

2. The Context for Linking Arrangements

Any programme of collaboration between institutions in different countries has to take account of the changing international, national and institutional environment in which it has to function.

2.1 The Commonwealth framework

The 49 countries of the Commonwealth are at different stages of economic development and have different systems of government. They have differently organized systems of health care delivery, and cultural and educational traditions. The systems of government and administration, and the relationships between institutions and the state vary widely, and both these, and the institutions themselves, are evolving rapidly. There are great differences, for example, in the way training programmes are organised and in the emphasis given to post-graduate education and research as opposed to primary health care development. Further diversity can be found in funding systems, in the adequacy of funding and in the language of academic dialogue. An open and pragmatic approach is needed to cope with such a varied set of countries, institutions and circumstances and to draw on the rich resources and experiences that are available.

2.2 Donor Assistance

Most links depend on funding from aid agencies. Agencies are increasingly selective in the activities that they will support and in defining the length of time that financial support will be available. They also ask for the measurement of the effectiveness of a link to be planned for and discussed from the commencement. Frequently they seek proof that a link will lead to a practical contribution to a country's economic development - a wider objective than, say, an increase in the number of teaching schedules or research activities. Attention tends to be focused on scientific and technological subjects as opposed to the social and cultural aspects of the development process. Increasingly, also, Northern donors expect commercial benefit to flow directly or indirectly from aid programmes. For example a link arrangement may lead to an increase in the number of foreign students attending a particular university in the North, raising its fee

income and enhancing its research capability. This means that from the beginning potential link arrangements are carefully documented, and costs and benefits systematically appraised.

2.3 The Impoverished Learning and Operational Environment of many Developing Country Institutions

Many institutions in Less-Developed Countries (LDCs) operate in a difficult and impoverished learning and working environment. There are severe domestic financial constraints on all activities and a critical shortage of foreign exchange to further involvement internationally. For those who are involved in the daily operation of health institutions certain common factors can be identified:

- o a strong sense of isolation, of being apart from much of the creative and intellectual thought and recent research that is being undertaken and published. Lack of money has left training institutions, district health authorities, even the Ministry of Health, without access to new books, journals, video films, computers and data bases. Many operate without reliable photo-copiers or telephone and postal system.
- o a single operator in a national field. Many LDCs have, with difficulty and sacrifice, established one medical college, one college offering courses in health administration, one specialist hospital or treatment centre for the treatment of cancer or AIDS. This results in a lack of specialized networks able to advance research, produce and circulate articles or journals, or initiate team projects.
- o promotion of North-South rather than other directional links. Where financial help is available from donors it usually assists staff to travel to Europe or North America rather than to other countries of Africa or other provinces of India. South-South links, regional networks, publications and meetings remain weak activities.

The LDC institutions find themselves isolated from the information-based culture of the Developed Countries [DCs] and remote from the specialized networks, journals, conferences and research and consultancy documents that are the vehicles of that culture.

2.4 **Financial Constraints on DC Health Institutions and in the Health Sector generally.**

Many DC institutions, particularly those in higher education and the health sector in general, have been subject to financial constraint by DC governments in recent years. The growth of social sector expenditure, the share of national resources consumed by the health and education sectors and the effectiveness and efficiency of expenditure have become matters of vital concern for Governments of most DCs. Governments have looked for restraint in public expenditure growth and the reduction of government deficits. Privatisation, decentralization, charging students and patients, attention to effectiveness and efficiency have all been key strategies in this new approach. This has had an effect on the climate for scholarship and research which can be illustrated with 3 examples:

- o Less public subsidy has meant substantially higher fees being charged to students from LDCs. In many institutions this has led to a drop in the number of overseas students attending courses, with all its ramifications.
- o The ratio of students to teachers has been increased involving a heavier teaching load and less time for staff to undertake other activities.
- o The freezing of public funds has meant curtailment of activities, even closure of entire departments of universities. Commercial sponsorship has frequently been sought as replacement funding with emphasis on research linked to immediate commercial and national uses.

In this difficult environment the putting in place of academic links and other forms of international co-operation will be scrutinized on a cost-benefit basis as closely as investment of resources and time in other activities. This problem emerged earlier in the USA than in Europe. [Family Health Care Inc. 1979].

2.5 **Need for expertise in strengthening health systems for a Primary Health Care approach.**

2.5.1 Many LDCs are finding difficulty in pursuing a Health for All by the Year 2000 strategy and in reorganizing Ministries of Health to actively promote Primary Health Care (PHC). The concept of PHC encompasses not only the provision of a wide range of services for health promotion, disease prevention and treatment of common ailments (with referral of patients as necessary) but also basic principles of equity. It stresses community participation and collaboration between sectors in active pursuit of a healthy population and healthy living conditions.

Ministries of Health are failing to serve as the directing and co-ordinating authorities for the PHC approach. The reasons have been identified by a WHO Expert Committee [WHO 1988] as:

- o an inadequate or inappropriate range of responsibilities.
- o an isolated role in the national health system.
- o excessively centralized responsibilities.
- o poor management and weak leadership.
- o inadequate links with other sectors.
- o limited involvement with the community.
- o lack of financial resources.

The Expert Committee went on to list seven strategies for overcoming these weaknesses and the relevant technical, political and cultural factors to bring about change. In the Recommendations made by the Committee the importance of the exchange of information and experience both of a technical and factual nature was stressed.

2.5.2 One Network that already exists to promote the change of curricula in medical schools to a PHC community-oriented approach, and to assist institutions in

countries that have decided to introduce innovations in the training of health personnel, is the Network of Community-Oriented Educational Institutions for Health Sciences. The Network is based at the University of Limburg, Maastricht, The Netherlands. It has financial backing from WHO. [see Appendix 6]. Many Commonwealth institutions already belong to the Network. Links and collaborative approaches have a great deal to offer in solving the problems that Ministries have to face.

2.6 **The Challenge**

This, then, is the changed and still changing background of the 1990s. It has to be taken into account in the planning of new links or the strengthening of existing ones. The challenge is to create conditions in which scholars and administrators in health from the different countries of the Commonwealth can work together in useful and productive ways.