EDITORIAL

Rethinking public health training: What would be ideal for the 21st century?

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It was only at the latter half of the last century that public health training started in Ethiopia. If we consider Gondar Public Health College as the locus for the beginning of public health training in Ethiopia, it has been a mere 60 years on its journey. Gondar College focused on the training of health officers and community midwives, working in rural areas at rudimentary health centers, who were tasked primarily with preventive health (1). The basic philosophy behind their training and deployment was the basic health services approach that dominated public health thinking in the 1950s and 1960s (2).

Even though the basic health services approach attempted to provide basic curative, preventive, and health promotive services nearer to the community, these services remained largely facility-based and could not fully address the needs of rural and underserved populations. Globally, links between health and social, environmental, economic, and political factors (3) were resolved in 1977, when the World Health Assembly adopted the historic resolution on 'Health for All by the Year 2000'. At this point, equity, community involvement, appropriate technology, and a multi-sectoral approach were adopted as the underlying principles of health development, and health was reaffirmed as a fundamental human right (4). As a result, there emerged a need for the inclusion of several other concepts: primary care must be accessible as well as acceptable to all; it must be prevention-orientated rather than curative; the community it serves must actively participate in decisions regarding its working; and its overall provision should engage all development sectors (5). Such a re-examination of health care practices and options was further informed through the alternative practices and success stories in community participation and health outcomes (in Tanzania, Cuba, China, Costa Rica), and finally led to the adoption of the primary health care approach using community-based health interventions and a new cadre of community health workers (6, 7).

The Ministry of Health in Ethiopia adopted and initiated the district health management training program, along with other measures commensurate with the ideals of primary health care, by offering graduate training in public health for medical practitioners, parallel to (then merged with) the graduate program in Addis Ababa University (8). Based on an initiative from the World Health Organization (9), the district level was considered crucial to the implementation of primary health care activities because of several advantages over the centralized and regional levels of management (10). Furthermore, with the launch of medical training in Gondar and Jimma – along with an increase in scholarships in medicine offered by eastern Europe countries and Cuba – the health officer training program in Gondar was phased out in the 1976/77 academic year (11). The assumption was that the public health physician practices medicine but with a difference, in that the goal is prevention as well as cure at both the individual and community levels (12). It was with this purpose that universities began to offer graduate degrees in public health – special training needed to equip individuals for the application of medicine in the field of public health. Graduate public health training was also made widely open to people with baccalaureate degrees in non-health fields (especially those from social sciences) in order to reflect the need for multi- and trans-disciplinary approaches for health action.

At the end of the 1990s and with the launch of a series of health sector development programs (in line with the sector-wide approach to development), the government re-started public health training activities (that had previously been discontinued) through the initiation of the 'Accelerated Expansion of Health Officers Training Program' in selected hospitals in Ethiopia (13), and as part of the accelerated expansion of primary health coverage (14). This decision was based on the expectation that baccalaureate-level health officers would be able "To effectively and efficiently tackle the health and health-related problems of individuals, families and communities at district levels" (11).

The final decades of the 20th century witnessed rapidly changing political situations and severe economic upheavals, and most developed nations, as well as a few developing countries, experienced demographic and epidemiological transitions (15). Against this backdrop, the WHO advocated a new paradigm that viewed health as central to development and quality of life (16).

It is with this perspective that today's public health thinkers in Ethiopia – some of them products of the initial era and pioneers in some of its innovations* – contemplate the 60-year path in public health training in the country, and the search for a workforce that is ideal for the new century.

* In this regard, it would be fair to mention the late Professor Makonnen Assefa, who was one of the early graduates of the Gondar Public Health Training Program, and who was also the most instrumental in initiating and developing the innovative community health (CBTP and TTP) training programs at Jimma University (then Jimma Institute of Health Sciences).

This search for the ideal 21st-century public health workforce is driven by the realization that there is a myriad of challenges that the workforce needs to address in view of the unfinished agenda of poverty reduction, as well as the emerging challenges of climate change and the growing burden of non-communicable diseases (17). The efforts made by public health training institutions in Ethiopia to equip public health professionals with competencies that meet contemporary expectations, gaps and suggestions were found to be unsatisfactory in that graduates seem to have failed to contribute to public health functions and to fit into existing systems and leadership responsibilities (18). The taskforce also observed the persistence of various definitions of 'public health', compounded by the absence of units/departments of public health philosophy and public health journals, and called for mechanisms to articulate an appropriate philosophy for the discipline in the country (19). The analysis to validate core competencies in the Master of Public Health program identified substantial capability gaps in domains such as financial planning and management, cultural competence, policy and program, and leadership and systems thinking (20). Based on these gaps, the taskforce has formulated 87 core public health competencies that are expected to stimulate the re-design of standardized curricula across training institutions in the country (21).

What is the yardstick for an ideal public health workforce? Is it altruistically seeking to address the gaps in equity that are manifest in today's health status among populations? Increasingly, public health is challenged to respond to, among other things, the impacts of ever-increasing privatization and commercialization of health and health services throughout the world (22). Commercialization of the profession has also been compounded/manifest in the proliferation of high-level professional consultants and public service contractors. In this regard, one cannot avoid thinking that there is a possibility that the current proliferation of public health training is to a certain degree driven by self-interested elitists of the market era targeting the profession as a profitable enterprise/venture. Of course, the rationalist would justify this as pure market forces driving entry to the profession, governed by considerations of the internal rate of return. The presence of a significantly higher rate of return to more specialized education has been ascribed as a reason for the tendencies of health professionals to seek to specialize and subspecialize, and to choose careers other than those in primary care and serving remote and disadvantaged people (23).

Furthermore, public health, in its broad terms of definition (24), is vastly different from the exercise of purely police power to enforce the health-related regulations of authorities (which has been its principal manifestation in the past) (25). There is a need for 'organizers and propagandists for the cause of health, capable of building wisely the great scheme of health protection of the future and of enlisting in its support the enthusiastic cooperation of the peoples of the earth' (25). Of course, looking for such an ideal might seem tantamount to the plight of Diogenes of Sinope – holding a lantern to the faces of the citizens of Athens in search of an honest man (26).

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