programs in several countries (1984-2005)
- Within-country public health education and research networks strengthened by international collaboration
- Leadership on emerging health problems and challenges e.g. SARS, early childhood and maternal mortality, chronic disease prevention/management, environmental health, injury prevention/control etc.
- Implementation of research and other projects within and between countries
- Sharing of institutional and other resources
- Forums/conferences to influence policy and accelerate change



Asia-Pacific Journal of Public Health

- It is the only English language journal devoted to public health issues of the Asia and Pacific region
- The Consortium publishes the **Asia Pacific Journal of Public Health**, which focuses on health issues of the Asia-Pacific region
- The journal is published bi-annually
- The editorial office is currently based at the University of Malaya, Malaysia
- www.apjph.org.my



Recent Projects

1. APACPH Tsunami Project

A longitudinal, multi-country project to study the impact of the 2004 Indian Ocean Tsunami on the health, well being, and recovery of affected individuals and communities (led by University of Southern California + other institutions)

Collaborating partners in India and Sri Lanka

- National Institute of Epidemiology, Chennai, India
- Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum, Kerala, India
- Eastern University, Batticaloa, Sri Lanka



2. Public Health Curriculum Development Project

A working committee has been set up which includes APACPH members and non-members from Thailand, East Timor, New Zealand, Australia and USA.

Objectives include:

- The development of a peer support network.
- The collection of data on the current status of undergraduate education in public health at both APACPH member and non-member institutions
- Determining which APACPH member institutions might be interested in offering undergraduate programs in the near future and how such a network might be able to provide support and assistance.
- The defining of competencies for undergraduate education in public health.



3. Asia Pacific Early Career Network in Public Health (APECNPH)

APECNPH will represent individuals in the Asia Pacific Region who are in the early stages of their Public Health training and at all levels of study. The network aims to:

- Promote interaction between APACPH faculty members and trainees
- Increase awareness of global public health issues
- Enhance and supplement the educational and mentoring experience of professionals and early trainees in the public health field
- Provide opportunities for the participants to be involved in international public health issues.



4. International Cyber University for Health

<http://licuh.yonsei.ac.kr>

ICUH was established to help students prepare to meet the challenge of opportunities to continue their education and advance their careers without disrupting their current lifestyles and schedules.

Target for the Cyber University

- Students and health professionals for APACPH member universities
- Health professionals in WHO/WPRO member countries

First year Development of free courses

Second year Development and implementation of short courses

Initiation of degree program

Third year Development and implementation of degree program

Evaluation of short program



Future APACPH projects to develop

- Public health leadership and training
- Establishing a research network related to chronic disease prevention and management (particularly diabetes)
- Other ideas????
- Cross-regional and global partnerships



APACPH Conference 2004

"Public Health Networks and Alliances: Building Capacity in the Asia-Pacific Region". Brisbane, Australia – 1-3 December 2004



APACPH Conference 2005

"Health Security & Emerging Disasters in the Asia-Pacific Region." Taipei, Taiwan – 21-23 November 2005

The APACPH annual conference is open to members and non-members alike and provides:

- Opportunities for researchers in the region to showcase their projects
- Networking between researchers, health ministries and representatives from international funding agencies
- Pre and post-conference workshops on specific topics
- Scholarships for those in most need

For more information on the 37th APACPH Conference visit the website www.apacph2005.org



APACPH Conference 2006

The 38th APACPH Conference will be held in Bangkok, Thailand, December 2-5, 2006

Conference theme:

"Health threats and challenges in a rapidly changing world"



APACPH Communications

APACPH Website – www.apacph.org

Up-to-date list of APACPH Members and Executive Board

Activities of APACPH

Conference information

APACPH Newsletters

APACPH business documents

Calendar of Events

The APACPH website is currently being revised. Improvements will include comprehensive member institution information, an interactive bulletin board and a new APACPH projects and activities section.



APACPH Communications

APACPH Newsletters

- Update on APACPH Activities
- Updates on member faculty and programs
- Profiles of key APACPH Personnel
- Useful resources
- Information on meetings and reports



For more information

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Website: <http://www.apacph.org>

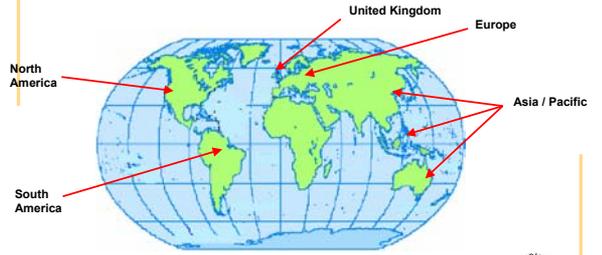




<http://www.isbm.info/>



Member Societies



Announcement:

**Symposium of Central Eastern European
Behavioural Medicine Network**

Location: Targu-Mures, Romania

Date: 14-16 October 2005



WORKSHOP 5

Workshop 5

Monday, 19 September

EXCHANGING EXPERIENCE: HOW CAN SCHOOLS OF PUBLIC HEALTH ENGAGE WITH THE WIDER COMMUNITYMartin McKee, martin.mckee@lshtm.ac.uk

London School of Hygiene and Tropical Medicine, UK

Purpose

Public health is, ultimately, about making the world a better place. This means that schools of public health must engage effectively with the communities among which they exist. They must be both proactive, for example by drawing attention to issues that would otherwise be overlooked or ignored, such as the needs of disadvantaged communities, and reactive, responding to the issues identified by communities and their leaders. Only in this way will schools of public health ensure their continued relevance in the twentieth century. This workshop seeks to provide a forum through which ASPHER members can exchange experiences, both positive and negative. It will begin with a presentation setting out the issues, drawing widely on experiences of academic-community involvement, and highlighting why this issue is important. This will introduce concepts such as lay epidemiology and will examine the role of narratives in complementing epidemiological research. Then will follow a series of brief presentations of practical experiences that will provide the basis for a wider discussion among those present about how to move forward.

The workshop will focus in particular on the skills that are required for this role, including how to tackle controversial and contested issues, especially when they feature in the media spotlight, how to engage in advocacy, and how to identify, enlist and develop key stakeholders. In particular it will explore how to overcome forces that are hostile to public health, such as the tobacco industry and, in some cases, the food industry.

It is anticipated that the output of the workshop will be a paper to be published in a public health journal.

Objectives

The objective of the workshop is to distil the experiences of ASPHER members in engaging with their communities, so as to produce a report for publication that will provide generalisable lessons.

Exchanging experience: How can schools of Public Health engage with the wider community?

Martin McKee and Ted Tulchinsky

The workshop was introduced by Martin McKee and Ted Tulchinsky. Each gave a presentation providing examples of how schools of public health can engage with the wider world to contribute to the policy agenda. Martin McKee began by drawing on examples in the area of tobacco policy. One was where a major hospital had decided to build a suite of rooms for patients to smoke in, following a major rebuilding programme in which open spaces at the end of old wards had disappeared. He highlighted:

- the importance of rapid action, in this case drawing attention to the issue by a letter to the local media;
- involving others, in this case asking colleagues from other countries to also write to the newspapers;
- providing an evidence-based alternative, in this case by means of an editorial in the British Medical Journal that drew together the evidence for the effectiveness of policies to stop smoking in hospitals.

His second presentation looked at the role of the public health professional as an investigator, showing how he and Swiss colleagues had exposed a secret testing plant operated in Germany by Philip Morris. This involved detailed study of internal tobacco industry documents released under US court orders. A key figure in this story was a Swedish professor of Environmental Health, who sued for libel and lost. The main messages were:

- The importance of taking a stand, even when confronted with powerful opposing forces;
- The importance of marshalling the evidence carefully.

The remaining examples highlighted the importance of concerted international action, for example working to support staff in the US Congress who are seeking to expose the corruption of scientific evidence by the administration of President George W Bush.

Ted Tulchinsky's presentation looked at a series of areas where schools of public health could make a difference but where only a few had done so. He began by discussing the nature of evidence, citing John Last's definition "*Application of the best available evidence in public health policies and practices.. derived from epidemiologic, demographic, sociologic, economic and other relevant sources, preferably published, peer-reviewed, and critically appraised articles and reports.*"

He set out a series of principles for action:

- Identify population health problems
- Assess the evidence for effective intervention
- Define the case for action
- Identify objectives and targets
- Spell out intervention programs
- Enlist support

He then illustrated these points with a series of case studies. The problems addressed should be those that are amenable to action, such as prevention of cervical cancer, birth defects, and effective detection and treatment of hypertension. He noted that each campaign does not require a new systematic review of the evidence. There is

already much available in “gold standards” guidelines that is not acted on. A major challenge is to make decision makers, the media, and the public realize there is a problem and something that can be done about it, a point he illustrated with the case of food fortification. However, even when these groups become aware it is necessary to fight lethargy and inertia. He called for resistance to what he described as “zombies” i.e. old dead stories that keep coming back, such as some of the fears associated with immunization. Finally he emphasized the importance of national standards and guidelines as a basis for evidence.

An active discussion followed. There was a sense that schools of public health could do more, but they were often inhibited by a variety of factors that included lack of time, lack of confidence to tackle powerful vested interests, a potential conflict with the governments that provided their funding, a fear of being seen as political, and a sense of isolation. On the other hand, there were many examples of local successes.

There was a widespread acceptance that many schools of public health needed to provide better training in advocacy. This is an issue that will be addressed in a series of seminars that will be conducted in Salzburg over the next three years, funded by the American Austrian Foundation, to which staff from schools of public health will be invited.

WORKSHOP 6

Workshop 6

Monday, 19 September

PEER REVIEW AS A TOOL FOR CONTINUOUS QUALITY IMPROVEMENT IN PUBLIC HEALTH TRAINING

Ramune Kalediene, kaleda@kaunas.omnitel.net
Kaunas University of Medicine, Lithuania

Purpose

In the context of enlarged Europe, it is an increasing need to train public health professionals, meeting the necessity to respond to emerging new health challenges. New programs of public health training are developing, and the diversity of understanding of public health education curriculum becomes obvious.

One of the core concerns of ASPHER is the development of a quality assessment mechanism of public health education programmes. The PEER – Public Health Education European Review was devised with the aid and support of the WHO EURO, as a voluntary initiative of institutions in 1993. The PEER Review is a supportive and developmental tool based on improving the quality of public health Education throughout the European Region. The PEER operates as a mechanism, in terms of programme content and quality standards, to develop curricula, provide guidance and steering in development and share best practice throughout the region. This procedure combines a self-assessment study and a review by a team of peers based on a list of criteria described in the procedures. The first school to complete PEER Review in 1993 was School of Public Health in Bratislava, Slovakia. Up to now, 21 schools or programs were reviewed. Generally, great satisfaction was expressed with the review procedure both by the heads of institutions and the staff where programmes had been evaluated. The public use of the PEER reports by many of the reviewed institutions is a good indicator of this satisfaction. Since the procedure of accreditation of Schools or programs of Public Health is in the process of establishment, the PEER review should be considered as major developmental stage towards mutual recognition of programs, courses or institutions.

Objectives

The aim of this workshop is to promote PEER review for the future active development of quality across public health training institutions.

Objectives:

- to share experience of PEER review among the Schools of Public Health
- to develop the idea of PEER Forum
- to gather suggestions on PEER development



Experiences of PEER

OSI ASPHER Program

Yerevan, September 2005



Julien Goodman
Program Manager
ASPHER

<http://www.aspher.org>



OSI ASPHER PROGRAM

Program Stream 1 <PEER Program>

Strengthening and deepening public health education and training.

Program Stream 2 <PARTNERSHIP Program>

Building public health education and training capacity.



<http://www.aspher.org>



6 PEERs Conducted between 2002 and 2004

INSTITUTIONS

- 2 Faculties within Medical University
- 2 Schools within Faculty of Medicine
- 1 School in Institute of Occupational Medicine
- 1 College of Health Sciences

PROGRAMS

- 3 Masters of Public Health
- 1 MSc in Public Health
- 1 Master of Public Health Management
- 1 Certificate of Public Health



<http://www.aspher.org>



ASPHER PEER Criteria

1. THE DEVELOPMENT AND THE MISSION OF THE SPH
2. EXTERNAL ENVIRONMENT
3. INTERNAL ORGANISATIONAL ENVIRONMENT
4. TEACHING STAFF
5. STUDENTS AND GRADUATES
6. TRAINING PROGRAMMES
7. TEACHING/ LEARNING FACILITIES
8. RESEARCH
9. INSTITUTIONAL QUALITY MANAGEMENT SYSTEM



<http://www.aspher.org>



Common themes?

Recommendations made more than once in different schools

Criteria 1 Mission and Development

- 3 Advisory board with stakeholders
- 2 Improve dissemination of mission statement
- 2 Strengthening core curriculum

Criteria 2 External Environment

- 4 Establish and strengthen links with stakeholders
- 3 Advocate recognition of MPH as requirement for PH leading positions
- 2 Expand range of training, e.g. continuous training, short courses, certificates



<http://www.aspher.org>



Common themes?

Criteria 3 Internal Environment

- 4 Establish and formalise Student representation in decision making processes
- 3 Creation of broader management structures, such as Curriculum or quality committees

Criteria 4 Teaching Staff

- 6 Use of external lecturers / practitioners
- 4 Faculty development / capacity building

Criteria 5 Students

- 4 Provide information / guidance on career pathways
- 3 Increase student diversity
- 2 Create an alumni association



<http://www.aspher.org>



Common themes?

Criteria 6 Curriculum

- 5 Establish, develop and define teaching methods
- 3 Improve organisation of courses / modules
- 3 Review / improve course learning materials
- 3 Strengthen English teaching
- 3 Curriculum review by faculty
- 2 Organise the program around the capacity of the dept
- 2 Relate contents of course to competencies
- 2 Make Curriculum ECTS compatible
- 2 Determine student workload
- 2 Curriculum to include 'core' public health subjects
- 2 Increase field practice experience



<http://www.aspher.org>



Common themes?

Criteria 7 Teaching / Learning Facilities

- 4 Continue to upgrade computer facilities
- 2 Expand library opening hours

Criteria 8 Research

- 4 Increase European / International support for research
- 3 Develop Research Teams / committees

Criteria 9 Institutional Quality Management Systems

- 3 Co-ordinate and systematise quality management processes
- 3 Use external stakeholders as part of processes



<http://www.aspher.org>



Universal recommendations based on 4 or more mentions:

Could these be used as a basis for future ASPHER projects?

- 6 Use of external lecturers / practitioners
- 5 Establish, develop and define teaching methods
- 4 Establish and strengthen links with stakeholders
- 4 Establish and formalise Student representation in decision making processes
- 4 Faculty development / capacity building
- 4 Provide information / guidance on career pathways
- 4 Continue to upgrade computer facilities
- 4 Increase European / International support for research



<http://www.aspher.org>



Thank you for your attention



Julien Goodman
Program Manager
ASPHER

<http://www.aspher.org>

A Short History of the PEER Activity

XXVII ASPHER ANNUAL CONFERENCE
Yerevan
September 17-20, 2005

FRANCO CAVALLO

DEPARTMENT OF PUBLIC HEALTH
University of Torino

Three Phases:

a) Pioneer phase (1st to 7th review): ended with the review of reviews 

b) Setting out a standard: searching for uniformity and objective criteria (8th to 14th) – Ended with publication of ASPHER criteria, 2001 

c) OSI-ASPHER project and systematic work on the basis of pre-defined criteria 

LIST OF REVIEWS COMPLETED PER YEAR
1993-2004

Reviews	Year	Reviewers
School of Public Health, Bratislava, Slovakia	24-26 November 1993	Philo Berman Jacques Bury Lorenz Köhler
School of Public Health, Krakow, Poland	11-13 October 1993	Jacques Bury Lorenz Köhler
School of Public Health of the Postgraduate Medical Center, Warsaw, Poland	12-14 November 1993	Jacques Bury Lorenz Köhler
School of Public Health of the Postgraduate Medical School, Prague, Czech Republic	8-9 May 1993	Jacques A Bury Lorenz Köhler Ulrich Laaser
School of Public Health, Faculty of Health Sciences, University of Bielefeld, Germany	18-18 June 1997	Ralph Bloch Jacques A Bury Lorenz Köhler Paul Schnabel
Department of Medical Sociology, Heinrich Heine University, Düsseldorf and Academy of Public Health, Düsseldorf, Germany	10-12 June 1997	Theodor Abelin Jacques A. Bury Lorenz Köhler Morton Warner
European Training Consortium in Public Health, Cagliari, Italy	20-22 August 1997	Jacques A Bury Franco Cavallo

LIST OF REVIEWS COMPLETED PER YEAR
1993-2004

Reviews	Year	Reviewers
National Danish MPH Programme, University of Aarhus, University of Copenhagen, Denmark	21-24 September 1998	Jacques A Bury Franco Cavallo Christopher Puckram
Master of Public Health, Faculty of Health Sciences, School of Public Health, Maastricht University, The Netherlands	27-29 April 1998	Jacques A Bury Franco Cavallo Lorenz Köhler
Training Centre of Public Health (Trop) in Tallinn, est. The Department of Public Health at The University of Tartu, Estonia	17-20 May 1999	Jacques A Bury Franco Cavallo Evelyn de Lesau
Master of Public Health, Institute of Social and Preventive Medicine of the University of Geneva Medical School, Geneva, Switzerland	27-30 September 1999	Esteban Manuel de Kebaboy Lorenz Köhler Evelyn de Lesau
Master of Public Health, Nordic School of Public Health, Göteborg, Sweden	16-19 November 1999	Jacques A. Bury Franco Cavallo Charles Normand
Interuniversity Postgraduate Programme in Public Health of the Universities of Basel, Bern and Zurich, Switzerland	12-15 March 2001	Jacques A. Bury Franco Cavallo Thierry Louvet Gudjon Magnússon

LIST OF REVIEWS COMPLETED PER YEAR
1993-2004

Reviews	Year	Reviewers
Certificate of Public Health, School of Public Health, Nofar Institute of Occupational Health, Lodz, Poland	10-13 June 2002	Franco Cavallo, Julien Goodman, Thierry Louvet, Richard Madelay, Esteban Meunier
Master of Public Health, College of Health Sciences, American University of Armenia, Yerevan	7-10 October 2002	Esteban Manuel de Kebaboy, Julien Goodman, Allan Krasnik, Thierry Louvet, Joanna Meunier
Master of Public Health Programmes, Hebrew University (Hadasa) Branch School of Public Health and Community Medicine, Jerusalem, Israel	2-3 February 2003	Andreas Faldsberg, Thierry Louvet, Joanna Meunier, Charles Normand
Master of Science in Public Health, School of Public Health, Medical and Health Sciences Center University of Debrecen, Hungary	18-20 June 2003	Julien Goodman, Soren Kiergaard, Ulrich Laaser, Thierry Louvet, Richard Madelay
Master in Public Health Management, Faculty of Public Health, Kaunas University of Medicine, Lithuania	1-5 December 2003	Franco Cavallo, Julien Goodman, Allan Krasnik, Thierry Louvet, Stagniew Sitko
Master Program of Public Health at the Faculty of Public Health, Medical University, Varna, Bulgaria	12-16 October 2004	Ramona Koleskova, Thierry Louvet, Michael Thompson, Theodore Tschinsky
Master of Public Health, Department of Public Health, University of Tartu, Estonia	11-15 October 2004	Ulrich Laaser, Thierry Louvet, Tom Kuiper, Stagniew Sitko, Julien Goodman

Characteristics of different phases

(a) Pioneer Phase

- It was a promoting phase: the main objective was to stimulate the need for ...
- PH in Europe searching for an identity (culturally and professionally)
- First reviews in EEC (Czech republic, Slovakia, Poland): most anxious to join Europe
- Then two reviews in Germany, a country with the most consolidated tradition in PH but looking for new approaches
- Criteria were general, no attempt to formulate standards

Some reflections:

- Judgement too discretionary
- No referral to commonly agreed cultural areas of PH
- No referral for the reviewers to a specifically defined set of criteria agreed upon by the schools
- The process is expanding anyway and creating a great interest around Europe
- The EMPH project starts to develop, in great synergy with the PEER activity

The Decision:

- The Executive Board agrees to commission a Review of completed Reviews to a set of Independent experts (October 1997):
 - ◆ Pat Evans
 - ◆ Christian Rollet
 - ◆ Theodor Abelin

Main Recommendations:

- insist on a pre-review on the basis of the documents from the self-assessment
- organise a structured follow up
- try to manage a clearing house of "best practices"
- provide technical assistance to the schools
- concentrate on the review of the quality of self-assessment methods within the institutions
- not only focus on process but at least glimpse at outcomes
- more visible and systematic use of criteria

Characteristics of different phases (b) *Developmental phase*

- Many prestigious European Schools get involved in the process, while the development in Eastern Europe goes on
- Similar developments in other scientific communities in the QA area
- Collaboration with EUPHA and EHMA
- The EMPH project stimulates the development of the QA process
- Following recommendations of experts, ASPHER develops, in collaboration with the Mérieux Foundation, a full set of criteria and standards

Some Reflections:

- A phase of intense cultural development and of internal debate
- Difficult to establish an autonomous and independent agency
- No real development of a 'European' need for accreditation
- Mostly, national structures are set up or consolidated

Characteristics of different phases (c) *OSI-ASPHER Phase*

- The centre of gravity of the process is again in the Eastern part of Europe. The focus is on developing new PH schools with a European standard
- The process is centred not only on QA but also on favouring development of new schools
- The criteria set up by ASPHER are accepted and widely used as a standard for Quality Evaluation

Some Reflections:

- The pressure for accreditation on the other European schools is decreasing
- The EC leaves 'harmonisation' within the health area to the national governments
- The debate focuses again on setting up an autonomous agency giving stability and continuity to this activity beyond the OSI project

OPEN PROBLEMS

- **... BUT IS THERE A REAL NEED FOR ACCREDITATION IN EUROPE?...**
(see Ramune Report...)
- **... WHAT ABOUT THE ACTUAL LEVEL OF COLLABORATION WITH OUR 'SISTER' ASSOCIATIONS?**
- **WHAT HAVE WE LEARNT FROM THE OSI-ASPHER EXPERIENCE?**
(see Julien Report ...)

PEER REVIEW AS A TOOL FOR CONTINUOUS QUALITY IMPROVEMENT IN PUBLIC HEALTH TRAINING

Workshop

2005, Jerevan

The mission of ASPHER

to improve the quality of Public Health education and to ensure standards

The aim of the workshop

- to promote PEER review for the future active development of quality across public health training institutions
- Objectives
 - to overview the history of PEER review
 - to share experience of PEER review among the Schools of Public Health
 - to develop the idea of PEER Forum
 - to gather suggestions on PEER development

- The PEER operates as a mechanism, in terms of programme content and quality standards, to develop curricula, provide guidance and steering in development and share best practice throughout the region.

Historical development of PEER review

- 1992 General Assembly gives mandate to EB to organize a process for mutual recognition
- 1993-1994 PEER – Public health Education European Review was devised
- 2001 "Quality Improvement and Accreditation of Training Programmes in Public Health" published
- 2001 the Executive Board set up an Accreditation Task Force chaired by J. Sitko
- 2001-2003(4) Program aimed at developing quality in Public Health Teaching Programs, across 13 countries throughout the CEE region
- 2002 Accreditation framework document prepared

PEER committee

- Franco Cavallo
- Ramune Kalediene (chair)
- Richard Madeley
- Gudjon Magnusson
- Stojgniew J.Sitko

Process of continuous quality improvement and mutual recognition

- Preparatory stage
 - Self-evaluation based on agreed criteria
- External review
 - ASPHER PEER review
 - National accreditation agency review
- Pre-examination by Accreditation Agency
- Accreditation

Where are we now?

- Up to now 21 SPH reviewed
- 2004 Project LEONARDO DA VINCI Community Vocational Training Action Programme "Public Health European Review of European Schools of Public Health" prepared (rejected)
- Survey on the situation and the needs of PEER review performed

Questionnaire survey June, 2005

1. Was your SPH/program reviewed by ASPHER?
2. What was the major challenge related to the PEER review process?
3. What was the major benefit from PEER review?
4. Would you like to have your programs PEER reviewed in the future?
5. If Yes, when, and what is the title of the programs?
6. Would your institution be able to pay for PEER review procedure?
7. If you would not like to have your programs reviewed, why?
8. What would you suggest to the PEER review committee for improvement of the review process?

Results from the survey

- Number of responses 29
- Interested in PEER review 17 (14 definitely, 3 in principle), mainly in 2006-2007
- Able to find finances for this procedure 17 (14 sure, 3 might be or partly)

Major challenges related to PEER review

- Time consuming
- Developing the report
- Handling the comprehensiveness of the process
- Comparison with European standards is complicated for some newly established SPH
- Recognition of diplomas
- English language for some SPH

Major benefits from PEER review

- Enabled to reassess programs critically
- Highlighted strengths and weaknesses
- Constructive criticism
- Initiated new activities
- Waking up the sense of team work and common aim
- Adding an external perspective from highly skilled experts
- Essential tool within own quality assurance system
- Useful for communication with local and national authorities
- Served as a basis for comments to a succeeding national review
- International support

The reasons of not willing to have PEER review

- Programs are in the active process of development or innovation
- Difficult to find money
- No recognition of the review process in the National system
- Universities are subject to a wide range of review processes, additional work load for the staff
- **Not sure of benefits**
- Internal politics of institution
- Time consuming
- National accreditation is not completed
- Would like accreditation to be the next step

Suggestions for improvement

- To have formal agreement at the European level or among scientific and professional health societies of the review process
- Formalizing the status of PEER within National accreditation procedures and systems
- To assure more institutional recognition on international horizon
- Guarantee the independency of the experts
- Establish links between PEER and accreditation
- Upgrade PEER criteria
- Help to find financial resources
- Follow up after one year
- Clarify the guidelines
- Make it less time consuming
- **To convince SPH that PEER is worthwhile!**

Next steps

- Project has to be resubmitted
- Further plan for PEER should be developed
- Establishment of PEER Forum (League)?



Possible role of PEER Forum

- Quality League
- Reviewed schools
 - Sharing good practices
 - Consultations on documents/procedures
 - Mutual support
 - Resubmission of EU grant project



$$e = mc^2$$

e – enthusiasm

m – mission

c – cash and congratulations



WORKSHOP 7

Workshop 7

Monday, 19 September 2005

ASPHER MEMBERSHIP CRITERIA AND STANDARDS

Rosa Giuseppa Frazzica, frazzica@cefpas.it, CEFPAS, Italy

Anders Foldspang, af@mph.au.dk, University of Aarhus, Denmark

Introduction

Cyclically, organizations need to critically look at their goals and objectives, at the way they operate and sustain themselves. They need to assess if the direction in which they are heading is the most appropriate one and responds to the present and future challenges of this ever-changing world. Likewise, organisations must evaluate if they keep on meeting effectively and efficiently the needs and the expectations of their constituencies. If necessary, they look at their organisational structure and introduce innovative elements in order to keep abreast of time.

As in other occasions, ASPHER is taking the opportunity of this annual conference to brainstorm with as many as possible of its associates to look at the past, at the present, but, mainly, to focus on the future of membership, which is the heart of any organisation, and try to define elements of effective development.

General Objectives

This workshop's main objectives are:

- Review the current situation of Schools of Public Health in Europe;
- Outline the present criteria and standards for ASPHER membership;
- Identify elements of new criteria and standards for ASPHER membership.

ASPHER MEMBERSHIP CRITERIA AND STANDARDS WORKSHOP 7

**Monday 19 September 2005
16:00 - 17:30**

Chaired by:

**Rosa Giuseppa Frazzica, CEFPAS, Caltanissetta (Italy) & Anders Foldspang,
Aarhus University (Denmark)**

Introduction

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Programme Outline

16:00 – 16:15	<i>The current panorama of Schools of Public Health in Europe</i> Thierry Louvet, ASPHER Executive Director
16:15 – 16:30	<i>ASPHER membership criteria and standards</i> Thierry Louvet, ASPHER Executive Director
16:30 – 17:15	Brainstorming session in small groups on <i>Criteria and Standards for ASPHER Membership</i> Facilitated by: Pina Frazzica, Executive Board Member and Anders Foldspang, President
17:15 – 17:30	Presentation of results in plenary

Some of the questions to be discussed by groups

- On what criteria should ASPHER membership be based? eg. number of faculty, number of students, number of courses...
- The type of programme offered, its duration, the number of ECTS, the methodology: should these be considered for ASPHER membership?
- Should curriculum and training modalities make a difference? eg. Residential versus Distance Learning...
- Should ASPHER open its membership to individual Public Health practitioners, not only Schools of Public Health?
- Others..

Two groups were formed as follows:

1) a **consolidating group** (with L. Georgieva, G. Kallischnigg, M. Kulzhanov, E. Likke Mortensen, A Malina and A. Foldspang (facilitator))

2) an **innovative group** (with C. Birt, K. Faisst, A. Meijer, C. Normand, S.J. Sitko and P. Frazzica (facilitator))

The consolidating group identified the following points/issues as needing to be taken into consideration in a discussion on membership:

- similar interest;
- mission of the institution;
- length of establishment of institution applying for membership;
- coverage of PH perimeter;
- number of graduates and number of students;
- the student to faculty ratio is more important as it represents the interface between a teacher (institution) and a learner (student); we need to define what the appropriate student to faculty ratio would be.
- a credible and consistent teaching programme. Criteria relating to that need also to be developed.
- need for a coherence and credibility assessment.

In summary, for the consolidating group, ASPHER membership should be granted to an institution on the basis of a credible and consistent teaching programme to be demonstrated through information related to the mission and to the teaching programme itself.

The innovative group identified the following points/issues to be taken into consideration in a discussion on membership:

- PH undergraduate programmes;
- Possibility to open individual membership to non eligible institutions;
- Associate membership open to institutions from outside (including outside the European Region);
- larger constituency for ASPHER?

In conclusion, it was agreed to continue this discussion with as many of those involved in this workshop as possible by e-mail and/or other appropriate means.

Workshop 7 “ASPHER Membership Criteria and standards”

XXVII ASPHER Annual Conference
Yerevan

Thierry Louvet
Executive Director
ASPHER

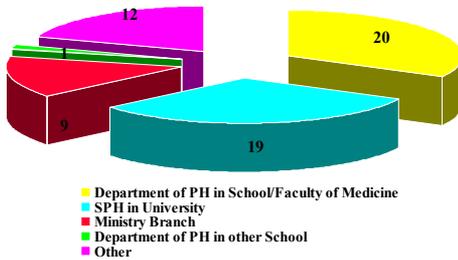
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Schools of Public Health in Europe are characterised by their diversity in terms of:

- Types of “Schools of Public Health”.
- Types of titles issued.
- Size (expressed in staff size).

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Types of "Schools of Public Health"



From E. de Leeuw 1995 (updated)

www.aspher.org

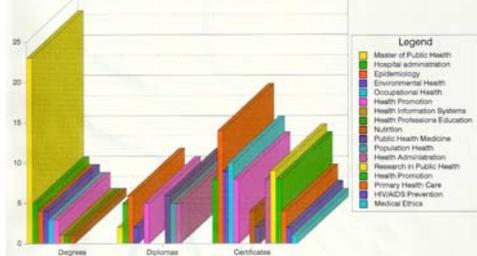
Public Health training leads to ...

- Degrees (full curricula)
- Diplomas (set of courses)
- Certificates (1 course)

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Public Health Training leads to ...

Degrees (full curricula), diplomas (set of courses) and certificates (1 course)



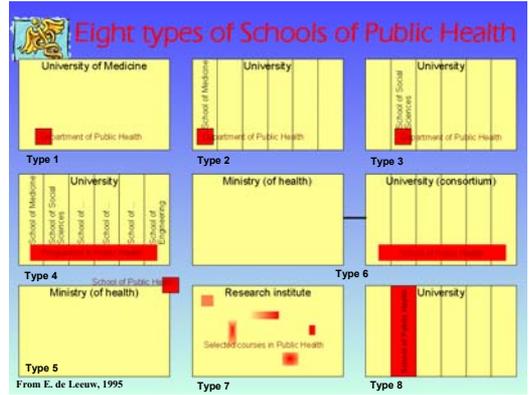
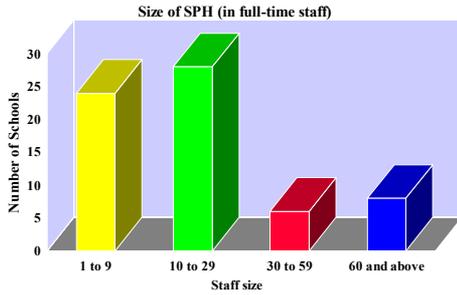
From E. de Leeuw, 1995

www.aspher.org

These titles can be in ...

- Master of Public Health
- Hospital administration
- Epidemiology
- Environmental Health
- Occupational Health
- Health Promotion
- Health Information Systems
- Nutrition
- Public Health Medicine
- Population Health
- Health Administration
- Research in Public Health
- Health Promotion

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Public Health jobs

- Public Health doctors;
- Health promotion specialists at various levels (municipalities, counties, regions, etc.);
- Epidemiologists operating in various settings;
- Environmental engineers;
-

Essential Public Health Functions:

- Monitoring the health situation.
- Protecting the environment.
- Health promotion.
- Prevention, surveillance and control of communicable and non-communicable diseases.
- Occupational Health.
- Specific Public Health Services.
- Public Health legislation and regulations.
- Personal health care to vulnerable/high risk populations.
- Public Health Management.

From Bettscher D., Essential Public Health Functions. International Delphi study (1998).



Workshop 7 “ASPHER Membership Criteria and standards”

XXVII ASPHER Annual Conference
Yerevan

Thierry Louvet
Executive Director
ASPHER

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- What are the present “criteria” in order to be accepted as an ASPHER member?
- Need to describe current procedure and recent practice in our membership policy.
- Presentation limited to institutional membership (the only one giving voting rights at General Assemblies).

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A fairly open membership policy

- Article 4 of ASPHER statutes:
“institutional membership is open to institutions like schools or faculties, departments or units responsible for education in public health within the European Region. It carries the right to appoint 2 representatives to the General Assembly, only one of whom will be entitled to vote.”

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...based on information collected by the secretariat via an ad-hoc form.....

- The form covers aspects such as:
 - full contact details of institution (Department / Faculty / School) applying for membership;
 - contact details for Dean/Director;
 - contact details for contact person nominated by Dean/Director;

../..

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...based on information collected by the secretariat via an ad-hoc form.....

- information on size of Institution applying for membership (number of equivalent full-time staff, of undergraduate /postgraduate students per academic year, date of academic year and exam period);
- information on Mission Statement and finances relating to the institution applying for membership (Mission Statement, source of funding, size of ordinary budget);
- information on type of institution (e.g. University or not, central/local government; etc.)

../..

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...based on information collected by the secretariat via an ad-hoc form.....

- information on teaching Programmes in Public Health (Undergraduate and / or Postgraduate) as a list;
 - information on ECTS;
- Recently additional and more detailed information has been requested by the Executive Board on:
- Number of graduates for the last two academic years (2003 and 2004).
 - Structure of the programme, i.e. names or titles of modules and sections.

../..

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- Duration of the training in ECTS or equivalent (total duration, duration of modules and sections);
- Title(s) issued by institution;
- Whether the programme(s) is (are) officially accredited in the home country;
- Indicators of PH research activities and their balance with teaching as concerns resource consumption;
- A lecture timetable in English.

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.....with two decision-making bodies, one being the “judge of last-resort”.

- Article 4 of ASPHER statutes:
“The Executive Board may, before the closest General Assembly, decide to grant provisional membership and the members thus temporarily admitted are bound to pay the contribution as decided ; they enjoy full rights except voting rights which will only be granted as soon as officially confirmed at the General Assembly.”

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- Current practice tends to give the Executive Board a sort of vetting role prior to submitting membership applications to the General Assembly.
- Once the GA gives its approval, the new member receives the call for membership fee for payment.

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Our membership reflects the diversity of the PH scene with a:

- Mixture of University based and non-University based institutions; SPH or not.
- MPH type of degrees and continuous vocational training;
- Advanced/established and developing institutes even not fully established (OSI-ASPHER programme).

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- Need to be sure about the issue.
- Is it about being more restrictive in terms of who to accept as members?
- Should we be less inclusive or holistic in our membership policy?
- Is the solution simply to give the EB a more formal vetting role (as is already the practice)?
- Do we need criteria or standards?
- Is a revision of the membership questionnaire sufficient?

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Thank you for your attention.

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WORKSHOP 8

Workshop 8

Tuesday, 20 September

STRENGTHENING HEALTH SYSTEMS IN DEVELOPING COUNTRIES: HUMAN RESOURCES DEVELOPMENT VIA ELEARNINGAlena Petrakova, petrakovaa@who.int, WHO, Switzerland

Tom Cook, thomas-cook@uiowa.edu, University of Iowa, USA

Purpose

Human resources for health (HRH) are increasingly recognized as a crucial element in improving health systems and health services, and attaining the Millennium Development Goals (MDGs). The HRH crisis presents strong political challenges at national, regional and international levels. Unfortunately, insufficiencies in the health workforce are becoming a major constrain to achieving the MDGs in many developing countries. Overall shortage is commonly aggravated by skewed distribution within countries and a movement of health workers from rural-to-urban, from public-to-private, and from employment-to-unemployment or jobs outside the health sector. The situation is exacerbated by insufficient training opportunities, unemployment in the health labor market, the increasing death toll from HIV/AIDS and the effect of migration.

Furthermore, it is widely recognized that traditional methods of education delivery are inadequate to produce the health workforce needed in these countries; there is an urgent need to train more than 1 million of health professionals in the countries of Sub-Saharan Africa in next 10 years to strengthen their health systems and to stop dramatic decline in their health outcomes.

Training is a key mechanism through which WHO implements its health strategies, influences national health policies and health care practices as well as shapes health service delivery. Training needs to be of the highest quality together with its cost-effectiveness. eLearning may be the most appropriate training method for health workers in developing countries because it can be:

- Personalized: eLearning allows a program of study to be customized for a region, a country, a district, or a small group of learners.
- Interactive: eLearning can engage the learner in a “give-and-take” type of learning that involves depiction of real-world events and sophisticated collaborations with other learners and instructors throughout the world.
- Just-in-time: eLearning can be easily modified to be adapted to each learner’s or group of learners’ rate and level of progress.
- Current: eLearning allows rapid and easy adaptation of educational materials to evolving health issues.
- User-centric: eLearning focuses primarily on the needs of the learner, instead of on the abilities of the instructor.

Most HRH strategies require long-term vision and thus high level commitment and involvement. The combined Global Public Health Campus (The University of Iowa College of Public Health) of WiderNet, Virtual Hospital, Elluminate, and Polycom provides a comprehensive scheme for using information and communication technology for meeting the global training needs for increased numbers of health workers. Close collaboration with the University of Iowa College of Public Health is important for developing and implementing this eLearning programme.

Objectives:

- To brief participants on new WHO eHealth resolution adopted by the 58th World Health Assembly in May 2005;

- To discuss the importance of HRH challenges for strengthening health systems and achieving Millennium Development Goals;
- To highlight the importance of ICT for HRH development with special focus on developing countries.

Strengthening health systems in developing countries:

A strategy for human resources development via eLearning

Alena PETRAKOVA & Yunkap KWANKAM

World Health Organization, Knowledge Management and Sharing

Thomas COOK & Cliff MISSEN

College of Public Health, The University of Iowa, USA



Definition

- **E-learning**...“instruction delivered on a computer” using CD-ROM, Internet, or Intranet.

Includes:

- content
- instructional methods
- media elements (text, narration, music, still graphics, photographs, animation, etc.)

Perspectives on e-Learning

- Student
 - Traditional (full-time, on-campus)
 - Non-traditional (part-time, off-campus)
- Practicing Professional (continuing ed.)
- Faculty
- University
- Public
- World

Does e-Learning Work?

Computer-based training has been around for 30+ years and has indicated that “greater complexity does not necessarily ensure more learning.”

“With few exceptions, the hundreds of media comparison studies have shown no differences in learning.”

(Clark & Mayer, 2003)

Is e-Learning better?

“What we have learned from all the media comparison research is that it’s not the medium, but rather the instructional methods that cause learning. When the instructional methods remain essentially the same, so does the learning, no matter how the instruction is delivered.”

(Clark & Mayer, 2003)

Proposed Advantages of e-learning

- **It can be Personalized:** eLearning allows a program of study to be customized for a region, a country, a district, or a small group of learners.
- **Interactive:** eLearning can engage the learner in a “give-and-take” type of learning that involves depiction of real-world events and sophisticated collaborations with other learners and instructors throughout the world.
- **Just-in-time:** eLearning can be easily modified to be adapted to each learner’s or group of learners’ rate and level of progress.
- **Current:** eLearning allows rapid and easy adaptation of educational materials to evolving health issues.
- **User-centric:** eLearning focuses primarily on the needs of the learner, instead of on the abilities of the instructor.

Proposed Practical Advantages of e-learning

- flexibility of the sites of learning,
- can use expertise from multiple institutions,
- use multiple modalities to reinforce traditional classroom-type activities,
- economies of scale, and
- replicability/consistency.

-SAFE WORK in the 21ST CENTURY
(Institute of Medicine, 2000)

Proposed Disadvantages of e-learning

- infrastructure costs,
- absence of hands-on skill instruction,
- potential isolation of students,
- faculty resistance and the need to train faculty,
- lack of capability for informal consultation, and
- potential high direct costs.

"Connected" World

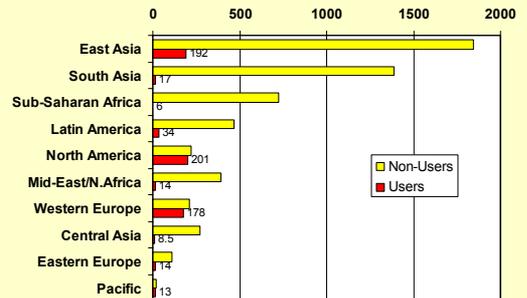
Health

Information/Communications Technology

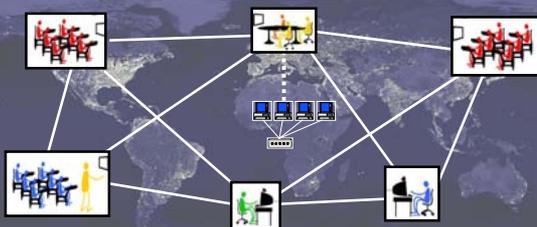
- \$1 trillion Internet investment since 1996
- Internet used by 1/8th of world's population
- Great geographic differences in access

Internet Users/Non-Users by Region – 2003

(millions)



Global Public Health Campus



Information/Communications Technology

- as appropriate for each location's level of internet connectivity

Four Levels



Global Public Health Campus

Four Levels of Connectivity

- I. Enhanced Local Area Networks
0 bits/sec

WiderNet
Creating a Wider Net
.Org



Global Public Health Campus

Four Levels of Connectivity

- I. Enhanced Local Area Networks
0 bits/sec
- II Web-Based Resources
= "slow" and/or intermittent



Global Public Health Campus

Four Levels of Connectivity

- I. Enhanced Local Area Networks
0 bits/sec
- II Web-Based Resources
= "slow" and/or intermittent
- III Graphics-Plus-Audio
=> "reliable" 28 Kb/sec



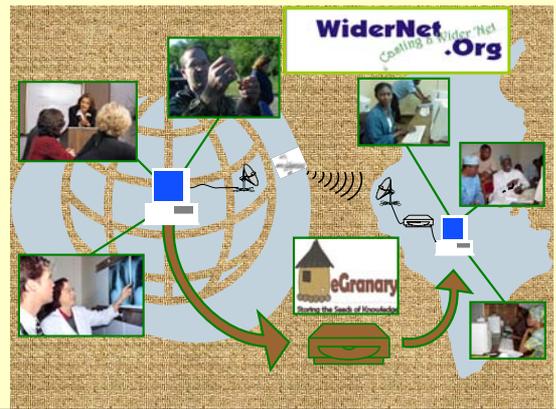
Global Public Health Campus

Four Levels of Connectivity

- I. Enhanced Local Area Networks
0 bits/sec
- II Web-Based Resources
= "slow" and/or intermittent
- III Graphics-Plus-Audio
=> "reliable" 28 Kb/sec
- IV Interactive Video
=> 156 Kb/sec



Level I. Enhanced Local Area Networks



Level II. Web-Based Courses and Resources

The screenshot shows the 'Academics' page of the University of Iowa College of Public Health. It lists various resources for learners and educators, including 'Virtual Hospital' and 'October Health Spotlight'. The page is organized into sections for providers, patients, and other commitments.

Level III. Graphics-Plus-Audio

The screenshot shows the 'Eliminate Live!' interface, which is a web-based platform for graphics-plus-audio. Red lines and boxes highlight various features and controls, such as 'Default window layouts', 'Participant list and privileges', 'Emotion indicators', and 'Click to raise your hand'. The interface includes a chat area, a list of participants, and various navigation tools.

Level IV. Interactive Video (video conferencing)

Polycom Worldwide U.S. 1.800.765.9286 Outside U.S. 1.925.924.800

POLYCOM
Connect. Any Way You Want.

Choose Region [Map] Contact Search

Company Info Products & Services eSupport Partners Investor Relations Store

Polycom.
Connecting the world.
any time. any way. any where.

Dean Merchant, on the Iowa Oakdale campus, presents a lecture on Rural Health to participants at a workshop in Trnava, Slovakia, using internet-based videoconferencing. -June, 2003

Level III

(Example = Elluminate Live)

- Important Features
- Demonstration
- Examples

THE UNIVERSITY OF IOWA

Elluminate
Where Bright Ideas Meet.
LIVE

- High resolution graphics
- Two-way audio communication
- Interactive features & tools
- Slower-speed internet connection
- Recordable

Conclusion

THE UNIVERSITY OF IOWA

Elluminate
Where Bright Ideas Meet.
LIVE

Demonstration

Conclusion

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NIOSH National Institute for Occupational Safety and Health

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NIOSH Agricultural Centers

Level III Example

Summer Institute for Rural and Environmental Health
June, 2004 and June, 2005, Trnava, Slovak Republic

THE UNIVERSITY OF IOWA

The University of Medicine and Pharmacy
Cluj-Napoca, Romania

Southern Denmark University
Esbjerg, Denmark

University of Trnava
Slovak Republic

Level III Example



Association of Schools of Public Health in the European Region

Welcome to the Association of Schools of Public Health in The European Region

ASPHER is the key independent organisation in Europe dedicated to strengthening the role of public health through the training of public health professionals for both practice and research.

Founded in 1968, ASPHER has over 65 institutional members. These are located throughout the Member States of the European Union (EU), the Council of Europe (CE) and the European Region of the World Health Organisation (WHO).



**Faculty Development
Pedagogic Institute,**
Dubrovnik, Croatia
May 27-31, 2005
ASPHER-OSI-NIH

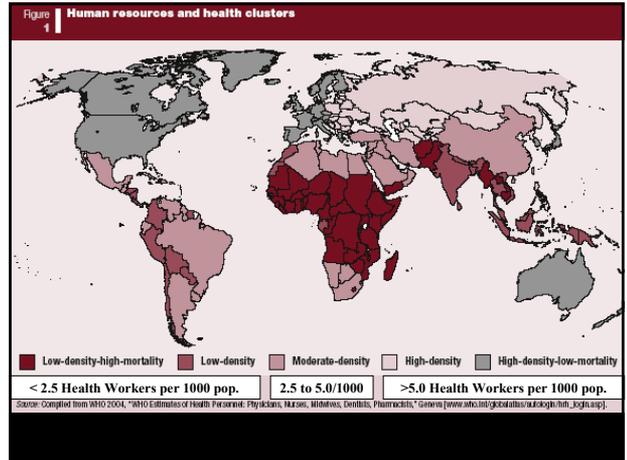
Level III Examples



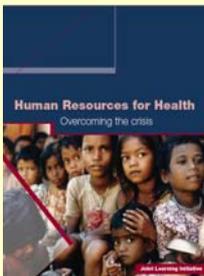
Level III Example

Level I (Example = Widernet)

- Need for Level I
- Demonstration



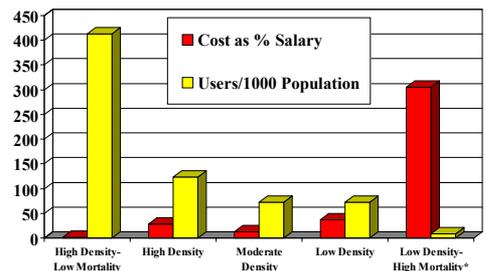
"JLI" Report: November 2004



**More than 1,000,000
New Health Workers
are needed in next 6
years for the
countries in the Sub-
Saharan Africa to
deliver the basic
services.**

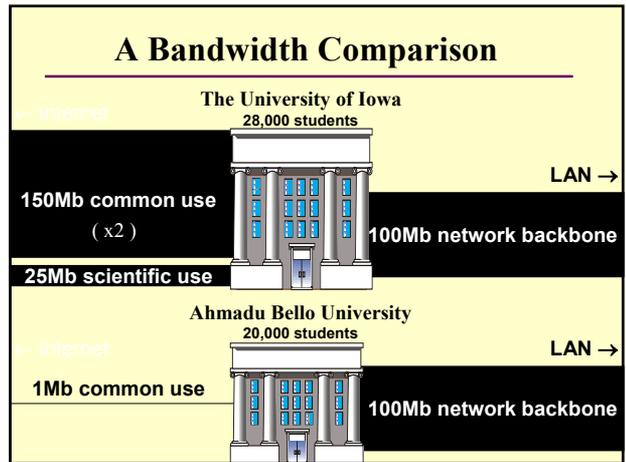
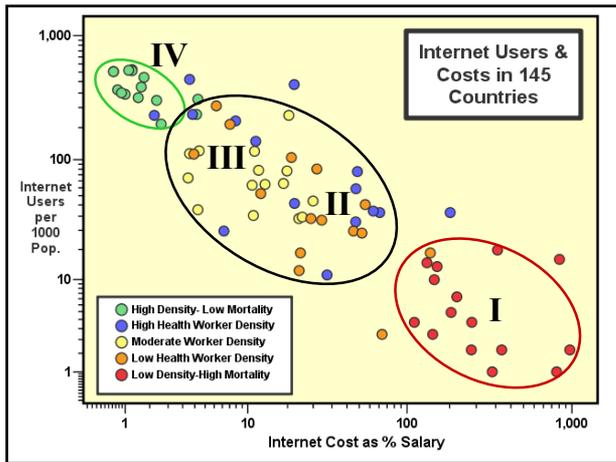
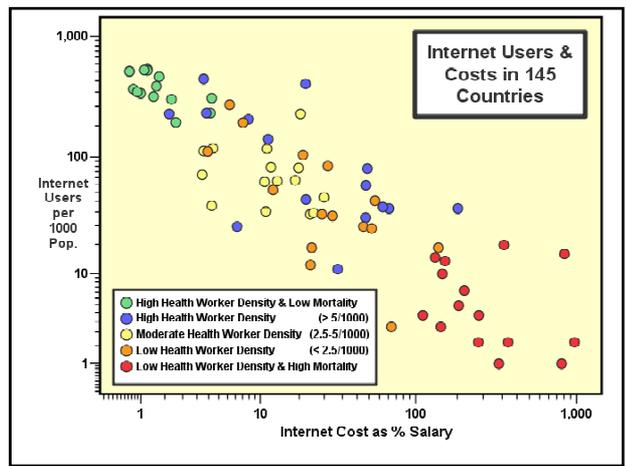
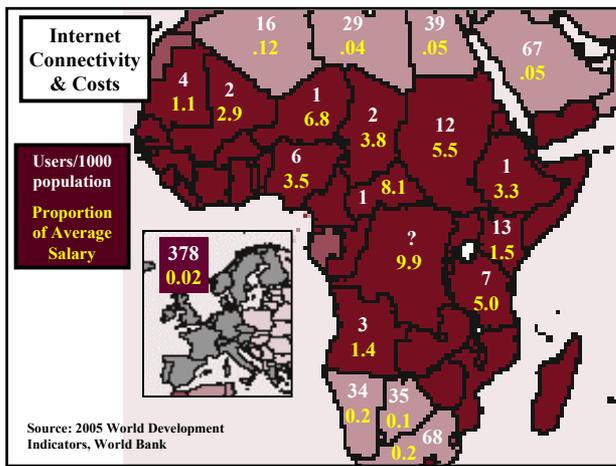
<http://www.globalhealthtrust.org>

Internet Costs and Use



Countries Grouped by WHO Clusters
(based on health worker density & mortality)

* 35/45 of these countries are in Africa.
Sources: Cost and user data from World Bank, 2005; country groupings from WHO, 2004



The Bandwidth Conundrum

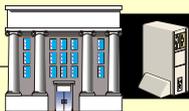
The **cost** of bandwidth influences who and how many can participate.

Type of Connection	Annual Fees	Initial Set-up	Simultaneous Web users
56Kb modem	\$800	\$400	2-4
128Kb sat.	\$28,000	\$60,000	6-12
1Mb satellite	\$110,000	\$60,000	30-70
10Mb LAN	Negligible	\$60,000	800+ (offline)

- ### The Reliability of the Internet Connection
- Very rarely 24 x 7
 - Many institutions hard pressed to deliver 6 hours a day
 - Frequent lapses of a day or more
 - Occasional lapses of a week or more
 - Many points of failure, the external connection to blame about 50%

Replacing Bandwidth with Storewidth

- 250+ GB information store inside LAN
- Millions of educational documents
- Collection created and maintained by librarians
- Multimedia, audio, video at full network speeds
- No bandwidth costs
- Can augment a conventional Internet connection

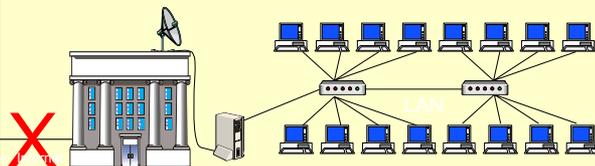


← Internet ??????

LAN →

... giving every computer high-speed access to hundreds of thousands of documents and multimedia files.

Even when the Internet connection is broken!

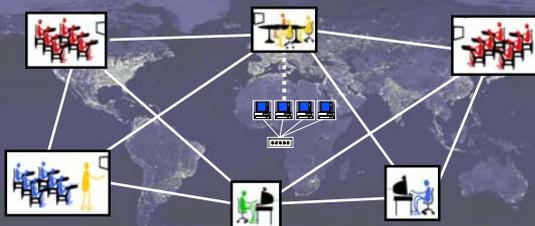


WiderNet .Org



Demonstration

Global Public Health Campus



Information/Communications Technology

- as appropriate for each location's level of internet connectivity

Four Levels

More Information

<http://globalcampus.uiowa.edu>

<http://www.widernet.org>

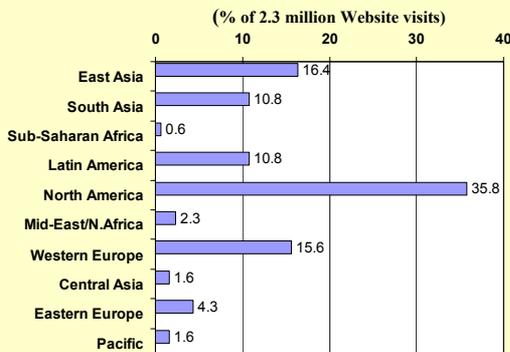
<http://www.vh.org>

<http://www.public-health.uiowa.edu>

thomas-cook@uiowa.edu

petrakovaa@who.int

Geographic Distribution of Visits to MIT Website Containing 500+ Open Course Ware Items



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