



INTERVIEW

Making a Difference: An Interview with Charles Boelen Uniting Stakeholders in Improving Health Care throughout the World

J Westberg

Associate Editor, Education for Health

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Charles Boelen is currently an international consultant in health systems and personnel. During his 30 years (1972-2001) with the World Health Organization, he developed and shepherded numerous national, regional and global projects that brought health professions educators together with stakeholders in the health services. The goal of these projects, some of which are ongoing, is to ensure quality, equity, relevance and cost-effectiveness in health care. This edited and abridged interview is based on my conversations with Dr. Boelen in September and October 2006 as well as e-mail exchanges in 2007.

Jane Westberg

Associate Editor, Education for Health

What drew you into medicine?

Both the scientific and the social facets of medicine. My parents had separate ambitions for me. My father wanted me to do well; my mother wanted me to do good. In my last year of medical school, I chose to do my internship in surgery. But after two years of surgical internship, I made two big decisions: one, not to go for a career in surgery, and second, not to stay in Belgium. Born in a



little village of Flemish Limburg I was doomed to be a globetrotter. Somehow I feel sorry for having disappointed my parents by not staying close to them, at least geographically, as they wanted.

You were going into unknown territory.

Yes, that's what I did. It caused some anxiety for my family and for myself as my professional plans were far from clear. I asked some professors in my medical school for advice on how I should prepare myself for what I called "public health," but I received little guidance. So I set off on an adventure largely based on a dream rather than on a role model for a different kind of professional life.

What steps did you take in your career path?

I did my public health training in Montreal (at McGill University and Université de Montréal). Then, as a substitute for military service in Belgium, I chose to spend two years as assistant professor at the School of Public Health, Haile Sellassie University, in the city of Gondar, in the northwestern part of Ethiopia. In Ethiopia my time was shared between teaching health officers, community midwives and sanitary technicians; conducting epidemiological research; and running a pediatric ward in the teaching hospital. This was my first experience of mixed work in health service organization and health manpower development, with extensive exposure to community health activities. It was also my first immersion in a well-experienced group of national and international staff members.

While I was in Ethiopia, a high-ranking team of the WHO, UNICEF and USAID representatives visited the school. The team was led by Professor Aujaleu, a former Director General of Health in France, once a health adviser to General de Gaulle, also a past Chairman of the WHO Executive Board. Professor Aujaleu's English was not that fluent, so I helped him during his stay. At the end of the visit he suggested I should join the WHO. He was quite supportive in obtaining my first assignment with the WHO in 1972. From then on, I realize how important it was to speak several languages!

How did your public health education in Montreal prepare you for your work in Ethiopia?

I felt that my MPH (master's in public health) was too theoretical, but at least I learned some new vocabulary and began to have a better idea of what my professional goals could be. Fortunately, I obtained the best score in my class. This allowed me to receive a grant from the Government of Quebec to register for a master's program in epidemiology and medical statistics at McGill University. In 1970 I became the first holder of such a master's degree in Canada.

My training contributed to reinforcing my sentiment that public health might be a domain in which I could make a career. At least I felt more secure in identifying health development challenges and in elaborating projects in the health sector. But my main learning took place the next two years in Ethiopia.

What did you learn in Ethiopia?

The people and the culture fascinated me, and my work at the University gave me an incredible opportunity for grasping the enormous challenges for best meeting people's priority health needs.



My frail knowledge in public health was immediately and permanently confronted with the harsh realities of life. I was immersed in a world of complex interrelationships of health, social, economic, cultural and political issues. There were urgent needs to respond immediately to suffering people, and, at the same time, there were urgent needs for long-term planning and the development of human capacities and infrastructures.

How did you respond to this experience?

Being immersed in the intricacies of individual care and community development is an unforgettable experience. Since then, I have been struck by the necessity to adopt a system approach to ensure sustainable achievements in people's health. It became obvious that narrow and specialized interventions would not suffice. In contrast, the alliance of different forces and talents in different sectors was imperative. In short, I discovered what "health" meant: how it was closely linked to literacy, culture, social and economic opportunities. I was mutating from the status of a medical professional to the status of a health professional! My subsequent years in international health have been built on this experience.

Also, I had the chance to be associated with the smallpox eradication campaign. The WHO eradication team asked if I would coordinate the campaign for the northwest province of Begembir and Semien. In doing this, I learned how to plan a program, motivate colleagues at work, track diseases, organize mass vaccinations of children and do program assessment. By the way, the last known human case of smallpox was from this province. This had nothing to do with me, of course, but this experience helped me learn how to mobilize resources to make things happen.

What was your first WHO assignment?

I was assigned to Algeria, in North Africa. My mission was to contribute to setting up an Institute of Public Health in the Constantine, in the northeastern part of the country. The Institute trained 15 different categories of health workers while medical doctors were trained in a nearby medical school. After two years of teaching and research I was asked to lead the WHO team of 15 professionals all older than me. Quite a challenge!

They must have had a lot of confidence in you at your young age.

Those were crazy and exciting years! The local context favored the emergence of daring and innovative ventures. Algeria was seen as a natural leader of the so-called "non-aligned" countries. The country gained independence after a bloody struggle, and the socialist ideals combined with the wealth of petrol and gas put the nation under international spotlights as a young and ambitious country. A revolutionary government with strong political leadership, fostered fundamental reforms in many key sectors: the economy, agriculture, education, and health. The leitmotiv was clear: it is imperative to serve the priority needs.

I remember two national reforms launched a few months apart, which shouldered us tremendously in our work. One reform was based on the premise that education should serve the country's general interest. The second reform was based on the promise of free primary health care for every citizen. For our WHO project, these reforms were a gift from heaven!

The reforms occurred six years before the Alma Ata Declaration on Primary Health Care. In a time when clinical and public health services were usually separated in most countries, we were given the chance to create integrated health centers that provided a wide spectrum of health and social services to entire districts. All clinical and community health activities, including environmental



health, for a given population were planned and implemented by multidisciplinary teams of health workers based in a single setting. A lot of attention was given to testing mechanisms to facilitate the integration of various inputs from different partners. Our students were from the fields of medicine, nursing, midwifery, social sciences, and economics. In teaching these students we applied what then were regarded as innovative educational approaches: planning by objectives, community orientation and community-based education, learner-centered approaches, learning in teams, and assessing acquisition of competences. We realized that to be sustainable such initiatives needed the support of local politicians, health service managers and other existing educational institutions in health sciences. This could only be achieved through mutual respect and real partnerships.

Did you achieve mutual respect and partnerships?

Yes, after 5 years, our local Algerian colleagues were prepared to fully take over the management of the project. I left Algeria for a new WHO assignment in Tunisia where I was requested to create a National Center for the Education of Health Professions. Our mission was to promote educational methodologies and community health in medical schools and other health professions schools. In short, the charge was to improve both the purpose and process in health professional education. This suited me well as I was inclined to coordinate improvement of health service and human resources development.

Was it difficult to convince faculty members about the need for primary health care and community health work?

In Ethiopia, because of prevailing social conditions, it was obvious that training and practice in primary health care were priorities. In contrast, in Algeria and Tunisia, where most faculty members were trained in France and wanted to reproduce European models, one needed to be more convincing. As everywhere, resistance to change existed. To win over a critical mass, we needed to patiently demonstrate the usefulness of the new primary health care-focused educational approaches.

Knowing that co-ownership is vital to ensuring sustainability, I involved representatives of both Ministries of Health and Higher Education as much as possible in planning and assessing health manpower development projects. They were also involved in our workshops and scientific meetings.

Another challenge is to reconcile short-term and long-term expectations, particularly when one works with political leaders. Arguments suggesting that things may change in the next five years do not impress Ministers who are more likely to request changes in the next 12 months.

Ensuring consistency was also a challenge. During my 6 years in Tunisia, I worked with 6 different Ministers of Health.

What did you do next?

In the WHO, you could work at three different levels: the national, the regional or the global. In 1982, I started the regional phase of my career. For three years I was the regional adviser in health manpower development for the Western Pacific Regional Office based in Manila, The Philippines. The task was to promote health manpower development in 25 countries. For the next two years, I had a similar level of responsibility in the African Regional Office based in Brazzaville, Congo, with 45 countries to look after.

During my years in the WHO Regional Offices, I discovered that the WHO was also a political agency, with its positive and negative aspects. In my view, the negative aspects consisted of pleasing governments and compromising the WHO's professional



ideals. In a couple of cases, I had a hard time with bureaucrats more inclined to dispense individual favors than to promote the national interest. The positive aspect of a regional experience was the opportunity to develop projects in different countries in Asia and Africa. Some countries were as small as Solomon Islands or Equatorial Guinea; others were as big as China or Nigeria. I grasped how to tackle cultural diversities and learned how to temper my enthusiasm in front of political, social and economic constraints.

This experience prepared me quite well for my next WHO assignment at the headquarters' level in Geneva, Switzerland.

In 1988, Tomas Fulop, then the Director of the Division of Health Manpower Development, invited me to be in charge of health professional education. I accepted the position and progressively broadened the spectrum of my work to include linkages with professional associations and health service organizations. This broadening of the scope of my work was prompted by my previous national and regional experiences where I learned that reforms in the education of health personnel are more productive when closely coordinated with health system reforms.

Did you meet with any resistance as you tried to work more collaboratively with health service organizations and others?

Actually, the need for coordination of health manpower and health services had been promoted by my predecessors. The challenge rested in developing a framework by which major stakeholders, such as educational institutions, health service organizations, and professional associations, could be convinced to share a common commitment to serving people's priority health needs in the best possible way, and to do this in a coordinated fashion. Working as partners towards a greater sense of social responsiveness and accountability was a key issue.

Were you successful in getting the major stakeholders to work together?

Stakeholders always welcome the idea of working together but they are usually shy in diverting some time and resources to activities different from their current programs of work unless hard evidence is given of the benefit of collaboration. In other words, they are not inclined to take risks, which I can understand. It is therefore the task of the promoter of cooperative action to be convincing and patient. As for any institutional change, there is always a very small number of pioneers who do share a vision and can anticipate what may happen in doing things differently. However, the majority prudently wait to move until they hear about successful cases.

You've been an important pioneer in introducing social accountability in health professions education.

In the 1995 WHO document "Defining and Measuring the Social Accountability of Medical Schools," we promoted the concept of social accountability as an obligation to orient education, research and service activities in response to people's priority health problems. We also implied that these problems should be identified jointly by governments, service organizations, professional bodies and civil society, and that educational institutions should assume some responsibility for a proper use of their products, that is, their graduates.

In a nutshell, the aim is to increase chances for well-educated health personnel to find optimal working conditions to practice what they learned. This includes being able to serve communities with a sense of quality, equity, relevance and cost-effectiveness. We were also concerned that such responsibilities be reflected in standards for assessing the performance of educational institutions.



Part of social accountability is also giving significant weight to the preparation of primary health care professionals, including family physicians, general practitioners, and other health professionals. This brought me to forge working relationships not only with medical associations but also with associations of pharmacists, dentists, nurses, and other specialists. The intent was to gain support from professional organizations in defining and promoting profiles of health professionals that would be in tune with the evolving requirements of societies and health systems.

Were the profiles linked to the notion of a 5 star health professional?

The concept of the 5 star doctor emerged from numerous consultations with groups and organizations concerned with identifying an optimal set of aptitudes that each doctor, and eventually each health professional, should possess to be in the best position to respond to people's and societies' needs. Several governmental agencies, medical schools and professional associations worldwide referred to the "5 star doctor" model as a starting point to reassess their programs and promote new ones.

WONCA (the World Organization of Family Doctors) decided in 2004 to provide a "5 star doctor" award to an individual who complied best with the five groups of aptitudes. WONCA plans to also provide a 5 star doctor award in each of its regional and global congresses.

How did Towards Unity For Health (TUFH) emerge?

Experience tells us that innovative changes for both improving learning processes and preparing graduates to best serve priority needs of communities have been achieved by a handful of courageous and creative minds. In many cases, strong resistance to institutional reform had to be overcome. Too often, brilliant educational changes are not followed by proportionate changes in professional practice behaviors. For instance, a primary health care oriented curriculum can only lead to the effective practice of primary health care if working conditions and health systems are primary health care friendly. Hence, if educational institutions want their graduates to be properly recognized and supported, and if they want their graduates to be able to contribute to improving people's health, these institutions need to forge strong linkages with key stakeholders in their health system.

The Network, originally called the "Network of community-oriented educational institutions in health sciences", was created in 1979 under the auspices of the WHO as an initiative to encourage educational institutions to support the primary health care strategy by producing a relevant health workforce. But the primary health care strategy as a foundation for achieving "health for all" has been difficult to implement. One of the barriers has been the great fragmentation of the health system and the lack of coordination among different power structures. The basic concept of the TUFH is to foster a unity of purpose and action among main actors in the health sector: policy-making bodies, health service organizations, professional associations, educational institutions and civil society. Educational institutions should be great beneficiaries of the TUFH approach because this approach helps ensure that their creative efforts to produce proper human resources will be rewarded by the health system.

How has the TUFH approach been received?

While the need to create synergies may seem obvious, they are not easy to implement as one may see a threat in entering into partnership with others. Long-time traditions and prerogatives may indeed be questioned, and one may be reluctant to form partnerships even if it is for the common good. I noticed this when I tried to apply the TUFH concept within the WHO structure



itself, hoping for collaboration between several departments concerned with issues of health planning, health services organization, human resources development, health economics, etc. Although my WHO colleagues consistently supported the idea of breaking isolation and creating unity, vertical programs, existing budget structures, and current performance criteria and rewards proved to be serious constraints. In the end, concrete activities leading to the emergence of TUFH had to rely on external funding. We were grateful to the Kellogg Foundation (and to Ron Richards who was our great supporter within the Foundation at that time) to fund our historic WHO international TUFH conference in 1999 in Phuket, Thailand. Out of 200 participants from all over the world, we had a large WHO representation from regional offices and headquarters. In a way the WHO's participation was a sign of interest for TUFH and compensated somehow for the WHO's shyness in providing initial funding.

Kellogg also funded the publication and dissemination of the WHO TUFH monograph [available on the Network: TUFH website: http://www.the-networktufh.org/about_us/brochures.asp]. In addition, Kellogg funded 12 selected TUFH field projects, which were the first endeavors to document the application of TUFH principles in countries.

The publication of the special issue of Education for Health on TUFH, in the summer of 2007, was another important step to highlight pioneering work in TUFH. Out of more than 50 proposals responding to a call for papers, a dozen were selected by an international team of reviewers. The selection criteria focused on the projects' success in promoting integration in health services and success in fostering partnerships of educational institutions with other health partners.

The most important event took place in 2001. As I was about to retire from the WHO, we were able to secure the future of the TUFH project. We were given permission to contract with a non-governmental organization (NGO) to continue the work of TUFH. The NGO had to have an official relationship with the WHO. The best organization to develop TUFH to a further stage was naturally our Network, which in 2002 became The Network: TUFH.

The Network: TUFH is in a good position to help in the global struggle to improve health care for all people. Thanks for your past and your ongoing contribution towards this effort!
