Preventive and social medicine (PSM)/community medicine (CM)/community health (CH) is the study of health and disease among the population in countries in order to identify their health needs, and plan, implement and evaluate health programmes.

A Regional Conference on "Public Health in South-East Asia in the 21st Century" was conducted by WHO in November 1999. This led to the "Calcutta Declaration on Public Health" which highlighted the need to strengthen and reform public health education, training and research. Subsequently, a network of public health institutes was established and public health competencies identified with accreditation of guidelines of training programmes. Public health courses are imparted to undergraduate students in medical schools of the Region by the departments of PSM/CM/CH.

An expert group on PSM/CM/CH and education reviewed the existing curricula in countries of the Region and developed regional guidelines on the teaching of PSM/CM/CH. It is expected that this will standardize the teaching of PSM/CM/CH in regional institutions.
Review of Preventive and Social Medicine / Community Medicine / Community Health Curriculum for Undergraduate Medical Education

Report of the Expert Group Meeting
SEARO, New Delhi, India, 27-28 August 2009
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3. Opening Remarks by Dr Myint Htwe, Director, Programme Management, WHO Regional Office for South-East Asia at the Expert Group Meeting on Management of Preventive and Social Medicine/Community Medicine Curriculum for Undergraduate Medical Education, WHO/SEARO, 27-28 August 2009 ........................................ 24
Introduction and background

Health is a basic human right and WHO is an organization committed to Health for all people. The South East Asia Region of WHO has 25% of the world’s population and 30% of the global disease burden. The World Health Report 2006 clearly reflects the pivotal role played by the health workforce in achieving the health outcomes of Member States. WHO has been aware of the need to strengthen the development of health workforce as an important way to strengthen the health system as a whole. The landmark “Calcutta declaration”, adopted in 1999 at the Regional Conference on Public Health in South-East Asia, urged the promotion of Public Health as a discipline and an essential requirement of health promotion. An informal consultation on “Future Directions in Public Health – Calcutta and beyond” organized by WHO in New Delhi in 2003 assessed the progress and charted the way forward. Currently, public health is being taught to undergraduate medical students by the department of Preventive and Social Medicine (PSM)/Community Medicine (CM) / Community Health (CH) in most medical schools in the region.

Medical practitioners are an important section of health workforce providing health care to the people. In countries of the SEA region majority of the people do not have access to a qualified doctor. In most situations, preventive, promotive and rehabilitative care is more essential where health education plays an important role. The education and training of graduate doctors is very vital for this purpose. They should be equipped with proper knowledge, skills and attitude to meet the basic health needs of the vast majority of people.
It is well recognized that undergraduate medical education is most crucial for preparing a future doctor. The education and motivation to respond to the needs of people mostly obtained during this period. Unfortunately teaching and training of undergraduates are not taking place in the right direction. Policymakers and Governments have made several attempts to identify the problems and assess the needs. The most important area of medical education is the preventive and social medicine, community medicine or community health and public health which is being neglected. Good public health practices should be the mainstay of all efforts to develop a better quality of life for the people, especially the underprivileged, vulnerable and marginalized. Doctors need to be competent enough and attitudinally prepared to address the present-day health needs of the people. They need to be professionally sound, ethical in decision-making and compassionate in care.

Preventive and Social Medicine (PSM)/Community Medicine (CM) / Community Health (CH) is the study of health and disease in the population of defined communities or groups in order to identify their health needs, and to plan, implement and evaluate health programmes to effectively meet these needs. The major goal of PSM/CM/CH is protection and promotion of public health. It is the branch of medicine concerned with the health of population and uses population health knowledge and skills to play leading and collaborative roles in the maintenance and improvement of the health and well-being of the community.

To enable the graduate doctors to achieve this goal an appropriate curriculum is essential to guide educators, learners, administrators and stakeholders. The curriculum needs to be continuously reviewed and updated with the present-day context and societal health needs in mind.

Understanding this need the initiative to review the undergraduate PSM/CM/CH curriculum was undertaken in order to make it more rational, logical and adapted to changing scenarios. An expert group meeting was organized by WHO-SEARO in New Delhi on 27-28 August 2009. The guidelines for the curriculum of PSM/CM/CH was finalized in consultation with the experts from the regional countries.
Objectives

General objectives

The general objective of the meeting was to review and improve the preventive and social medicine/community medicine/community health curriculum, focusing on the common health problems and contemporary public health issues in countries of the SEA Region.

Specific objectives

The specific objectives of the meeting were:

1. To share and review the PSM/CM/CH curriculum for undergraduate medical education in countries of the SEA Region.
2. To build consensus on the necessity of change and improvement in the content and process.
3. To develop guidelines on PSM/CM/CH curriculum medical education in countries of the SEA Region, to be shared in a meeting on “Teaching of Public Health in Medical Schools” in December 2009.

The present meeting brought together professors in PSM/CM/CH from medical schools, institutes and universities of 7 out of 11 Member States of the South-East Asia (SEA) Region (see Annex).
Inaugural session

In welcoming participants, Dr Sangay Thinley, Director, Health Systems Development, WHO/SEARO, mentioned that PSM/CM/CH curriculum has been taught in medical schools in countries of the SEA Region for many years, and public health forms a part of it. However, in view of the contemporary public health issues and other common health problems, there is a need to review the curriculum from a public health point of view. He said that based on the meeting’s deliberations and consensus on the issues, a guideline on teaching PSM/CM/CH is expected to be finalized.

In his opening address (see Annex 3) Dr Myint Htwe, Director, Programme Management, WHO/SEARO, recalled the Calcutta Declaration of 1999, which clearly emphasized the need to “strengthen and reform public health education, training and research as supported by the networking of institutions and the use of information technology, for improving human resources development”. Dr Myint Htwe hoped that this meeting would fulfill that vision and will have long-term beneficial effects in the field of public health. He further emphasized that the professionals, who are steering and leading the public health arena, especially medical doctors, paramedical workers and professionals from other allied disciplines, should be well-informed about the basic principles of public health. Because of globalization, new issues such as socio-cultural approaches for considering and dealing with public health problems are becoming important. The teaching and learning of preventive and social medicine were
needed. Teachers in medical schools and allied institutes should be well-versed in teaching skills and have good professional attitude as well.

Dr Myint Htwe hoped that the objectives of the meeting would be fully achieved and said that the contributions from the experts would be extremely useful for promoting the field of public health in the South-East Asia Region.

Following this address Dr Muzaherul Huq, Regional Adviser, Human Resources for Health and Fellowships, WHO/SEARO, presented the background and objectives of the meeting. He emphasized that since the medical graduates ultimately need to work in the public health area and for that it is very important that the PSM/CM/CH curriculum include current public health issues. The Regional Conference on Revitalizing Primary Health Care (2008) recommended strengthening of human resources with appropriate training of health workforce, consistent with the needs of primary health care and review of the curriculum. He also mentioned that the Regional Meeting on Teaching of Public Health in Medical Schools, to be held in Bangkok in December 2009, would (a) review the situation of public health teaching in medical schools; (b) share innovative teaching methods to improve teaching in medical schools; and (c) develop a regional framework for strengthening public health teaching.
Presentations and proceedings

4.1 Public health competencies for medical graduates

Dr. Huq mentioned that the regional consultations held in 2002 reviewed the status of public health education and training at basic, middle and higher levels; accreditation guidelines for educational/training institutions; and networking of institutions. Community sub centres, primary health centres and district hospitals were identified as the three important settings for public health teaching and training. Medical officers, nurses, public health officers and allied health supervisors need to be trained in public health at the primary health centres. Technical, administrative, managerial and self-development skills are essential competencies for medical doctors. The curriculum should consist of all essential competencies, community-oriented, flexible and dynamic, culturally and gender-sensitive and based on needs assessment.

4.2 Country presentations

Bangladesh

Prof. Falahuzzaman Khan of Bangladesh Medical College, Dhaka, presented a paper on teaching of community medicine in undergraduate medical education in Bangladesh. The first undergraduate medical curriculum in Bangladesh
was developed in 1988 with support from the United Nations Development Programme (UNDP) and WHO. However, the curriculum was revised in 2002. The current curriculum aims at producing basic doctors capable of fulfilling community health needs and contains a two-part course. One part focuses on concepts of community medicine, health and diseases, behavioural science, health education and communication, and the other part focuses on epidemiology, primary health care, maternal and child health, family planning, nutrition, environmental health, public health administration, disasters and accidents. The topics are being taught as lectures (130 hours), tutorials (160 hours), field visits (40 days) and practical work. The student assessment methods include formative assessment with written, practical and structured oral examination. The faculty is comprised of professors, associate professors, assistant professors and lecturers. They get exposure to teaching technology and educational science in government sectors, private sectors, and other medical education units and research cells. The contents of the curriculum should include relevant and essential information. Seminars and research projects should also be included in the teaching methods.

India

Dr B.S. Garg presented the salient features of the curriculum being used in Mahatma Gandhi Institute of Medical Sciences, Sewagram, India. Among the innovations being introduced at the institute are: a 15-day orientation camp for students immediately after admission to get them acquainted with Gandhian principles and programmes; and a 15-day social service camp under the “village adoption scheme” to enable students to learn about rural life, environmental sanitation, socioeconomic conditions and health problems in the community. Students look after the health needs of their allotted families and form emotional bonds. There is also a 15-day rural camp during the final year for training students in managing primary health care centres with minimum resources in rural settings. Dr Garg emphasized the need for training of medical teachers on teaching technologies, implementation of decisions taken by the health ministry, improvement of field practice areas and at least 40% time for public health education at undergraduate level.

Dr J.P. Muliyil presented the curriculum currently being used by the Tamil Nadu Dr M.G.R. Medical University at Chennai, India. Though India produces more than 25 000 doctors annually, which should be large enough workforce to meet the needs of the country, to a large extent this capacity is not utilized optimally. Dr Muliyil said that there is a need to take a fresh look at the whole teaching and training process, course contents, teaching
methodology, evaluation process and the competency of teachers. He stated that “health care needs to be a charitable enterprise rather than a commercial enterprise”. Imparting training in medical technology without a framework of community health would make medical care a commodity for sale. The community health perspective should permeate all other subjects so that issues related to equity in health care and social justice resonate throughout the entire medical curriculum.

**Indonesia**

Presenting the medical curriculum of community health in Indonesia, Prof Hasbullah Thabrany from the University of Indonesia shared with the meeting that community or public health has been taught to medical students since the independence of Indonesia. In the early 1970s, mandatory service of new medical graduates in public health centres was launched to prepare them to be leaders in public health programmes in every sub district. In the late 1980s, five schools of public health were established in the country offering a bachelor’s degree in public health. In 1998, a new democratic reform introduced liberalization of universities. Medical and public health schools were given licences after 2000, which resulted in growth of public health and medical schools to large numbers. As an example of PSM curriculum, he presented the curriculum of the University of Gadjah Mada, Indonesia. The typical teaching principles being used in Indonesia included: (i) students active learning; (ii) problem-based learning; (iii) integrated teaching; (iv) community orientation; (v) early clinical exposure; (vi) evidence-based learning; (vii) advanced teaching technology; (viii) professionalism; and (ix) research. He mentioned innovation in teaching, improved faculty-based accreditation, inculcating reading habits in both students and faculty, and alignment of the curriculum with government programme as challenges. More involvement of community posting is required, but remains a challenge due to lack of financial incentives.

**Myanmar**

Dr Tin Min of the University of Public Health, Yangon, presented the PSM curriculum in undergraduate medical education in Myanmar. Public health is a component of both undergraduate and postgraduate curriculums in medical schools and universities in Myanmar. There are 14 universities under the Department of Medical Sciences/MOH offering a bachelor’s degree in medicine, dental, nursing, health assistance and traditional medicine. There are other training schools/centres that produce allied health personnel and paramedics. Knowledge, attitudes and skills are covered in the curriculum for undergraduates. It also contains (i) concepts of health and social medicine;
(ii) disease control; (iii) health management and administration; and (iv) field teaching programme/practice as the core and additional contents. Dr Tin Min also informed that imbalances in the teacher–student ratio, lack of information from the MOH on its updated programme, the low priority given to equipment and supplies and a distinct gap between classroom teaching and field practices were some of the challenges. Some innovations in teaching and assessment in Myanmar included “best teacher award” by students; a guardianship system; more assignments; and community-based teaching methods. Accreditation of teaching and practice, regular revision of the curriculum, strong linkages to the health system and a good balance between theory and practice would be very useful for improving teaching of PSM/CM/CH.

Nepal

Prof. Ishwar Bahadur Shrestha of Institute of Medicine, Tribhuvan University presented the paper on teaching of community medicine in Nepal. He informed that until 1972, when the MOH took over the training of basic health workers, only the Civil Medical School, Health Assistants School and Auxiliary Health Workers Schools were producing health workers. However, in 1978, all these programmes were brought under Tribhuvan University and the Institute of Medicine started its first diploma course in medical science (MBBS). He also informed that undergraduate medical curricula in Nepal are community-oriented, student-centric, self-directed and problem-based with integrated teaching and learning. The major areas of the programme are: (i) curative health services; (ii) preventive health services; and (iii) planning, management and education. Prof Shrestha also briefed on how the community medicine curriculum is being taught in the three universities – Tribhuvan University, BP Koirala Institute of Health Sciences and Kathmandu University. In order to produce competent and responsible professionals in the area of public health, Prof Shrestha advocated that the academic institutions should have a separate entity in public health.

Sri Lanka

Prof A.R. Wickremasinghe of University of Kelaniya, Sri Lanka gave an account of the medical education in Sri Lanka with specific emphasis on the medical university. Integrated organ-system based curriculum was introduced in 2004, in which integration is done in three phases: Phase- I (years 1 and 2), phase-II (years 3 and 4) and phase- III (year 5).
Community health teaching is intended to enable the students to acquire skills in using the tools necessary to promote community health, to learn about the determinants of health and diseases of communities, learn about the organization and delivery of health-care services and develop appropriate attitudes to practise public health medicine. During phases one and two classroom-based teaching is offered. In addition, there is a community component, community medicine clerkship and research project during phase two. Wide areas of content are covered in the classroom–based learning module.

In the community component, 40 students are assigned to a community of 100 households for one year. The research project dedicates time for data collection and report writing. The community medicine clerkship is of four weeks duration and the topics covered are related to public health. The assessment is both formative and summative type. Due weightage is given to the community aspect during these assessments.

**Thailand**

Dr Amnach Sriratanaban, former associate professor of medicine, Chulalongkorn University, Thailand gave a presentation about the curriculum in Thailand. He stated that there are 18 medical schools in Thailand and the curriculum of PSM/CM/CH is essentially oriented toward preventive and social medicine because the health promotion concept is more evident than clinical discipline. The faculty of medicine of Chiangmai University is more progressive and innovative in terms of PSM/CM/CH teaching.

A series of courses on medical professional development is added in the curriculum during the second and third years which benefits the teaching and learning of PSM/CM/CH at the undergraduate level in faculty of medicine of Chiangmai. Family health care, medical ethics, communication skills, human rights and epidemiology are important contents in the curriculum. During years four, five and six, community health, family and community medicine and a community medicine clerkship is offered. Groups of three or four students are placed in community hospitals for supervised training for four weeks. This is an integral part of the clerkship. The teaching methods are classroom-based, home visit and group projects. Assessment is both formative and summative type including provisions for self-assessment. The credit hours are generous for PSM/CM/CH, the course contents are extensive and innovative teaching methods are employed.
Dr Orapin Singhadej, Secretary-General, Network of WHO Collaborating Centres and National Centres for Expertise in Thailand gave a brief history of the evolution of health care and the origin of public health. She presented the result of a survey that was conducted through a structured questionnaire sent to the heads of departments of PSM/CM/CH in Thailand. The study showed that most of the faculty members were well-qualified in their field. Most had more than 10 years teaching experience and were exposed to training in teaching technology/educational science. Most medical schools in Thailand review their curriculum every two to three years. The identified challenges for the discipline of PSM/CM/CH are that the final year students prefer clinical subjects rather than community studies. The clinicians felt that the subject should be taught to public health students rather than medical students. Some teachers of this subject have low self-esteem.

Dr Deoki Nandan, Director, National Institute of Health and Family Welfare, New Delhi, India, made a presentation on “A Visionary framework on preventive and social medicine curriculum for the future”. He cited the Medical Council of India statement, “Undergraduate medical curriculum is oriented towards training students to undertake the responsibility of a physician of first contact who is capable of looking after the preventive, promotive, curative and rehabilitative aspects of medicine”. He then presented an example of the curriculum which is being taught at S.N. Medical College, Agra, India. The curriculum included didactic lectures, demonstrations, tutorials, family studies, clinics and seminars for a total of 380 hours. Out of this 130 hrs are devoted to lectures and 250 hours devoted to practical studies (ratio 1:2). He claimed the current PSM curriculum is mostly theory based; topics covered in para-clinical and clinical subjects are taught separately with no linkage between the two. Field visits are without proper guidelines and hence more like excursions, and the curriculum is less systematic. In view of students preparing for the pre-PG exam, internship is a wasteful exercise, he added. Career paths and employment opportunities in public health are not addressed duly; the faculty development plan is inadequate, institutions are not updated on government policies and programme.

As a vision for future, he described “5-star” community physician, a competent care provider, community health team manager, community catalyst, communicator and compassionate decision-maker. He advocated for a paradigm shift in curriculum and pedagogy based on knowledge, skills and attitude to newer and more relevant areas, giving higher priority to community interest and lowering that of faculty. He emphasized that skills need to be acquired at the community, PHC and district levels. In pedagogy, he advocated for hands-on training, participatory learning, social audit of events/services and
community action, organizing of health exhibitions, and team teaching and learning. He was also of the view that an integrated/multidisciplinary teaching and enabling environment will help to improve the situation. To improve the evaluation process, he suggested evaluation of community medicine in each professional examination covering the topics taught during those semesters, restructuring of internships and conduction of pre-PG entrance test after final MBBS.

Dr Dulitha Fernando made a presentation on “Review of PSM/CM/Community Health Curriculum” based on the presentations made by the experts from the Member States. She summarized as

(a) The presentations highlighted that the place and the role of the “newly qualified medical graduate” varied widely among countries. This aspect needs to be taken into consideration in training of community medicine at the undergraduate level.

(b) The responsibility for making decisions related to the undergraduate medical curriculum varied among countries. In India, the Medical Council of India (MCI) is the body that decides on undergraduate training including internships. However, in some countries the institutions/faculties in the universities are able to make decisions by themselves, in some instances within the minimum requirements specified by the respective medical councils. In countries like India, where the MCI is responsible, all undergraduate training institutions are expected to follow the same training programme. However, in practice, the extent and the method by which such programmes are implemented vary widely. There is no formal mechanism by which quality assurance of the training is ensured.

(c) The content areas included in the curriculum could be broadly categorized as core areas and non-core areas. These are presented in the documents made available to the participants, even though they were not discussed in detail during the presentations. The content, timing of the content, amount of time allocated for each of the content areas also varied widely.

(d) An important area that was considered is the field-oriented/field-based training which is a crucial component of the undergraduate programme. A wide range of
community-based programmes were discussed following the presentations. The need for adequate supervision, availability of staff with field experience, linkages with the “formal” health system were among the important areas that were considered to have an influence on the quality of field-based teaching. The duration of the field training programmes, methods of implementation and assessment of performance varied widely between countries and within countries, especially among the training institutions in the private sector.

(e) The timing and the methods of assessment also varied. In some countries, the “final” assessment in the teaching programme in community medicine was at the end of fourth year while in others it was at the end of the course. Involvement of non-health professionals in the training was discussed and some institutions used several such staff members who work on a full-time/part-time basis in their programmes.

(f) Field-oriented/field-based research is an important component of the undergraduate training in community medicine in all countries. Linking the research activities in community medicine and clinical disciplines was considered a useful approach.

(g) Issues related to the qualifications of teachers were an important area. The Medical Council of India has identified the criteria for recognition as teachers in medical schools, whereas in most other countries, the institutions/universities decide on such criteria. The need for the teachers to have experience in actual field settings was considered an important pre-requisite. Linkages with staff involved in service provision were considered as a useful input in settings where such facilities are available.

The need to review and revise the curriculum, taking into consideration the emerging issues relevant to health in a scenario where globalization and related changes have become important, was considered as a priority.
Dr P.T. Jayawickramarajah then presented the draft guidelines on PSM/CM/CH curriculum for undergraduate medical education.

**Mission**

To develop a well-rounded professional demonstrating knowledge and competence in population and primary health care, life-long learning, evidence-based practice, interdisciplinary teamwork, a balance between disease management and disease prevention/health promotion, professional and ethical behaviour, optimal use of available resources and consciousness of well-being of self and colleagues.

**Objectives**

After completion of undergraduate course, the medical graduates should be able to:

- Use basic epidemiological principles in the investigation of diseases and outbreaks and apply health promotion and prevention of communicable and non communicable diseases prevalent in the country.
- Contribute to national health system performance as a member of the public health team in the generation and efficient utilization of human and material resources for provision of health services.
- Promote healthy living, nutrition and environment in the community, school and workplaces and advocate for elimination of personal and environmental hazards.
- Identify health-care needs of populations and population subgroups, undertake relevant interventions and evaluate the impact.
- Provide patient-centric comprehensive primary health care including referral to specialized services while continuing care and responsibility.

**Educational programme**

- Curricular strategy
- Curricular structure, composition and duration
- Specification of outcomes/competencies/objectives
- Scientific thinking/evidence-based medicine/research
Curriculum components (faculty-based and community-based)
Subject content (Core plus behavioural and social sciences)
Interaction with health sector

Faculty position and recruitment
- Recruitment policy (balance of skills required, part-time, full-time and medical - non-medical)
- Staff development programme
- Staffing policy (based on balance between teaching, research and service)

Teaching and learning strategies
- Use of communities as “laboratories” or settings for skill learning
- Role models, role plays
- Workshops, seminars etc.

Educational resources
- Physical facilities
- Educational materials
- Facilities for field/clinical training
- Information technology
- Pedagogical expertise

Assessment methods, relationship between learning and assessment.

Monitoring and evaluation of programme
Mechanism, student and teacher opinion, student performance in relation to the curriculum, feedback on evaluation information.
**Linkage with Ministry of Health**

- Field practice areas, district hospital, organizational arrangements.

**Continuous renewal of the PSM/CM/CH programme**

- Adaptation of mission, objectives
- Modification of competencies
- Updating educational resources
- Adaptation of organizational structure to changing circumstances

This was followed by a long discussion, suggestions for improvement and building of consensus on the issues to be considered for finalizing the guidelines.
Meeting outcome

The participants contributed to building the consensus on the relevant issues for improvement and the finalization of the “Regional Guidelines on PSM/CM/CH Curriculum” for the undergraduate medical education.
Conclusion and recommendations

The following recommendations were arrived at the end of the meeting.

For Member States: To organize national meetings of PSM/CM/CH department to further discuss the curriculum guideline and its implementation.

WHO Country Offices: To (a) support and facilitate organizing of national meetings and (b) support and facilitate faculty exchange among institutes.

WHO/SEARO: To provide technical and other support to the countries in disseminating and sharing the curriculum guidelines.
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<tr>
<td>0830-0900</td>
<td>Registration of Participants</td>
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<tr>
<td>0900-0930</td>
<td><strong>Opening Session:</strong></td>
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<td></td>
<td>• Welcome remarks by Dr Sangay Thinley, Director, Health Systems Development, WHO/SEARO</td>
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<td>• Opening address by Dr Myint Htwe, Director, Programme Management, WHO/SEARO</td>
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<tr>
<td></td>
<td>• Background and objectives of the meeting by Dr Muzaherul Huq, Regional Adviser (Human Resources for Health and Fellowships), WHO/SEARO</td>
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<td>• Group Photograph</td>
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<tr>
<td>0950-1000</td>
<td><strong>Business Session:</strong></td>
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<td></td>
<td>• Competencies in Public Health curriculum in medical graduates – by Dr Muzaherul Huq</td>
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| 1000-1230    | • Country presentations on “Teaching of Preventive and Social Medicine /Community Medicine / Community Health”  
|              |   o Bangladesh                                                         |
|              |   o India (2)                                                          |
|              |   o Indonesia                                                          |
|              |   o Myanmar                                                            |
|              |   o Nepal                                                              |
|              |   o Sri Lanka                                                          |
| 1330-1400    | • Country presentations continued…                                     |
|              |   o Thailand (2)                                                       |
| 1400-1500    | • Presentation on “A Visionary Framework for a Future PSM Curriculum” by Dr Deoki Nandan, Director, National Institute of Health and Family Welfare, New Delhi.  
|              |   • Discussions                                                        |
| 1500-1530    | • Review of PSM/CM/Community Health Curriculum – Moderator, Dr Dulitha Fernando |
| 1600-1700    | • Presentation of an outline of guidelines of PSM/CM/Community Health Curriculum – Moderator, Dr P.T. Jayawickramarajah |

**28 September (Friday) 2008**

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<tr>
<th>Time</th>
<th>Session</th>
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<tr>
<td>0830-1030</td>
<td>• Group Work on guidelines – Moderator, Dr C.S. Pandav and Dr P.T. Jayawickramarajah</td>
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<tr>
<td>1030-1130</td>
<td>• Presentation of Group Work (2 presentations)</td>
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<tr>
<td>1130-1230</td>
<td>• Consensus building on guidelines</td>
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| 1330-1430    | • Preparation of the final guidelines – Moderators, Dr Palitha Abeykoon, Dr C.S. Pandav, Dr P.T. Jayawickramarajah and Dr Ainun Afroza.  
|              |   • Presentation of the final guidelines by Dr P.T. Jayawickramarajah |
| 1500-1510    | • Presentation of recommendations by Dr Muzaherul Huq                  |
| 1510 onwards | • Closing remarks by Dr Sangay Thinley.                                |
Annex 2

List of participants

Experts

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Mrs Neena Khanna, Administrative Secretary (Human Resources for Health and Fellowships), WHO/SEARO.
Dear Participants and WHO Staff members,

First of all, I would like to relay the greetings of the Regional Director, Dr Samlee Plianbangchang as well as his wish that this meeting achieves very concrete and specific outcomes.

I would like to welcome you to this very important meeting, which will have long-term beneficial effects in the field of public health.

You may recall that in November 1999, WHO conducted a Regional Conference on “Public Health in South-East Asia in the 21st Century”.

Annex 3

Opening Remarks by Dr Myint Htwe, Director, Programme Management, WHO Regional Office for South-East Asia

at the

One of the outputs of this conference was the “Calcutta Declaration on Public Health”.

The declaration clearly states that we need to “strengthen and reform public health education and training and research as supported by the networking of institutions and the use of information technology, for improving human resources development.”

This meeting will also fulfill that vision.

Dear Participants,

The professionals, who are steering and leading the public health arena, especially medical doctors, paramedical workers and professionals from other allied disciplines, should be well-informed about the basic principles of public health and contemporary developments in this field.

In other words, graduates from medical and allied institutes must be fully equipped with proper knowledge of the subject, in addition to possessing epidemiological thinking skills.

It is, therefore, important that they must be kept abreast of the current topics of importance in the field of public health.

In that context, we need to regularly review the topics being taught in the preventive and social medicine classes of medical schools so that the prevailing topics of importance are updated and included in their curriculum.

Because of globalization, many topics that were considered less important or useful in the past are now becoming increasingly more important.

One example is sociocultural approaches for considering and dealing with public health issues faced by the community at large.

Other topics that have come to the fore include intellectual property rights issues, Framework Convention on Tobacco Control, emergency and humanitarian issues, health care financing, patient safety, climate change, etc.

Your expertise will be very useful in selecting important topics to be highlighted in the overall curriculum, especially in the preventive and social medicine classes.
It is also important that we review current teaching methods and approaches so that students are able to grasp the subject with ease and achieve good understanding.

It is also worth mentioning that students, especially in this part of the world, are somewhat reluctant to speak out or ask questions to their teachers.

We need to collectively think on how to change this situation.

Asking questions, whether for clarification or to seek additional knowledge, enhances analytical and critical thinking skills which are essential for managing health programmers after they graduate from the medical schools and paramedical institutes.

Along the same line, it is also important that teachers in the medical schools and allied institutes are well-versed in teaching skills and have a good attitude as well.

It means that we have to look at the learning environment from the students’ as well as from the teachers’ point of view if we are to improve the teaching standards and approaches in the medical schools and allied institutes in the field of public health.

Addressing the issues I have alluded to can be considered as a long-term investment in order to improve many aspects of public health domain in our Region.

I would like to mention that this expert-group meeting output will in turn serve as very good input for our forthcoming Regional Consultation on Teaching of Public Health in Medical Schools, which will be conducted in December 2009.

Although I have emphasized the curriculum in the preventive and social medicine subject area, we should not forget that there are many public health aspects and issues in the fields of medicine, paediatrics, obstetrics and gynaecology, as well as other subjects.

I hope that we will achieve the objectives of the meeting and I am sure that your contributions will be extremely useful for further promoting the field of public health in the South-East Asia Region.

I wish you all a pleasant stay in New Delhi.

Thank you.
Preventive and social medicine (PSM)/community medicine (CM)/community health (CH) is the study of health and disease among the population in countries in order to identify their health needs, and plan, implement and evaluate health programmes.

A Regional Conference on "Public Health in South-East Asia in the 21st Century" was conducted by WHO in November 1999. This led to the "Calcutta Declaration on Public Health" which highlighted the need to strengthen and reform public health education, training and research. Subsequently, a network of public health institutes was established and public health competencies identified with accreditation of guidelines of training programmes. Public health courses are imparted to undergraduate students in medical schools of the Region by the departments of PSM/CM/CH.

An expert group on PSM/CM/CH and education reviewed the existing curricula in countries of the Region and developed regional guidelines on the teaching of PSM/CM/CH. It is expected that this will standardize the teaching of PSM/CM/CH in regional institutions.

Review of Preventive and Social Medicine / Community Medicine / Community Health Curriculum for Undergraduate Medical Education

Report of the Expert Group Meeting
SEARO, New Delhi, India, 27-28 August 2009