



## **Meeting Summary**

# **Resourcing Public Health in the 21<sup>st</sup> Century: Human Resource Development in a Global Environment**

*The Rockefeller Foundation  
Bellagio, November 15-19, 1999*

## **1. Introduction**

In 1978, the Alma Ata Conference envisioned Health for All by the year 2000. Twenty years later, poor health remains the norm for millions of vulnerable people living in the least-developed countries of the world. The broad determinants of health have changed drastically since Alma Ata. Globalization, poverty, health system reform, structural adjustment, rising health costs, and social and environmental threats increasingly endanger the well-being of the world's poorest. The time is right to reflect on the many challenges to good health and to attempt to translate them into opportunities to strengthen public health into the new millennium.

The Rockefeller Foundation is committed to supporting efforts to improve public health and has a long-standing history of programs that have sought to address public health problems. During the 1990s, however, it became clear that rapid demographic change, pervasive health care reform, new technologies, and people's proven problem-solving capacity necessitate strategic rethinking for the public health and donor communities alike. Recent explorations by the Health Sciences team have resulted in a new strategy, whose goal is to advance health equity globally by pursuing the reduction of avoidable and unfair differences in the health status of populations, especially the poor and excluded. Three sub-themes will be pursued: Harnessing the New Sciences, Resourcing Public Health, and Strengthening Global Leadership.

Resourcing Public Health is the health equity strategy sub-theme that advances the Rockefeller Foundation's concern about the health of populations in poor countries and the role of knowledge in finding solutions. The hypothesis of this sub-theme is that the generation, sharing, and use of knowledge-based resources through partnership and cooperation can strengthen the capacity of health systems to support the efforts of the poor and excluded to improve their health, negotiate inclusion, and redress inequities.

In November 1999, the Health Sciences team of the Rockefeller Foundation organized a consultative meeting, *Resourcing Public Health in the 21<sup>st</sup> Century: Human Resource Development in a Global Environment* which was held in Bellagio, Italy. The theme of the meeting was the role played by people in improving their own health and the availability of supportive knowledge. The proceedings of the meeting will be published, but this short report attempts to summarize the issues discussed and recommendations made.

## **2. Meeting structure and objectives**

The objective of the meeting was to identify opportunities for cooperation to strengthen the knowledge base of public health, by recognizing the central role that people play in public health, and by examining ways of strengthening the human resources required to meet the major challenges facing public health in the coming decades.



Participants were invited from Africa, the Americas, Asia and Europe, and represented a wide range of disciplinary and professional backgrounds in governmental, non-governmental, and community-based organizations, and donor and educational institutions in health and in other sectors.

### **3. The People's Perspective**

The first full day of the meeting opened with a panel on the people's perspectives of their health with presentations from South Africa and the Philippines and case studies from Sri Lanka, Tanzania and the United States. These sessions dealt with some of the challenges to health that the poorest and most excluded people experience, how they strive to overcome severe constraints, and what sort of health systems might better meet their needs.

In South Africa, as in many developing countries, there remain great disparities in health status along political and economic lines. The incidence of HIV/AIDS is increasing at dramatic rates and institutions struggle to confront its manifestations with community based interventions. The eradication of hunger and poverty in the Philippines was underlined as an essential prerequisite for health, especially in light of the expanding gaps between the 'haves' and 'have-nots'. Organized community groups, women, and young people were identified as agents of change. Experience at La Clinica in California indicated that it was important to locate the individual within the context of the root causes of ill health and to expand the involvement of stakeholders. The Tanzanian case demonstrated the need to develop the skills and resources to meet the demands of communities. All these lessons were brought together in the description of the activities of the Sarvodaya Shramadana self-help movement in Sri Lanka. A particular lesson was the importance of integrating cultural values, in this case Buddhism.

Discussion among participants noted the need to respond to people's initiatives in order

to reduce inequities. The struggle for health embodies a struggle for social justice. Participants agreed that the stakeholders who define well-being and the health agenda include: the people, community based organizations (CBOs), community leaders, non-governmental organizations (NGOs), governments, national institutions, and donors. Capacity must be created and sustained amongst all these stakeholders to place people at the center of public health systems by strengthening networks between and within sectors.

There was strong consensus that knowledge comes in different forms and that shared understandings are needed. Quite often, scientists and governments have an optimistic view of the people's health status, whereas those very people have pessimistic perceptions of their own health. More complete health indicators, formulated together with communities for their own use, and disaggregated by gender, age, and other key sub-groupings will lead to more appropriate responses to health needs.

### **4. Institutional Responses**

The remainder of the day was devoted to the institutional response to the people's perspectives as voiced by participants representing ministries of health, NGOs, and educational institutions. Local, district, national, regional, and international systems are in place to set policy, train and deploy health personnel, allocate resources, and perform management functions. While such institutions may share a common vision, they often seek to realize this vision in radically different ways, coming from distinctive world views and disciplines. For certain approaches to public health problems, the biomedical model is the most appropriate, for others a human rights framework is essential, for others reform is chosen, and for still others, a political or economic analysis provides the necessary insight. In an economic model, the people are the demand-side of the equation. Health systems should, therefore, be prepared to address a wide range of perspectives.

Government health systems in developing countries face numerous challenges in meeting the health needs of the people. Standards in training and accountability are difficult to regulate. Institutions are perpetually underfunded. Community health workers are often underpaid, if even at all, for their services. Government facilities can be difficult to sustain. Donor funding often sets the health agenda, as in the case of structural adjustment. The poorest remain unable to share costs for health care.

Civil society boundaries are porous and artificial. There are different types of civil society institutions: formal organizations directed toward humanitarian aims; membership organizations; NGOs; and organizations that have legal accountability to trustees. CBOs and NGOS generally represent the voice of the people and give support to civil society. NGOs empower CBOs in several ways, in particular, helping them to organize around their interests and make demands of the biomedical health system. Some engage in delivery of health services, but there is no empirical evidence that NGO health services are cheaper than government services, or that they reach the poorest of the poor. Moreover, the sustainability of large scale delivery services is in doubt as NGOS are much subsidized by donors, and their organizational structures are often distant from those meant to receive their services. Nonetheless, their capacity to reach far-flung under-served areas and to deal with people in humane ways is recognized.

Due to globalization, the health sector is undergoing a transformation in terms of focus, access, human resource deployment and distribution, essential care, and technological advances. Capacity building is more challenging than ever. Learning must take place in different forms, under varied circumstances, for a wide variety of purposes. The link between societal needs and education systems places huge obligations on universities and other educational institutions. Many universities are seeking to respond to these rapid changes. For example, higher education curricula in public health in

Australia, North America, and the United Kingdom are internationalizing. The number of foreign students is increasing in those universities. In addition, distance learning programs based in the developed world have grown exponentially. As a result, developing world national educational institutions for public health are facing intense competition. Their survival is threatened, unless appropriate protective measures are taken by governments and educational institutions.

Clearly, public health is an alliance of many stakeholder institutions, organizations, and movements. Public health must be owned jointly by the people and professionals. Systems must be in place to ensure the accountability of all institutions involved in public health. The greatest challenge is to find new approaches to meet the unfinished health agenda and discover new opportunities to combat evolving health threats.

## **5. Supply of Human Resources**

Elements in the supply of human resources include: (1) recruitment, selection, deployment, retention; (2) the continuum of training, graduate, post graduate, continuing education, lifelong learning; (3) the process of defining need and priorities in product development and curriculum content and (4) the incorporation of the population perspective and the involvement of poor communities. Three learning models presented at the meeting were: community-based training of nurses in South Africa, district based master of public health training (MPH) in Africa, and MPH training by distance learning in the US.

The Community in Health Personnel Education Initiative is a community-based education program for student nurses managed by the Border Institute of Primary Health Care in South Africa. In this initiative, the community selects the candidates and helps develop a mission statement and curriculum. A strength of this approach is the nurtured partnership between the community, training institutions, and health

services. The selection of students by the community has shifted the focus from academic achievement to the student's participation and involvement in community activity. Some challenges have arisen. There has been some university resistance because of the 'non-academic' nature of the program. There have also been some problems in developing trust between the community, training institutions, and health services. Yet, more than 200 students participate in the program each year.

The Public Health Schools Without Walls (PHSWOW) program was established in 1992 in response to public health capacity needs in Africa. The program aim is to foster locally appropriate health training that emphasizes experience as learning. Intended as a highly flexible training initiative, the PHSWOW model encourages collaboration between the national university and/or equivalent national training institution and the Ministry of Health. The guiding principle of PHSWOW is that public health training is best provided through a combination of rigorous academic content and extensive supervised practical experience emphasizing the capacity to pursue rather than memorize knowledge. Many of the lessons learned have been shared within a wider network of Schools in Africa and Asia who have adopted similar principles.

The distance learning approach to education is transforming professional education through the use of improved information and communications technology. The Johns Hopkins School of Hygiene and Public Health uses this approach to make credentials more widely accessible and to enhance the quality and productivity of its students. Through this model, students across the globe now have an expanded choice of learning institutions, unlimited learning resources, and collaborative learning opportunities. Even students in remote areas can be linked to such programs through print media, audio and videotapes, and video-conferencing. A very real obstacle to this approach is the inequity in access to technology and connectivity

across the globe and within populations. The poorest and most marginalized people are less likely to have access to or knowledge of computers and the internet.

Traditionally, public health training has been more available in the developed world, thus posing challenges for the participation of developing country health personnel. The development of local-based public health training fosters the retention of health personnel in-country, and slows the brain-drain. Alternative settings for learning, such as community-based training featuring people-health personnel partnerships, allow for experiential learning in the field. In addition, distance learning drawing on information and communication technology is shifting the educational paradigm toward a future university setup where students define their learning needs and draw on diverse resources to fill them. Educational institutions should strive to be better linked with each other (south-south and north-south) and with communities by sharing lessons, solutions, training materials, and data.

## **6. Human Resource Development**

In the latter half of the 20<sup>th</sup> Century, health gains have begun eroding due to the AIDS epidemic, structural adjustment, wars and natural disasters, refugees and internally displaced people, the increasing burden of disease, sky rocketing poverty rates, and rural to urban migration. This situation demands a global vision of human resource development as a system to plan, train, manage, utilize and retain. With the lens of future global health trends, participants began envisioning what sort of public health system and workforce would meet health challenges in 2020. The group debated such topics as: health needs assessment, curriculum development and continuing education, and resource allocation that enhances partnerships with poor communities.

Empirical evidence is crucial in assessing the health care needs of a people, their

community, and nation. The information knowledge base for human resource development is deficient. Incomplete health indicators or data lead to inappropriate responses to the health needs. Prior to devising a human resource development plan, a nation must assess the essential functions of public health in light of local social, cultural, and health contexts. Issues of equity (gender, age, and ethnic concerns), access, and health sector reform must also be considered. The type of human resources needed for health vary from country to country. Many countries are overproduction oriented, constantly dealing with deficiencies and with demand failures.

Quite often there is a mismatch between health needs, the allocation of resources to meet these needs, and the response of the academics who train the human resources. In Kenya, for example, there is training for public health dentists and technicians, but a lack of resources and equipment to do their work. In many developing countries, deployment of human resources and equitable distribution is hampered in remote, rural areas where health personnel demand special incentives to be sent to such areas. In some countries, there are too many doctors and too few nurses, while in others, most of the resources go to hospitals and not primary health care. The composition, distribution, and deployment of health providers are critical to the success of a health system. The development of multi-sectoral teams broadens the context and skills of health workers. As such, cross-disciplinary perspectives can be brought to the table to define and measure the impact of human resource development programs.

Education and people empowerment are key components to human resource development in the health sector. A broad educational infrastructure can work to meet the needs of health personnel. Human resource development can make use of innovative methods through curriculum content, lifelong learning skills and attitudes, learning and teaching approaches, shared modules, community based sites,

partnerships, continuing education, and flexible learning. Ultimately, of course, the center of the learning process should be lodged in active communities re-educating themselves and others in people's health matters.

## **7. Mechanisms for Sharing Knowledge**

The 21<sup>st</sup> century offers many opportunities for cooperation globally and at all levels of society. With increased communication capacities, the sharing of knowledge is amenable to cooperation between institutions, communities and individuals across continents, borders, and boundaries. The purpose of this session was to examine some existing models for knowledge sharing and explore possible new forms of cooperation.

How can the global health community develop a broader view of future human resource needs? The situation demands networking at local, national, regional, and global levels and across sectors. Enthusiasm and capacity can be created through communication in support of community organization and social mobilization, learning lessons from others, tooling human resources with appropriate analysis and political skills, and facilitating transnational partnerships.

Information and knowledge can be shared across the globe through increased access to the Internet and wider use of the media. Virtual education systems, databases, and distance learning programs attempt to take advantage of the opportunities offered by globalization. However, it is important to keep in mind the widening information gaps for those not in the connectivity loop. All too often, these include poor women, children, youth, older persons, migrants, refugees, ethnic minorities and similarly excluded groups. The Foundation for Media Alternatives in the Philippines is one such organization that is striving to democratize information and communications technology for civil society.

Regional and national resource centers are

another mechanism for exchanging information, research findings, and learning tools. The Centre for Educational Development in Health Arusha (CEDHA), a professional institute for health personnel development in Tanzania, has noted six areas for collaboration and information exchange: training, research, AIDS/HIV, public health center, health science research, and management and evaluation of programs. Such collaboration between organizations will further promote the capacity strengthening of health professionals and ministries in policy process, development, advocacy and evaluation. Practical, hands on learning by present and future decision-makers will help bridge the gap between institutions and communities through direct dialogue.

Networking and information sharing can occur at local, national, or regional levels. The Mekong Basin Surveillance Network is an attempt to share information about disease outbreaks at an intercountry level. Due to the spread of epidemics across provinces and international borders, this regional surveillance network has been formed to strengthen outbreak control and may serve as a model for future knowledge and information sharing in other regions of the world. The Regional Tropical Medicine and Public Health Network (SEAMEO TROPMED), composed of four regional Centers in Indonesia, Malaysia, the Philippines, and Thailand is an excellent example of regional cooperation.

Mechanisms for knowledge management need to be developed. Information and communication technology will change institutional forms and types. The hierarchical organization of institutions is giving way to horizontal structures especially in the service sectors such as health, evolving into flexible organizational arrangements. New types of institutional arrangements must be considered. The values that underpin, and form public health need to be globalized just as values for human rights have been globalized.

## 8. Resourcing Public Health: the way forward

There was common consensus that:

1. 'Resourcing Public Health' is a suitable title for a program that has as its vision: *'the enhancement of all people's well-being in a sustainable system that ensures equitable access to essential public health knowledge and services'*. In this context, people in 'public health' are 'resourced' to enhance well-being through the sharing and use of knowledge (ideas, stories, research, data, guidelines etc.).
2. A set of common principles requires that:
  - every individual has the right to health and well-being;
  - public health is based on social, political, and economic justice;
  - people have the capacity to address their own health and have the right to decide;
  - public health is sensitive to diversity and accountable to people;
  - health care is affordable, of high quality and accessible; and,
  - all stakeholders appreciate that knowledge comes in different forms.
3. A strategy to 'Resource Public Health' can be developed and it should:
  - target civil society, the health workforce, and public health institutions;
  - work at several levels, community, district, state, regional and global;
  - take advantage of the changing global environment;
  - seek sustainable social empowerment through connectivity and collective action;
  - develop a workforce based on shared wisdom, knowledge, evidence, and values;

- strengthen public health institutions;
- include human resource development, research, policy and advocacy, and monitoring and evaluation; and,
- focus on cooperation to share knowledge between all stakeholders and lay down principles for ethical partnerships.

### 9. Jujitsuing globalization

*In the Japanese martial art of Jujitsu, the Samurai wrestler uses the power of the opponent to throw the opponent down. A guiding principle of Jujitsu is to strive to overcome limitations through maximum efficiency with minimum effort.*

*There are forces brought on by globalization that impinge on the capacity to deliver public health. The global economy is causing unprecedented poverty and richness simultaneously in different parts of the world and, in some countries, within different segments of the population. There is an attack on the state that has had a major responsibility for public health, for its failure to deliver public health. If these forces continue as they are, the situation for public health is pessimistic.*

*Is it possible to jujitsu with the gorilla of globalization and leverage its energy to win better local public health outcomes?*

## Appendix

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