This is the published version (version of record) of:


Available from Deakin Research Online:
http://hdl.handle.net/10536/DRO/DU:30016862

Reproduced with the kind permission of the copyright owner. ANZAHPE website

Copyright : 2009, ANZAHPE (formerly ANZAME)
The Need and Options for Teaching Global Health

E. de Leeuw

Abstract
A conceptual and developmental approach to teaching global health is presented. We outline the differences between international health (traditionally, the connections between nation-states, typically ‘the west’ and ‘the rest’) and global health (a value-driven systems approach). We see a need for curriculum development in the area of global health, and describe how the health and tertiary education landscape in Melbourne (Australia) would be fertile ground for such a new programme. We illustrate our conceptual and strategic curriculum development efforts with local and international partners, and the outcome suggests we would be able to offer a Master of Global Health programme with two majors: an international health one (more disease oriented), and a global one (focused more on sustainability and political economy issues).

Key words: Curriculum development, ethics, global health, globalisation, international health, governance

The challenge of teaching global health
An increasing number of higher education institutions around the world are starting to offer degrees and qualifications in global health. Often, however, there is very little distinction between ‘international’ and ‘global’ health. We think such a distinction does exist, and that it is useful, particularly for capacity building purposes, to be analytical about any differences. We therefore start this paper with a very brief review of international and global health.

Addressing the world’s health challenges seems to require a paradigmatic leap. Typically, the notion of ‘international health’ is rooted in a history of tropical medicine and hygiene. It is no surprise, therefore, that most of the prestigious institutions in international health (e.g., the TropEd network) are based in member nations of the OECD (Organisation for Economic Co-operation and Development; predominantly industrialised welfare states). Inter-national health relies on a conceptualisation of the world as a coherent system of nation-states...
in which bilateral or multilateral governmental approaches to governance of health are assumed to promote world population health. Most of this international health seems unidirectional: institutes and financiers in ‘the west’ determine agendas for ‘the rest’.

The globalising world, however, has changed all this. As Castells predicted in his seminal series on the network society (2000a, 2000b, 2003) more and more phenomena escape these traditional governance systems. Bioterrorism and biosecurity issues, global mobility (either as ordinary, health, sex tourism, or refugee movements as a consequence of armed or ideological conflict), copyright issues preventing access by large portions of the world population to drugs (e.g. antiretroviral drug availability in most of the poorest nations on earth), and the flow of capital, knowledge and labour in globally inequitable patterns (resulting brain drain issues, challenges to gender equality, literacy, etc.) are just a few examples in the ‘global village’ where formal government control seems to fail.

In a pivotal European publication, Kickbusch & Lister (2006) follow a definition earlier proposed by the US Institute of Medicine: *Global health refers to those health issues which transcend national boundaries and governments and call for actions on the global forces that determine the health of people. It requires new forms of governance at national and international level which seek to include a wide range of actors. This wide range of actors includes industry, NGOs (Non-Governmental Organisations), and new representatives of a global civil society such as the People’s Health Movement. The latter has positioned itself strongly in this governance network with the publication of an alternative to the World Health Report, the Global Health Watch (2005, 2008).*

Clearly, there is a need for better understanding, research and teaching in global health. A global approach to health is attractive on ethical grounds, too. Because human life is precious, the value of a person’s health should not be proportional to their lifetime earning capacity in US dollars. Yet in a world dominated by market values, this is clearly not the case (Labonté et al., 2005). A strong argument can be made that a genuinely more equal and sustainable world, reflected by improved health of its inhabitants, is in the long-term self-interest of wealthy as well as poor populations, through means that include but also extend beyond the global microbiological security model (Soskolne et al., 2007) Likewise, several researchers have pointed out that bioethics could itself be improved by a consideration of global values, because, in the main, bioethicists hold, enforce and reproduce value systems which attribute fundamental differences in rights to people who are poor (Benatar & Singer, 1998; Farmer & Campos, 2004).

Most simply, global health is a mental model of health that arises in people who have a global consciousness. Rather than a primary identification with any one nation, religion, or ethnicity, an increasing number of people are starting to identify foremost as human beings who live aboard planet Earth. This may sound overly-idealistic. But history has spawned many movements whose success was once considered fantastic from abolitionists of the European slave
trade to activists opposed to South Africa’s apartheid.

The evolution of the worldwide web, in part driven by the vision and imagination of Whole Earth Network pioneer Stuart Brand (Lieberman, 2007) is not only an example and facilitator of an emerging global consciousness but one that is more benign than competing models of global order, such as that offered by the so-called “neocons” (George, 1999). The novels of Dickens catalysed social reform in Britain. Similarly, as globalisation progresses more people will identify their home as the world, rather than any one country (Frenk & Gómez-Dantés, 2002) As the scale of group identity expands, more people are likely to be concerned about the suffering, including that through poor health, of an increasing number of people in that entire world with which they identify (Henrich et al., 2006).

There is also evidence, including that in recent papers by the UK’s Chief Medical Officer (Donaldson & Banatvala, 2007, Donaldson, 2007) that the British government is moving beyond rhetoric to action in its efforts to promote genuine global health (Horton, 2007). While people who support these ideas are currently a minority, the development and promotion of the academic discipline of global health will provide an outlet and a stimulus for such views. The need for this thinking is increasingly urgent.

Global Health in Melbourne

Melbourne, the capital of the state of Victoria in Australia, is rich in academic institutions; it is the home to seven universities (Melbourne, La Trobe, Monash, Swinburne, Victoria, RMIT, and Deakin) and many other Australian universities have a branch in the city. In this rich knowledge environment a number of these institutions have branches or institutes focusing on international health (the Nossal Institute; the Australian International Health Institute; centres for International Child Health and Mental Health; the convenor of the International People’s Health University; the Macfarlane Burnet Institute for Medical Research and Public Health; and a Master of Public Health programme jointly offered by Monash, La Trobe, Melbourne and Deakin universities with a large international student body).

In this thriving environment, Deakin University considered it is well positioned to take this profound international health capacity to the level of global health as outlined above. With a confluence of new staff with interests ranging from global health (World Health Organisation Healthy Cities), ecology and climate change (and membership of the Intergovernmental Panel on Climate Change IPCC), mobility, equity and social exclusion, and effectiveness of humanitarian aid provision, an intellectual opportunity was generated to put global health teaching on curriculum maps, first at Deakin, but almost by necessity subsequently among other Victorian tertiary education providers.

Within Deakin, two Faculties (Arts & Education, and Health, Medicine, Nursing & Behavioural Science) demonstrated the knowledge and capacity to combine their efforts in health and global citizenship and
governance into a teaching approach to global health. In a unique inter-Faculty teaching development endeavour1 a steering group of committed individuals was established, and a research fellow appointed to provide support.

The exploratory approach

From the above this group gleaned two observations:

• there is a need to develop better knowledge and capacity in global health;
• there seems to be a strong foundation in Melbourne to start building this new knowledge and capacity.

Our approach for developing a teaching programme was based further on the following premises:

• any Deakin Global Health course should be complementary to any other tertiary education offering in Melbourne so as to avoid unnecessary competition over scarce resources;
• ideally, a Deakin Global Health course should build on synergies that can be created between active stakeholders locally and internationally;
• the development strategy of a Deakin Global Health course should reflect the values of the concept of Global Health and therefore be inclusive of a range of actors and situations.

We started the enterprise by reviewing the literature on international and global health. We soon realised that, probably for a number of valid but cynical market reasons, many initiatives labeled ‘global health’ were in fact of the more classical ‘international health’ persuasion. For instance, the Bill and Melinda Gates Foundation effort to identify and fund ‘Grand Challenges in Global Health’ (Varmus et al., 2003) centered around a fairly traditional, technocratic, a-political scientific effort, devoid of an awareness of the connectedness, ethics and values associated with ‘our’ conceptualisation of global health (Birn, 2005), cf. Figure 1 (inspired by Huynen, Martens & Hilderink, 2005). Yet, the emergence of several dozen Global Health programmes in tertiary education institutions (the majority in the United States of America, several programmes in the United Kingdom and Canada, and individual ones in Denmark, Sweden, and Switzerland) demonstrates the appeal of the rhetoric, whatever its substance. In a climate where higher education must be considered a ‘marketable product’ this is a further argument to explore teaching options.

We therefore established an international and inter-faculty reference group to validate and ground our perspectives beyond a belief system that might just be too idiosyncratic. Members of this group had associations with WHO, humanitarian aid agencies, gender-based development initiatives, and community development. Geographically, all WHO regions but the Americas were covered by group members. The discussions within the group led to a position paper, in which we described conceptual approaches to international and global health, the teaching and research growth potential in this area for the university, an analysis of workforce development

---

1 As a spin-off of this first endeavour the development of an interdisciplinary Master of Planning programme involving three Deakin Faculties was developed and implemented.
needs (where would potential students come from, and where would qualified global health specialists find jobs?), and an analysis of pre-existing coursework modules that could be slotted into a new degree programme.

In the course of this work we of course made a few discoveries. Apart from the obvious need to include ‘trendy’ global health issues in our discourse (such as climate change, refugee and mobility issues, and trade matters), we found for instance that the health and well-being of Indigenous peoples around the world is archetypal of global health considerations: their health and well-being is intimately connected to the land that transcends conceptual and cultural boundaries of nation-states; their resilience and cultural identity is under direct threat of economic forces of globalisation; and their governance structures escape the models so espoused by industrialised post-modern societies.

An Indigenous voice in Global Health debates we considered therefore critical.

In the spirit of collaboration and synergy that we embraced when embarking on this adventure we considered that this material should be shared with other Melbourne-based stakeholders. We organised a dinner, hosted by the Vice-Chancellor of Deakin University, professor Sally Walker, at which informal discussions around our ideas were enabled between politicians, international health leaders, and executive representatives of the Indigenous community, the People’s Health Movement, and a multinational humanitarian aid organisation.

**A curriculum suggestion**

Following these discussions, we suggest the development of a Masters of Global Health course in the Australian state of Victoria. It is proposed this course will have a common “head” which includes two core purpose-built units designed

![Figure 1: Our conceptualisation of Global Health](image)

**Figure 1:** Our conceptualisation of Global Health

- **Inner core:** Social and ecological justice and sustainability
- **Outer core:** Systems and institutions associated with stagnation or change
- **Mantle:** Distal determinants of global population health
- **Crust:** Proximal determinants of global population health
Introduction to global health
Primary health care
Elective placements (1 or 2 credits)
Political economy of global health
Nutrition in developing countries
Managing community based AIDS/HIV programmes
Global epidemiology
International child health
Minor project in international health (2 credits)
Biostatistics in global health
Global health impacts of illicit drugs

Semester 1  Semester 2  Semester 3

Figure 2: Master of Global Health with International Health (Disease) major

Introduction to global health
Human rights in global systems
Elective placements (1 or 2 credits)
Political economy of global health
Gender, war and peace
The United Nations and global governance
Global epidemiology
Sustainability
Minor project in global health (2 credits)
Biostatistics in global health
Medical and health anthropology

Semester 1  Semester 2  Semester 3

Figure 3: Master of Global Health with Global Health (Sustainability and Politics) major
for the global health course. These units, provisionally entitled “Political economy of global health” and “Issues in global health” will be designed, taught and refined by staff at Deakin University. These core units will be complemented in the first semester by a small pool of existing units drawn from the current public health course at Deakin. This group would include introductory units in epidemiology, biostatistics, health promotion and qualitative research methods. Several (but not all) of these units would be compulsory, and be undertaken in the first two semesters.

Students would then choose one of two majors. One path would comprise international health units, mostly taught by other Victorian institutions (see figure 2). The second route would consist of existing subjects currently taught at Deakin University but not traditionally associated with health. These topics would include politics, sociology, international relations, human rights, economics, law and sustainability (see figure 3). Several of these units may have to be offered by other Victorian universities (such as international law and health) because they are currently unavailable at Deakin.

Finally, we believe that there is potential to develop a genuinely global course, involving leading educational centres from around the world, including those identified above. Each institution would develop one or two units in which it specialises, accessed and taught through the internet, employing technologies that allow for e-lecturing, RSS-feeds, podcasting, and wikis to establish a global teaching, learning and research ‘commons’. While virtual teaching is not without problems (Maidment, 2005), internet-based learning is essential to nurture the effective and cohesive global community necessary to advance global health. Of course, this should be supplemented by as many opportunities for face to face learning and social interaction that are possible in a resource-constrained world. This approach will facilitate a virtual global community of students, educators, activists, teachers and researchers and could evolve to become a powerful instrument to materially improve global health.

Conclusion

There is both an intellectual as well as a developmental need to establish postgraduate curricula in global health. This need is grounded in governance, human rights, and ethical discourses on the global distribution of health and wealth. Graduates from such programmes would contribute to the expansion of analyses and interventions to promote health and its determinants in a global context. A critical prerequisite for the development of curricula in this field is a coming together of the current strengths of a range of institutions of higher learning and research around the globe.

Postscript

The development of a global health curriculum as described above has been discontinued since the first draft of this paper was submitted to this journal. With a change of leadership of the ‘home’ School in the Faculty of Health, Medicine, Nursing and Behavioural Sciences at Deakin University the Research Fellow in Global Health was re-allocated to teaching.
un-related subjects and subsequently decided to leave Deakin. The central executive of the University did not deem a Global Health programme potentially marketable and profitable. The initiative now seems to be with Monash University and the University of Melbourne: both universities have appointed Chairs in Global Health since Deakin University ceased its support for this enterprise.

Acknowledgements

Thanks to Philip McMichael, Colin Soskolne and Colin Butler for specific comments on the paper, and numerous colleagues for discussions which have informed its drafting, including Steve Connor, David Legge, Ilona Kickbusch, Sari Kovats, Ron Labonté, Tony McMichael, Thomas Pogge, Adrian Sleigh, Colin Soskolne and Madeleine Thomson.

References


