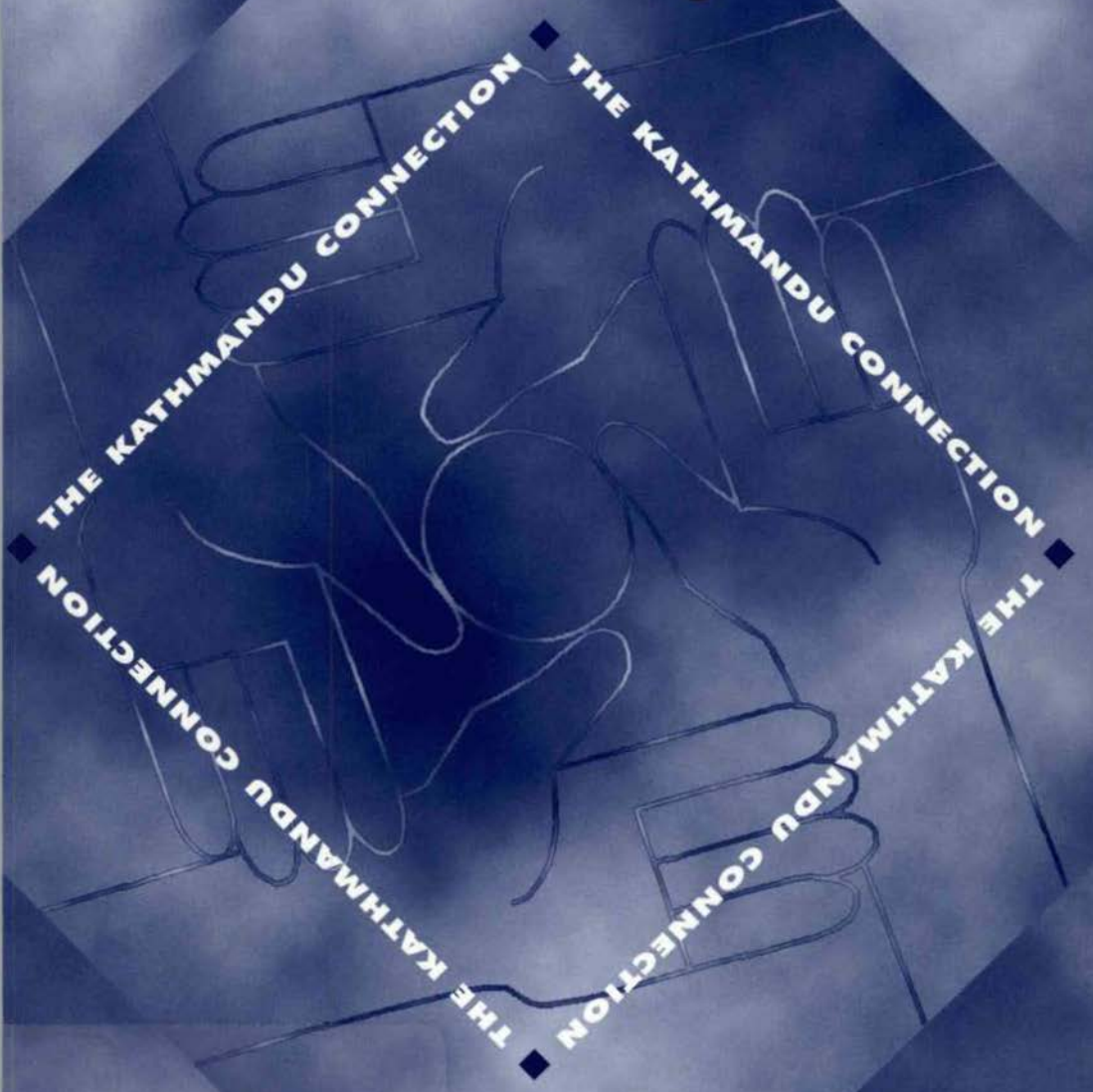
Partnering and Health Development



by MELVILLE G. KERR

Partnering and Health Development

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The Kathmandu Connection

by Melville Kerr

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Although I accept full responsibility for the judgements and opinions expressed in the following chapters, many friends have contributed significantly to their preparation. Those Canadian project managers who were responsible for the work that I describe have read sections of the text and corrected my errors and omissions. Bhisma Prasai, Dibya Shree Malla, Pramod Shresthra, Jojo Deles and Reggie de la Paz Ingente scrutinized and amended appropriate sections. Consequently, although this is a personal interpretation of events, my account has been significantly influenced by the advice of colleagues.

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List of Abbreviations

AIHD	Asean Institute for Health Development
CAP	Canada Asia Partnership
CFHA	Community Funding and Health Association
CHILD	Community Health Through Integrated Livelihood Development
CIDA	Canadian International Development Agency
DA	Diploma in Anesthesiology
DGO	Diploma in Gynecology and Obstetrics
DID	Division of International Development
DMSF	Davao Medical School Foundation
DPF	Development of People Foundation
HDP	Health Development Programme
IDRC	International Development and Research Centre
IOE	Institute of Engineering
IOM	Institute of Medicine
IPHC	Institute of Primary Health Care
MBBS	Bachelor of Medicine, Bachelor of Surgery
MNLF	Muslim National Liberation Front
MOH	Ministry of Health
NPA	New People's Army
ODA	Official Development Assistance
OIC	Organization of the Islamic Conference
PR	Participatory Research
QLC	Quality of Life Circle
SDF	Social Development Fund
SEAMEO	South East Asian Ministers of Education Organization
SHIELD	Sustained Health Improvement through Integrated Livelihood Development
TROPMED	Centre for Tropical Medicine
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

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Preface

In late 1976 I visited Nepal for the first time as a World Health Organization (WHO) short-term consultant. My mandate was to advise the fledgling Institute of Medicine of Tribhuvan University on the feasibility of establishing the first medical school in Nepal. I had recently resigned from an appointment at the University of Edinburgh in Scotland in order to take up a new position at The University of Calgary in western Canada. I spent the four months between appointments in Nepal.

In January 1980, I returned to Kathmandu with the blessing of the dean of the faculty of medicine in Calgary to explore the possibility of offering assistance from The University of Calgary to the Institute of Medicine. My return to Kathmandu triggered a chain of events which is still being played out. Throughout the decade of the eighties, The University of Calgary entered into a series of agreements with Tribhuvan University in order to strengthen its Institutes of Medicine and Engineering. From January, 1980, through to December, 1989, I was directly responsible for the management of this Kathmandu connection. The following chapters tell the story of this decade.

The Davao Connection

In the fall of 1986 I was invited to visit the city of Davao in the island of Mindanao in the southern Philippines. Following the overthrow of Ferdinand Marcos in 1986 and the restoration of democratic government under Ms. Corazon Aquino, Canada offered financial assistance to the new administration. Part of this aid would be provided in support of institutional cooperation. I was invited to explore the possibility of establishing links between The University of Calgary and the Institute of Primary Health Care of Davao Medical School Foundation.

Davao Medical School Foundation had been born during the dark years of martial law in the mid-seventies as a product of the foresight and sheer determination of a handful of health professionals and community leaders. Within a decade it had earned an enviable national reputation for its understanding and practice of community organization and primary health care. Although Calgary's relationship with Davao would not be untroubled, the Davao connection has been a remarkably enriching experience. This programme began formally in 1988 and I became directly responsible for its management from July, 1990, until December, 1992.

The Division of International Development

The University of Calgary is a young institution, having acquired its academic independence in 1966. It grew rapidly and is now one of Canada's larger campuses. The academic community of more than 1,800 faculty, together with the student body, had forged many links overseas and international exchanges had proliferated. The faculty of management has maintained a close working relationship with the Calgary business community and has wished to strengthen its role in international business. By the mid-eighties, a small number of international development projects were being operated in several faculties, including the Nepal project in the faculty of medicine. It was decided that it would be expedient to bring all these international activities together under one umbrella organization. In January, 1986, the Centre for International Education and Business was established with three divisions, including a Division of International Development.

I was appointed director of this new Division of International Development, a position I held for over six years. This provided the opportunity to explore the feasibility of mobilizing the resources of the Calgary campus and the community of southern Alberta in the cause of developing. New relationships were formed within and beyond our academic community and new links were forged with institutions in Latin America

and across south and southeast Asia. This essay at partnering at home has provided a salutary balance to the less demanding challenge of partnering at a discreet distance overseas.

A Word about Language

A fondness for the expression "connection" begs explanation. The "Kathmandu connection" surfaced early. I learned to appreciate the idea of connectedness – an expression that has become a synonym for partnering. The idea of connectedness is not prized in North American society, which prefers individualism and independence. However, it is valued highly by Asians who relish interdependence and the sense of community. "Kathmandu connection" is my code for "partnering between Kathmandu and Calgary." I use the same expression to refer to other partnering relationships with Mindanao and around the Calgary campus.

My choice of words betrays other idiosyncrasies. For reasons which will be explained in Chapter 7, I prefer, where possible, to use verbs or gerunds rather than nouns. It is for this reason that "developing" and "partnering" often appear when conventional usage would require "development" and "partnership."

The expression "programme" also appears where it would be technically more correct to use "project." This reflects an optimistic expectation that short-term commitments have the potential to become long term relationships – finite projects becoming open-ended programmes.

The crude categorization of First and Third Worlds is an anachronism – a relic of disconnectedness. It is preferable to think more precisely in terms of low-income or high-income countries, recognizing ways in which high-income countries are poorer than communities with lower incomes. From a similar perspective, I avoid the expression "New World" – as contrasted with the "Old World" of Europe – as it fails to respect the existence of indigenous people in the Americas for many centuries before Europeans stumbled on the Americas.

I avoid the pejorative and self-congratulatory categories of "underdeveloped," "developing" and "developed." All countries can perceive themselves as developing unevenly and capable of learning from the experience of others. Instead, the neutral expressions "North" and "South" serve as symbols for high- and low-income countries respectively. Although these words are geographically inaccurate and ignore the affluent countries of the southern hemisphere, I empoly them simply as convenient codes that avoid overtones of isolationism or hier-

archy. On occasion, I use "West" as equivalent to "North," for example in reference to "Western medicine" or "Western science."

Purposes

My initial intention was simply to document the connections which formed around three cities – Kathmandu, Davao, and Calgary. This provides the opportunity to tell two remarkable stories that have not been well documented – the epics of the formation of the Institute of Medicine in Kathmandu and Davao Medical School Foundation in Mindanao. In each instance, local women and men demonstrated unusual creativity and selfless determination in ignoring all the odds to pursue a dream – dreams they brought into reality. I have had the good fortune to become associated with each of these institutions and to become a friend of many of those pioneers. It is a singular honour to be able to tell their story.

Accounts of both the Kathmandu and Davao connections are long overdue. The Nepal Programme has become well known, if not always well understood, among the Canadian international development community. It may have attracted more bouquets than it deserved and has not been exposed to rigorous criticism. The Davao connection has received less public notice, although it has been under the baleful eye of some Canadian political organizations and has been the subject of a critical internal audit by the Canadian International Development Agency (CIDA). The coincident experiences which mushroomed in Calgary around the Division of International Development during its first quinquennium offer instructive parallels.

Although I have been heavily dependent on friends and colleagues for information and have benefited greatly from their advice and wisdom, this is not a committee report. I have taken the liberty to narrate a collective history and speak of the community of Nepalese, Filipinos and Canadians who have been partners in a collaborative enterprise. I can do no other than describe events and interpret situations through the eyes of one who was emotionally immersed in the process. I aim to present an accurate and balanced account of events without focusing on specific incidents or individuals and to be analytical without being judgmental.

My second purpose in these chapters is to reflect on these phenomena. This tale is not designed to celebrate unusual achievements by Canadians. It is not a eulogy of the record of Calgary or Canada in advancing the cause of international development. It will become painfully clear that we experienced our fair share of disappointment and

failure. Indeed, some may conclude wryly that we have rather more failures than successes to our credit!

However, judgments of failure would rest on a narrow definition of success. The products of our joint efforts were, indeed, sometimes less than satisfactory. Our efforts to produce a new breed of generalist doctors for Nepal and our first sorties into business development in Mindanao fall into this category. Nevertheless, the processes we pursued together – and which sometimes produced disappointing results – contained within them the seeds of success. The following chapters recount some substantial results in the form of products, but I derive more satisfaction from our exploration of the processes of learning and working together as partners.

These various connections are not presented as models for others to follow. Indeed, our encounters with difficulties and our limited success in surmounting them may be more instructive than any claims of notable achievement. These experiences have exposed the complexity of the ideas of developing and partnering – initially, we may have taken them too lightly as self-evident.

This is a cautionary tale. As I have reflected on my early enthusiasm for international development – which might more aptly be called transnational development – I have become a critic of many of these practices. Those of us who, for an infinity of reasons, are intent on engaging in international health must search within ourselves to discover our motives, to analyse critically the role we conjure up for ourselves, to recognize the inevitable negative impacts of our forays into foreign cultures, to recall the clinical aphorism that all therapeutic interventions have unintended side effects, and to follow the dictum "first, do no harm." These strictures apply with equal force to both individuals and institutions with overseas inclinations.

There is an alternative perspective. We can appreciate the strengths of colleagues and institutions in the South and recognize the benefits to be gained from entering into authentic partnering with them. We share many forms of the same human predicament and can learn together how to cope. Strategies for survival in the North may be learned from our southern partners – a form of appropriate technology transfer. The assumption that we can or should aid or teach the South has often little substance to commend it. A less confident attitude of entering into equitable relationships in order to learn together carries much more conviction – not least among those in the South who sometimes observe our posturing with bemused resignation.

A third aspect of the creative act of writing became evident only as I drafted the last few pages. As it has transpired, this is not an objective report or a retrospective analysis of past events designed to justify actions, to satisfy critics or to account for the expenditure of resources. Nor is it a conventional academic exercise in critical analysis. Instead, it has created itself as a personal memoir – a reliving of experiences spread over many years. At times, the words wrote themselves and revealed to me the meaning of past events.

My observations are based directly on the experiences which will be described in the first section, although their roots go much deeper. It will become clear that they are not based on a critical and comprehensive study of the literature. The following pages are not judiciously sprinkled with references, footnotes and endnotes, and lack a bibliography. This break with academic convention requires justification.

A Different Bibliography

My reflections on developing and partnering expose a singular ignorance of the literature of development. A flood of books and articles has been released on every conceivable aspect of development and yet I make no reference to this monumental body of information. On some occasions I fail to acknowledge the published experience and thoughts of others who could have corrected my errors and broadened the horizon of my mind. At other times I may claim originality for observations which have already been popularized. I lay myself open to charges of both ignorance of conventional wisdom and plagiarism. This confession requires a defence!

For more than twelve years I have experienced a form of hereditary blindness which deprives me of central vision while preserving peripheral vision. One result of macular degeneration is loss of the ability to read or write while retaining a tolerable level of independent mobility. In effect, I have acquired the stigmata of an unusual form of illiteracy. This explains my obvious lack of familiarity with recent publications. The impact of this visual deficit has been compounded by the fact that my training in obstetrics and gynaecology did not include formal education in the social sciences. I stumbled into the challenges of developing through a professional interest in medical education and population control. Newly acquired illiteracy has prevented me from compensating for this professional limitation by remedial reading.

I hasten to add that I do not share this personal story in a spirit of either apology or excuse but simply to explain the origin of a curious

blend of unwitting plagiarism and primitivism. The corpus of knowledge of development appears to be a treacherous quagmire of unsubstantiated opinion interspersed with occasional islands of solid ground of documented fact. In uncharted regions there is still a place for the amateur explorer.

Loss of central vision seriously impairs communication – I fail to recognize familiar friends and to pick up cues from facial expression and eye contact. I am cut off from books and periodicals and experience language in only its conversational and idiomatic form. Distance from good prose prejudices my ability to express ideas in a written form. I struggle to steer between cliches and slang, on the one hand, and stilted constructions, on the other.

Illiteracy also confers some unexpected benefits. The written word denied, I turn for relief to the spoken word, which forces dependence on family, friends and colleagues for new information, advice and reactions to my own inchoate ideas. My wife and close friends read to me and colleagues take time for protracted explanations, too polite to remark on my insatiable appetite for conversation. In effect, illiteracy creates a compelling stimulus to welcome the kind of interactive dependence that lies at the heart of authentic partnering. This thirst for partnering for personal survival and sanity may have played as large a role as external circumstances in moulding my thought. My use of the first person singular is, therefore, inappropriate to the extent that many of the ideas I claim for myself are, in truth, the fruit of conversations with generous friends.

Illiteracy has had another unexpected and disconcerting effect. Inability to read removes a favourite mechanism for switching off one's mind. Before losing my vision, I recall frequently using books as a form of intellectual anaesthesia: reading, far from stimulating thought, could easily become its substitute. To be deprived of books cuts off this escape route from active thinking. As a consequence, one is condemned to a life of unrelenting reflection.

The recent acquisition of a word processor and a voice synthesizer which takes the place of a monitor screen, reinforced by expert and patient instruction, is now enabling me to write this story. Within recent weeks I have also obtained an optical scanner which holds out the promise of converting the written word into speech. In effect, I am on the brink of regaining literacy. Until now, the campus library, only a few metres from my office, has remained tantalizingly beyond my reach.

Although it might be expected that I provide a bibliography to document the sources of my information and ideas, it will be apparent that I have been denied these conventional resources. However, the true sources of my reflection are as readily identifiable as books and articles. My references have been the experiences derived from partnering in joint programmes both at home and overseas. The many friends and colleagues whom a kindly fate has brought into my life have been, in a very real sense, my reference library. Instead of listing publications in a bibliography, I will describe as their substitute the sources of my reflection in terms of the people who have influenced the direction and content of my thought. In that sense, the first section of this volume is an extended bibliography which documents the origin of the ideas expressed in subsequent sections.

I.
A Tale of Three Cities

1

Tribhuvan University, Nepal

The purpose of this chapter is to introduce Tribhuvan University's Institutes of Medicine and Engineering. These are institutions with which The University of Calgary has partnered in recent years. I have selected for description only those features which are pertinent to an understanding of the origin of Tribhuvan's technical institutes and the environment in which they operate.

The first paragraphs sketch the geography, history, administration, culture and economy of Nepal. Particular attention is paid to the pattern of education in which Tribhuvan University has evolved. Since many of our efforts have been directed towards improving the health of the Nepalese people, the health-care system is outlined. A brief profile of Kathmandu, the home of Tribhuvan University, follows. Against this background I describe Tribhuvan University and its Institutes of Medicine and Engineering.

Nepal

Nepal is a small land-locked country within the Himalayas, encircled by Tibet and India. It is approximately 800 km from east to west and 175 km from north to south, with a land area of 147,000 km^2. Most of the

country is furrowed by high mountain ridges and deep gorges. Rivers course down from the Tibetan plateau to the plains of Bihar where they pour snow-melt and silt into the Ganges. The greater part of this mountainous region is inaccessible and inhospitable, and supports only a sparse and hardy population.

The entire Himalayan region from Afghanistan to Burma is home for many small tribal groups who are separated by national boundaries and by different languages, religions and cultures. They are united by a common identity as mountain people. This shared characteristic may be as significant as their nationality. Educated people from this region sometimes express a sense of solidarity with the mountain peoples of all continents and a common suspicion of lowlanders.

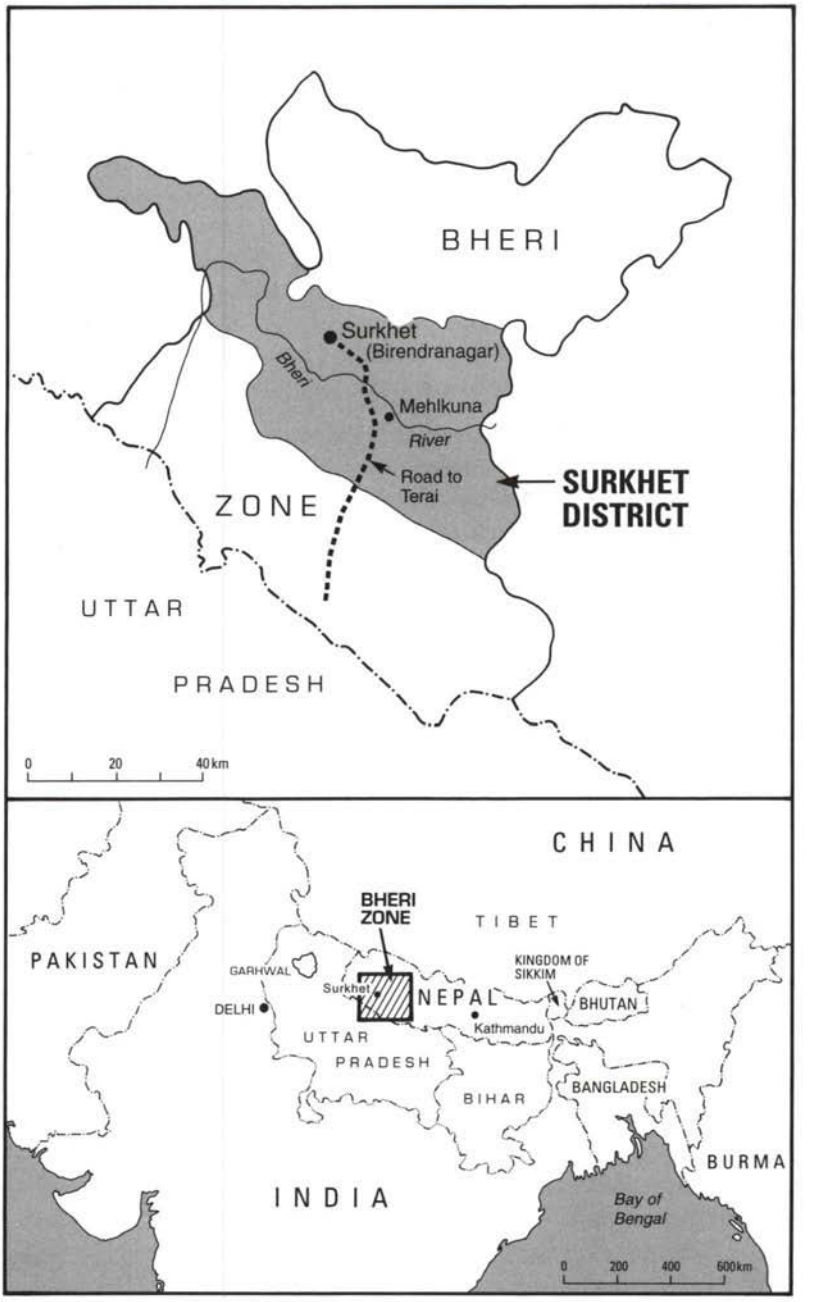
The rugged terrain makes transportation and communication extremely difficult. Roads are few in the hills and tracks are rough and physically demanding. Distances are measured in hours rather than kilometres. Wheeled vehicles are of little value. A fit person may take two full days to walk to the nearest district hospital. Radio and telephone links are still rudimentary in remote regions. These conditions are an obstacle to the organization of social services.

Throughout the centuries these isolated valleys have been home for distinct ethnic groups. To this day, over thirty societies with different languages and cultures continue to live in relative seclusion. However, population pressure and scarcity of land are forcing massive internal migration and beginning to merge these diverse cultures in a national melting pot.

The Himalayan chain is geologically unstable and is part of the earthquake zone which extends across Asia. Nepal is at constant risk of earthquakes and has suffered many disastrous tremors throughout the ages, most recently in 1934 and 1986. Other natural hazards ravage the people of Nepal – floods, mud slides and drought.

The foothills of the Himalayas descend into the Terai – a strip of 20 to 30 km of fertile land which is part of the northern periphery of the Gangetic plain. The Terai extends along the entire southern border of Nepal and merges imperceptibly into the plains of Uttar Pradesh and Bihar. Thirst for land has driven people not only south from the hills but also north from India into the Terai. Particularly in the east, the land has become densely populated and is close to saturation.

Only 35 percent of the total land area is habitable. Furthermore, deforestation due to lumber operations and the unceasing search for fod-



Map 1. Surkhet District in the Himalayan region

der and firewood is progressing at an alarming rate. The resulting soil erosion is reducing even further the capacity of the land to support the people. The land situation is critical and is barely able to accommodate the present population. This environmental crisis can be resolved only by immediate and dramatic controls and interventions to protect the forests and arable land. There is no evidence of action to give confidence that this is likely to occur.

Kathmandu is the only city of significant size. Many of the towns across the Terai are swelling as rural people flood in to search for employment and survival. Nevertheless, Nepal is still predominantly a rural country with approximately 90 percent of the people living in small towns and villages.

Nepal is the only country in the Indian subcontinent that has never been conquered by foreign invaders. Bhutan has remained independent, but India intervenes directly in some aspects of its internal affairs. The formidable terrain and the lack of lucrative resources have discouraged Nepal's conquest. During the late eighteenth century the Nepalese rulers entertained aggressive and expansionist ambitions. Successful incursions extended the borders of Nepal west into the Garhwal region of Uttar Pradesh, east into Darjeeling and south into Bihar. These forays brought them into conflict with the British forces and to two successive wars in which they suffered defeat. By the Treaty of Sugauli in 1817 Nepal returned these territories to the British Crown and adopted the boundaries which, with minor modifications, it retains to this day.

As throughout the entire Himalayan region, Nepal was divided into many separate and hostile Hindu kingdoms. The history of modern Nepal is the story of the domination of the Kathmandu Valley and subsequently the entire country by the Shah rulers of Gorkha in the mid-eighteenth century. Kathmandu became the capital of the modern nation of Nepal.

In 1847 the Rana family came to power in Kathmandu. They established a system of hereditary prime ministers and forced the king into a subordinate role divorced from any real power. The Rana prime ministers maintained this domination for a century. Throughout this time they isolated Nepal from the outside world and effectively insulated it from external influences.

Recent Events

During the 1930s the first underground political party was founded. Several of its leaders were arrested and either executed or sentenced to life imprisonment. The death of these martyrs is still commemorated

annually. From 1947 to 1951 a series of popular uprisings erupted against the Rana dynasty. In 1951 King Tribhuvan, accompanied by his family, fled the royal palace for India, presumably to escape the unstable situation in the country. However, at the instigation of Prime Minister Nehru, a compromise was reached whereby the king would return and restore the monarchy; the Ranas would forfeit their hereditary right to the role of prime minister, although the incumbent would retain his position; and democratic elections would be held.

Under these conditions King Tribhuvan returned to Nepal. The young Nepalese Congress Party chairman, B.P. Koirala, returned from exile to Kathmandu to lead his party. He became home minister in an interim cabinet which was led by the Rana prime minister. The latter was deposed within five months and this brought to an end the official domination of the Ranas. A senior Congress party member was appointed in his place. Elections were delayed foı eight years and it was not until 1959 that the people were enfranchised and returned the Congress party with a two-thirds majority. B.P. Koirala became the first democratically elected prime minister of Nepal.

In 1960, after only seventeen months of democracy, King Mahendra, who had succeeded his father to the throne, declared that this system of government no longer enjoyed the support of the Nepalese people and that it was not an appropriate instrument to facilitate economic growth. He dissolved the parliament, declared all political parties illegal and reintroduced an absolute monarchy. For the following three decades Nepal was ruled by a monarch who was regarded as a reincarnation of Vishnu. In effect, Nepal became a theocracy.

A one-party system of government, the Panchayat system, was introduced. The expression "panchayat" is familiar throughout the subcontinent. It is derived from the Sanskrit word for five and refers to the five Hindu deities who govern society. Throughout the eighties the country was divided into five development regions, fourteen administrative zones and seventy-five districts. Each District was composed of approximately nine ilacas, each comprising five or six panchayats. Finally, panchayats were divided into the smallest administrative units, the wards.

Panchayat councils elected representatives to a district assembly, or Jilla panchayat, which dealt with district affairs. Districts elected representatives to the National Assembly, or Rastra Panchayat. In addition to these elected members, the palace appointed twenty-five members. The palace also had authority to appoint the prime minister and cabinet. Despite popular pressure, political parties were forbidden and all mem-

bers belonged, at least nominally, to a common Panchayat party. There was a second appointed body, the Raj Sabha, which had only limited advisory powers.

A national referendum in 1980 rejected the option of a multiparty system in favour of retaining the partyless Panchayat system with appropriate reforms. These reforms were never implemented. Despite several minor demonstrations, the status of the monarchy and the Panchayat system seemed unassailable. This system remained in power throughout the decade of the eighties.

The situation changed abruptly and dramatically in the early months of 1990. A popular uprising in May of that year, led by the suppressed Congress and Communist parties, students and public employees, achieved a successful and relatively bloodless revolution. The Rastra Panchayat was dissolved; political parties were legalized; and King Birendra, who had succeeded his father Mahendra, to the throne in 1971, accepted the limited status of a constitutional monarch along the lines of the British model. An acting prime minister and an interim cabinet were installed with a mandate to draft a new constitution and organize elections to a new parliament based on a multiparty system. A national election was held in May, 1991 when the Congress party was elected to power with a small overall majority. Since the revolution the term "panchayat" has fallen into disfavour and Panchayats have been renamed Village Development Committees.

The People of Nepal

Ninety-five percent of the Nepalese people are Hindu, the remainder being Buddhist, Muslim or Christian. The Nepalese people are characteristically spiritual and tolerant in matters of religion. However, the Panchayat government forbade proselytizing by Christian missionaries and had the authority both to expel those who broke this law and to imprison those who converted to Christianity. The new constitution guarantees freedom of religion.

Hindu beliefs and practices pervade daily life and many people lead devout religious lives. The Hindu caste system is still a powerful force. The caste system can be regarded either as a valuable force which guarantees stability or as a repressive influence which perpetuates privilege, according to one's perspective. In parallel with these Hindu beliefs, each of the ethnic groups has its own structure of knowledge and practice. These have deep roots in animism and are influenced by both Indian and Tibetan traditions. Village life in Nepal is dominated by a complex

set of ethical values, practices and attitudes which are unfamiliar to outsiders. Respect for these different beliefs and behaviours is essential for those who wish to learn from the Nepalese people or to assist Nepalese colleagues to facilitate the processes of developing.

The Economy

Nepal consistently appears in the World Bank's category of the ten poorest, or "least developed" countries. Its main source of foreign exchange is tourism. This is a mixed blessing because tourism has been poorly controlled and is the source of serious social and environmental damage. Nepal has the capacity to be one of the world's major producers of electricity from hydroelectric power. However, its only potential customer is India. Although the World Bank has been poised to arrange for the financing of the enormous capital costs of construction, its help is conditional on India's willingness to purchase the power. To date, this approval has been withheld. In the past Nepal has been a net exporter of rice. However, with an exploding population, an inadequate food distribution system and shrinking arable land area, it has become a net importer.

In 1990 the average annual per capita income was 9,000 Nepalese rupees, or US$180. Inflation has continued to escalate at a rate which exceeds the growth in income. As a consequence, the purchasing power of villagers who were already impoverished is declining even further. Based on estimates of caloric intake it has been calculated that 55 percent of urban and 61 percent of rural people live in conditions of "absolute poverty." At the same time businessmen and speculators in Kathmandu and the Terai have become wealthier. This is reflected in the extraordinary high land values in the city, which now exceed comparable values in many European and North American cities. This highlights the widening gap between rich and poor both within and between countries.

Education

Lord Macaulay introduced the English schools tradition to British India in the nineteenth century and this system persists to this day. When a British Residency was established in Kathmandu in the nineteenth century under the terms of the Treaty of Sugauli, the Raj began to influence the pattern of education in Nepal. When Prime Minister Jung Bahadur visited Victorian London he was disturbed by his inability to converse in English and to fit into London society. Enamoured by English public schools, he encouraged, on his return home, the transfer of the English tradition to Nepal. He established a school in Kathmandu within the

confines of the Rana palace, primarily for the benefit of the Rana children. After his death, his successor constructed the Durbar School within the city and opened it to other non-Rana children of high status. Trichandra College was established in 1918 by Prime Minister Chandra Shamshir as the first post-secondary institution in the country. It was affiliated to the University of Patna and followed the curriculum and examinations of British India. This practice of modelling on British India accelerated after the revolution of 1951.

Nepal's traditional system of education, "gurukul," is based on the Sanskrit practice of the teacher instructing pupils through a process of repetition and memorizing. This system has a long and respected tradition throughout Asia and still survives today in Sanskrit schools and even at university level in the Sanskrit University.

Nepal's New Education System Plan (NESP) was instituted in 1970. The crown prince, who succeeded to the throne as King Birendra in the following year, played a key role in the drafting of this plan and incorporated many of the features which he had observed during his student days at Harvard. As events unfolded, many of these American practices proved to be uncongenial and were discarded in favour of more traditional British Indian systems.

The new plan required that primary schooling for three years should be made available to all children. It would be misleading to regard this as compulsory education since this goal is still not attainable. The "required" duration of schooling has since been extended to six years. Primary education is free in all government schools. Beyond grade 5 children can continue in lower secondary schools to grade 7 and up to grade 10 in secondary or high schools. However, education beyond grade six becomes costly and is beyond the means of most villagers. This financial barrier is reflected in the number of children who attended school in the year 1988-89. 2,526,000 children were enrolled in primary schools, but only 325,000 in lower secondary schools and 338,000 in high schools.

Privately owned schools are increasing in number. Some are managed by religious orders: for example, St. Xavier's School, which is operated by Jesuits in Kathmandu, has educated the children of the wealthy for many years. Others are run by foreign agencies or by local entrepreneurs. Private schooling is expensive and beyond the reach of the average citizen.

The new education system has little to offer to those adults who have received little or no schooling. The literacy rate among adults in the villages today is less than 10 percent and even lower for women. Pro-

grammes of non-formal education have been introduced to address this problem. One of the constraints which limits the ability of people to develop themselves is pervasive illiteracy. Girls continue to be underrepresented within the school system. While the numbers of boys and girls attending primary schools are approximately equal, the proportion of girls in secondary schools falls dramatically.

The annual revenue from taxation which was available to the government of Nepal in 1990 was approximately 74,775 million Nepalese rupees. In 1990 the Government spent approximately 11 percent of this income, or 2,104 million Nepalese rupees, on education, including 566 million Nepalese rupees for post-secondary education. By comparison, six percent was spent on defence and nine percent on debt repayment. The educational allotment breaks down to 500 Nepalese rupees per school pupil and 5,000 Nepalese rupees per post-secondary student. In terms of 1990 conversions, this is equivalent to just over $10 per school child per year and just over $100 per university student per year. These allocations have to cover both operating and capital costs.

Health

Parallel systems of medicine have coexisted in Nepal for many decades. The practice of indigenous Ayurvedic medicine derives from the Hindu Vedic system of knowledge and is based on herbal, mineral and homeopathic elements. This system dates back to antiquity and survives into the present day. The Institute of Medicine has had the dual responsibility to train practitioners of both Ayurvedic and modern Western medicine. Ayurvedic practitioners are still popular and provide a significant proportion of current health care.

Alternative health practices based on popular wisdom and customs exist outside the formal Ayurvedic tradition. These methods are practised by traditional healers, or *jhankris*. It would be easy to dismiss these beliefs and customs as no more than fanciful or superstitious. However, indigenous knowledge plays an important role in rural life and *jhankris* are respected healers.

European medicine entered the Kathmandu Valley in the first half of the eighteenth century with the arrival of Italian Capuchin missionaries. They continued to work in Nepal as part of their central Asian mission for over fifty years. After their departure Christian missionaries were not readmitted to Nepal until after the Democratic Revolution of 1951.

British doctors attached to the British Residence in Kathmandu established friendly working relations with the shah rulers and the Rana

families and had a significant positive impact on the attitude of the aristocracy to western medicine. Indian trained doctors, particularly from Bengal, entered Nepal in the latter part of the nineteenth century and were the sole resource for modern medicine until well into this century. The first few Nepalese students to train abroad in medicine and return to Nepal did not take up practice in Kathmandu until the 1920s.

Hospital construction in Nepal started around 1890 with the opening of the Bir Hospital in Kathmandu, rapidly followed by smaller hospitals in towns throughout the Terai and the middle hills. The Shining Hospital was opened in Pokhara in 1953 by the International Nepal Fellowship, an evangelical protestant mission. The United Mission to Nepal started medical work in Tansen in that same year.

Hospitals and health centres constructed by religious missions and secular foreign organizations, such as New Zealand's Hillary Foundation and the UK Save the Children Fund, have subsequently spread widely across the country.

It is difficult to assess the health status of the Nepalese people in reliable terms. The system for collecting data and the problem of communications within the country present enormous logistic obstacles. Official health statistics indicate that 125 out of every 1,000 liveborn children die within the first year of life and that a further 68 die before their sixth birthday. Life expectancy at birth for men is 55 years and 52 years for women. The major causes of death are acute and chronic infections superimposed on poor nutritional status. Acute respiratory infections and diarrhoeal diseases are the major killers among children.

These data are difficult to assess. On the one hand, when carefully controlled analyses were carried out in the late seventies in specific locations, particularly in remote areas, the outcomes were much worse than official figures suggested. On the other hand, recent health surveys in two middle hill districts indicate perinatal mortality rates as low as 50 per 1,000 live births. The last decade may have seen a significant improvement in health outcomes.

An accurate measure of population growth is equally elusive. Official statistics suggest that there were 721,000 births in 1989. The annual rate of population growth was 2.6 percent and the crude birth rate was 39 per 1,000 population. On average, women give birth to 5.8 children throughout their reproductive life. If this pattern were to continue, the current population of 18.7 million will exceed 25 million by the end of the century. Forecasts of population in Nepal have often exceeded actual outcomes.

The population changes not only by virtue of its fertility and mortality but also by the balance of in and out migration. Although data are scarce there is a strong impression that the shift of Indian people into the Terai and valleys is progressing rapidly. Control of the movement of people across the open border is beyond the political capacity of Nepal. Nepal is also vulnerable to massive shifts of refugees if other countries in the region, such as Bhutan, were to force people of Nepalese origin to return to their homeland.

While the training of all health-care workers is now the responsibility of the Institute of Medicine, the planning and delivery of health services is controlled by the Ministry of Health (MOH). The latter controls the construction of all government hospitals and health posts; provides equipment and supplies; and hires, assigns and promotes all health personnel.

Although there is an official policy to decentralize, decision-making is still concentrated in Kathmandu, despite the fact that there is a network of regional and district health administrators. Unfortunately, health administration in Nepal has been rigid and ineffective and has been unable to implement its own policies.

Within the districts, the responsibility for hospitals and health posts has been under separate management. There are currently eleven regional and zonal hospitals, each with over fifty beds. Of the 75 districts, only 65 have district hospitals. Not all of these are actively manned and many are inadequately equipped.

While this situation persists in the rural areas, hospital construction has proceeded rapidly in Kathmandu. In 1991 there were ten government hospitals in the Kathmandu Valley with a total of approximately 1,500 beds. This represented more than 50 percent of the total of 2,800 government beds in the entire country. Of all registered doctors, 60 percent worked in Kathmandu. This maldistribution is not peculiar to Nepal and can be seen duplicated in most countries.

Apart from this government health-care system, a private health sector is flourishing. Several private hospitals and clinics have been opened, especially in Kathmandu. Some are funded by foreign religious missions; some are supported by foreign-aid organizations; many are the initiatives of local entrepreneurs. Doctors can work outside the government service. Many were educated overseas in a variety of countries and institutions and returned to Nepal with widely diverse training. To date, the Nepal Medical Council has found it impossible to screen incoming doctors in terms of either number or quality.

The government spent four percent of its total revenue on health care in 1990. This constitutes a total of 632 million Nepalese rupees available to the Ministry of Health from all sources for both operating and capital costs. This translates into approximately 32 Nepalese rupees, or 70 cents US, per person per year.

Kathmandu

Kathmandu lies in one of the large fertile valleys found throughout the middle hills. The valley lies at an altitude of 1,500 metres and is approximately 40 km from east to west and 20 km from north to south. Modern Kathmandu is derived from three small kingdoms within the valley – Kantipur, Lalitpur and Bhaktapur. During the mid-eighteenth century the Shah rulers of Gorkha overcame these neighbouring cities from their valley base in Kirtipur and united them into a single kingdom.

Kathmandu remained a quiet secluded city until 1951, isolated from the technology and fashions of modern life. Small villages and the properties of the Ranas and royal family were scattered among neighbouring rice fields. The city was crowded around the central market area and nestled within the meandering of the Bagmati River. The population did not exceed 100,000 and there were few vehicles owned only by the very wealthy. Newari architecture added to the grace of the city. Many of these old homes, bazaars, temples and public offices have survived the devastation of the earthquake of 1934.

Although these features of old Kathmandu remain to this day, they are rapidly being submerged under the trappings of modernity. Since the opening up of Kathmandu to the outside world in 1951, the valley has continued to change rapidly and dramatically. New administrative offices, factories, private businesses, hotels, shops and modern homes have mushroomed haphazardly around the old city. They already occupy the entire western end of the valley and are rapidly encroaching on the adjacent hillsides. Streets are choked with traffic; pollution from vehicle exhaust and the chimneys of new factories creates a permanent haze over the city; there is barely enough electricity or water to provide for current needs; and the inability to dispose of waste is already critical. It seems inevitable that concrete will displace fields from the entire valley by the end of the decade.

The current population of Kathmandu is of the order of one million. It increases daily as people crowd in from the rural areas in search of education, employment and the dubious pleasures of city life. A large influx of resident expatriates, employed by embassies, United Nation

organizations and innumerable aid agencies, has been drawn to Kathmandu by the real needs of the people, the strategic situation of Nepal as a buffer between India and China and, not least, by the romance of its mountains. Tourists from every country crowd the narrow streets and bazaars and overwhelm the resources of the city.

Educated and underemployed students, underpaid public servants and those with unfulfilled dreams create an environment of instability and discontent. Kathmandu mirrors cities across Asia, Africa and Latin America. These urban centres will inevitably become the source of the global unrest which will surely dominate our planet in coming years.

Tribhuvan University

The Act which created Tribhuvan University was promulgated in 1959. At that time Trichandra College was still affiliated to the University of Patna. Under the new Act, Tribhuvan University assumed responsibility for supervising its curriculum and examinations. Over the following fifteen years, Tribhuvan University established a central administration but did not create any additional campuses nor develop its own academic programmes. It functioned primarily as an administrative and coordinating centre. During the sixties and seventies many private campuses were opened in Kathmandu and throughout the country. Most of these offered certificate-level training rather than degree programmes. Some were operated by government ministries; some were funded by foreign governments; and some were created by local initiatives. Tribhuvan University's role was simply to oversee their curriculum content and supervise examinations. In effect, its role was to coordinate educational resources in order to provide appropriate manpower to meet the immediate needs of a newly emerging society. The title of "university" may seem inappropriate in terms of conventional usage.

Under the New Education System Plan of 1970, Tribhuvan University assumed much greater responsibility and gained full control over all existing post-secondary institutions, including Trichandra College. It became directly responsible for the implementation of post-secondary education rather than being only a monitoring mechanism. Over the subsequent twenty years the scope of its activities has expanded exponentially in terms of both the range of disciplines and the level of education which it provides. Tribhuvan University now offers programmes at masters and doctorate level in several disciplines.

It operates through a series of faculties (humanities, science, social sciences, law, management, commerce and education), five technical

institutes (Institutes of Medicine, Engineering, Agriculture, Forestry and Science and Technology) and four research centres (Centre for Nepalese and Asian Studies, Centre for Economics, Development and Administration, Research Centre for Appropriate Science and Technology, and Centre for Education Research Innovation and Development).

From its new central administrative offices in Kirtipur, Tribhuvan University directly administers about 80 campuses within Kathmandu and across the country. Furthermore, in recent years the construction of small private campuses has been encouraged and over 100 are now in operation. Private campuses have been entirely responsible for their own internal management and for setting tuition fees and faculty salaries.

Tribhuvan University is an autonomous academic institution with a vice-chancellor as its administrative head. The minister of education acts as pro-chancellor and the king is the chancellor of the university. It has direct control over the examinations and curriculum content of all the private campuses. Tribhuvan University itself currently enrols 95,000 students but is also indirectly responsible for the additional 50,000 students on the private campuses. It recruits 5,000 faculty. Its annual budget of 560 million Nepalese rupees (approximately US$10 million) is derived from the ministry's annual budget of 2,104 million Nepalese rupees.

Tribhuvan University has grown so rapidly and widely that its administration has become a cause for serious concern. It may be divided into more manageable units, although the precise way by which this will be achieved is still uncertain. The only step taken in this direction is to create an independent Sanskrit university in Dang in the Mid West region. Kathmandu University, a privately funded institution, was established in 1991 and other campuses are planned.

The Institute of Medicine

Prior to the creation of the Institute of Medicine (IOM) in 1972, the ministry of health was responsible for training its own health workers. Formal health education in Nepal dates back to 1927 when an Ayurvedic school was established to train *vaidyas* and other health personnel. Allopathic health training started in 1933 with the opening of the Civil Medical School in Chetrapati which trained compounders and dressers. Compounders trained for two years and virtually ran the hospitals and health units under the supervision of doctors. In 1956, a nursing school was set up to train middle-level health workers and another was opened to train health assistants, analogous to the licensed medical practitioners of India. Other categories of health workers, intermediate in status between

health assistants and nurses, on one hand, and compounders and dressers, on the other, were subsequently introduced. This led to the creation of Auxiliary Health Workers (AHW) and Auxiliary Nurse Midwives (ANM).

The IOM was established within Tribhuvan University in 1972 under the terms of the New Education System Plan. Its mandate was to take over from the health ministry the responsibility for training all levels of health manpower up to certificate level. These certificate courses were of two and a half to three years duration following completion of the School Leaving Certificate. The IOM assumed responsibility for training at certificate level in general medicine, nursing, pharmacy, radiography, laboratory medicine and Ayurvedic medicine.

In 1978, the IOM introduced bachelor-level courses in nursing and medicine. Graduates from certificate-level programmes were required to work for the health ministry for a minimum of three years before being eligible for entry to the new bachelor programmes.

Over the last decade, the IOM has introduced postgraduate programmes in general practice, anaesthesiology, obstetrics, ophthalmology, otorhinolaryngology, radiology, paediatrics and public health.

One of the features which distinguishes the IOM from medical colleges elsewhere in the subcontinent is its mandate to train all grades of health worker from Auxiliary Health Worker or Auxiliary Nurse Midwife to postgraduates at masters level. This wide mandate was intended to encourage the formation of health teams and facilitate career development. The IOM is committed to working with communities and all of its programmes are intended to focus strictly on the unique health needs of Nepal.

The Institute of Engineering

Before the introduction of the New Education System Plan in 1970, there were two engineering campuses in Kathmandu – a civil engineering technician training programme at Pulchok, operated by an autonomous body, and a certificate-level programme in mechanical engineering at Thapatalli which was made possible by a donation from the government of West Germany in 1965. Both of these campuses became incorporated within Tribhuvan University after the introduction of the new educational plan. The Pulchok campus has subsequently become the administrative centre of the Institute of Engineering (IOE).

2

The Kathmandu Connection

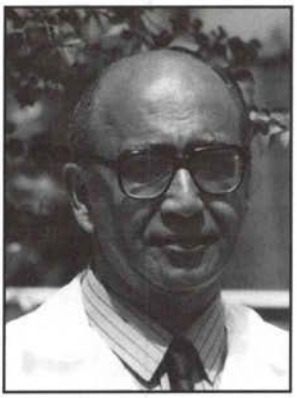
Origins of the Kathmandu Connection

Although the formal agreement between Tribhuvan University and The University of Calgary dates from 1980, the seeds of the relationship were planted in 1975. The South East Asia Regional Office of WHO organized a training course on "Human Reproduction, Family Planning and Population Dynamics" in Bangkok in October, 1975, and a workshop on Medical Education in New Delhi in the following year. Each of these courses was offered to delegates from those countries within WHO's South East Asia Region – India, Bangladesh, Nepal, Bhutan, Sri Lanka, Maldives, Burma, Thailand, Indonesia and Inner Mongolia. I was invited by WHO to participate as a short-term consultant in each of these courses. They provided an introduction to south and southeast Asia and led to contacts with medical educators throughout the region.

One of the participants at the New Delhi workshop was Dr. Moin Shah who represented Nepal. In 1972 he had been appointed as founding dean of the new Institute of Medicine (IOM) in Kathmandu and it was anticipated that the IOM should generate the capacity to train its own doctors. Moin Shah came to Delhi with this expectation clearly in mind. The work-

shop allowed time to explore ways by which new concepts in medical education might be applied to the unique circumstances of Nepal.

At the request of the IOM, WHO subsequently invited me to visit Nepal for four months to advise on the feasibility of establishing a medical school in Kathmandu. During this period, November, 1976, to March, 1977, the IOM began planning the undergraduate medical education programme. Since the IOM had already decided to create a medical school, advice on the feasibility of this action proved to be superfluous and my role became one of facilitating the process rather than advising on its propriety.



Dr. Moin Shah

The following account deals primarily with the decade from January, 1980, to December, 1989. Throughout that period I was responsible for the supervision of the Nepal programme and was intimately involved in the course of events. The programme has continued in operation since then but I cannot comment on these more recent years.

The Undergraduate Medical Education (MBBS) Programme

Origins of Medical Education in Nepal

The idea of establishing a medical school in Kathmandu dates back to the early sixties. Dr. D.N. Vaidya, Director of Health Services, believed that Nepal needed its own medical school. On his advice, the government set up an advisory committee in 1966 to study the feasibility of creating a medical programme based on the Indian model. The committee, chaired by Dr. Vaidya, received advice from a short-term WHO consultant and visited several Indian medical schools. By 1970 they had made considerable progress in planning a school which would admit students who had obtained the Intermediate Science Certificate, equivalent to the 12th Grade High School Certificate, as is the custom throughout India.

This plan appeared to receive a fillip by an unforeseen incident in that year. The queen was seriously injured in a shooting accident in the western Terai. She was not transferred to Delhi, as might have been anticipated. Instead, she was flown dramatically by night to Kathmandu and was admitted to the Bir Hospital where she was treated success-

fully by Nepalese doctors. This happy outcome earned the respect and warm gratitude of the palace towards the medical profession in Nepal and encouraged hopes for the early approval of a medical school.

However, the National Education System Plan (NESP), which was promulgated in 1970 with the active support of the crown prince, expressed a strong preference for modern educational methods and a distaste for the more conservative Indian system. This plan required that a new medical education programme should be designed to meet the specific health needs of Nepal. It stipulated that entrance to medical school should not be directly from high school or college but should follow completion of training in any of the IOM's certificate-level programmes and a period of at least three years service to the country. In effect, the recommendations of Dr. Vaidya's committee were shelved.

Dr. D.N. Regmi

Dr. Bhisma Prasai

By the mid-seventies the IOM had implemented all its certificate-level programmes and many of its graduates had worked within the health sector for several years. The conditions were ripe for the introduction of a medical school which would satisfy the requirements of the new educational system.

Fathers of the MBBS Programme

Dr. Moin Shah had been seconded from the Ministry of Health (MOH) to Tribhuvan University as dean of the IOM together with Dr. D.N. Regmi as assistant dean. The first physician to resign from the MOH in order to join Tribhuvan University on a permanent basis was Dr. Bhisma Prasai who entered the IOM in 1976. This small team of three Nepalese faculty, assisted by several medical colleagues, undertook the daunting task of creating the new medical school in Kathmandu.

One can only admire the vision and tenacity of this trio of pioneers. Dr. Moin Shah is a man of foresight and indomitable determination who allowed no obstacle to stand in his path. He graduated in medicine from the University of Hyderabad and subsequently trained and qualified as

a general surgeon in the United Kingdom. The MBBS programme could not have been implemented without his resolute leadership. He completed his term as dean in 1979 and was succeeded by Dr. Hemang Dixit.

Dr. Hemang Dixit

Dr. Dixit is a medical graduate of the University of London, England, and a British-trained paediatrician. He is also a local historian, author and an acknowledged leader in the medical profession. While Dr. Moin Shah managed the birth of the MBBS programme, Dr. Dixit nursed it through its early years. He was particularly supportive of young faculty and was respected by students for his fairness and commitment to their education.

Dr. Regmi soon returned to the MOH but continued to support the IOM from his vantage point in the ministry, particularly while he served as Director General of Health Services. Dr. Regmi is a deeply spiritual man who applied his ethical principles to his official duties.

Dr. Bhisma Prasai has played a unique role in the evolution of the IOM, having continued to serve the institute without interruption since 1976. He is a graduate of the University of Dacca and a British-trained pathologist. He was assigned the task of planning the new MBBS programme. When the medical school opened in 1978 he became responsible for its implementation. When the Japanese government agreed to construct a teaching hospital he planned the new facilities and subsequently became the first director of Tribhuvan University Teaching Hospital (TUTH). He became dean in 1989 and held this position during the stressful times of the revolution of 1990. He was the principal link between Kathmandu and Calgary and has been the Nepalese coordinator of the Health Development Programme since its inception in 1987. Apart from his professional duties, Dr. Prasai has played an active role in his own community and finds time to support village initiatives within the valley. He is also a published poet and a student and translator of the Hindu texts.

These brief biographical sketches serve to acknowledge not only the professional contributions of these four men to the IOM in its formative years but also the character which they brought to their task. The IOM which stands today and the many programmes which it sustains are their legacy.

Tribhuvan University Teaching Hospital, Kathmandu

Planning the MBBS Curriculum

When the IOM set out to plan a new undergraduate medical curriculum in 1976 it did so on the explicit assumption that the goal was to design a system tailored for the special needs of Nepal. It did not intend to duplicate the conventional model of medical education in the North or its variants which have been adopted uncritically in many countries of the South.

The first step was to review the health status of the people of Nepal. This assessment was based on the first-hand experience of the curriculum planners, some of whom had previously worked in rural districts, and on the limited health data which were available to them. The major causes of morbidity were acute infections – respiratory infections and water-borne diarrhoeal diseases; chronic infections – tuberculosis and leprosy; tropical diseases – malaria and amoebiasis; malnutrition – general protein and calorie deficiency and such specific deficiencies as vitamin A, causing blindness, and iodine, causing goitre; and trauma – including burns. All these conditions are directly linked to poor environmental conditions – shortages of food, lack of potable water, over-population, poor housing, exposure to domestic smoke and overcrowding. Non-access to land, unemployment and lack of education, particularly of women, conspired to ensure the persistence of insanitary conditions.

These are the diseases of marginalization and poverty. This pattern of disease bears little resemblance to illness in wealthier countries of the North.

The second step was to identify those competencies which a district medical officer would require in order to address this spectrum of disease in the conditions of rural Nepal. For decades to come they would be denied access to the modern medical technology which is taken for granted in the North – for example, laboratory facilities for biochemistry, microbiology, pathology and radiology, support from physiotherapists or social services and access to radiotherapy or chemotherapy. They should concentrate on simple diagnostic methods and inexpensive remedies. They should embrace three strategies which are difficult to combine within one individual – the prevention of disease, the treatment of common illnesses and the clinical management of life-threatening emergencies. Given the scarcity of resources for health care, they should acquire attitudes of respect for the ability of people to participate in their own healing and for alternative systems of healing. This job description is foreign to medical practice in the North.

The third step was to define those learning objectives, in terms of knowledge, skills and attitudes, which are required to gain these competencies. The planning committee deliberately focused on those elements of knowledge and skills which were pertinent to health care in Nepal. The profile of health and disease, the conditions in which health care was provided and the competencies which were demanded were unique to Nepal. It followed inexorably that the prerequisite learning objectives required to achieve these competencies would differ from those which were prized in the medical schools of the North. The IOM intended to train doctors specifically for practice in Nepal and not for an international market.

The final step was to design a "multidisciplinary, horizontally integrated systems" curriculum rather than adhere to a more conventional "vertical disciplinary" model. Circumstances dictated that there should be an eight-semester programme spread over four years.

Most traditional medical educators believed that knowledge should be acquired in a carefully managed sequence. Students first study the structure of the body, the functions of its organ systems and how they are integrated. They then learn how these structures and functions can be disrupted by disease and the principles of treating illness. Other basic topics are inserted into these "preclinical" years. Only after completing this theoretical training are students gradually introduced to patients and learn how this basic knowledge can be applied in clinical practice.

This pedagogic model was challenged by a few medical schools in North America, including McMaster University and The University of Calgary in Canada. These schools questioned the value of a didactic model which seemed to be more concerned with synchronized teaching than integrated learning.

They introduced a new "systems" method of curriculum design. Students studied each of the major body systems in sequence and learned the relevant anatomy, physiology, biochemistry, pathology, microbiology and pharmacology within the context of examples of clinical diseases which affect each system. It was this second curricular model which the IOM adopted.

The IOM planners also decided to follow a "problem-based" approach to learning rather than rely on structured didactic teaching. Students would be exposed to health problems in both community and hospital settings from the time of their admission to medical school. The adoption of problem-based learning was readily compatible with a "systems" curriculum model. Given the belief in the prime importance of understanding health and disease in the context of society, students would spend a significant proportion of their learning time in the community rather than within hospital wards.

The MBBS Programme

The product of this catalogue of learning objectives and the adoption of these learning strategies was a curriculum that was relevant to the needs of Nepal. However, some treasured aspects of academic medicine – for example, biochemistry, immunology and oncology – were either omitted or poorly represented. Other disciplines, which at that time often received little more than lip service, gained in relative importance. Thus, two of the eight semesters, including the first semester, were devoted to the study of health and disease in community settings.

While this programme had the full support of the IOM, it met with predictable and understandable scepticism from many physicians in Kathmandu. It raised particular concerns for those who put a premium on acceptance and recognition by the international academic medical community.

The first ideas for the new programme were presented to the medical community at the biannual meeting of the Nepal Medical Association in Kathmandu in February, 1977. The auditorium of the Bir Hospital was well filled when the dean and his team outlined these ideas. The plan was generally dismissed as a crank notion which could produce

only a second-class breed of physician. Nevertheless, the dean and his team held to their plan and it was essentially this curriculum which was implemented in 1978.

When planning was in progress in 1977 the new programme had been considered to be at diploma level. Its graduates would receive a diploma in general and community medicine from Tribhuvan University. According to the New Education System Plan, all first degrees from Tribhuvan University were designated "diplomas." However, following the unrest and referendum in 1980 this title was changed to "bachelor," bringing medical graduates in Nepal into line with their counterparts in the Indian subcontinent and the United Kingdom. The new educational system had proposed a smooth transition from certificate- to diploma-level training for health workers. The new designation of "MBBS" disrupted this orderly progression and emphasized the gap between certificated paramedical workers and degree-holding physicians.

The admission policy was crucial. Admission would be restricted to those who had completed certificate-level training and had served as health assistants or in equivalent positions for at least three years. The IOM would not admit students to the MBBS programme directly from college, as is the practice throughout the region. The goal was to train doctors who would understand conditions throughout rural Nepal and who had already shown that they were willing to work in the difficult circumstances which prevail throughout the hills and Terai.

A Royal Commission on Higher Education reviewed the programme critically in the early eighties. The entire student body and the majority of the IOM faculty stoutly defended their programme. Nevertheless, one major change was made in the admission policy. Fifty percent of entrants would now be recruited from holders of Intermediate Science Certificates while the remainder would still be selected from experienced certificate-level workers. The only additional modification has been an extension of the programme to four and one half years in order to provide more time for the basic sciences.

The Calgary Connection

By late 1979 the IOM was struggling to cope with limited resources and only a few experienced teachers. In response to a request from Kathmandu, I returned to Nepal in January, 1980, and met with Dean Hemang Dixit and his senior staff to see if The University of Calgary could offer assistance to the IOM. We agreed to try to establish a connection between Kathmandu and Calgary. The immediate objectives were

to offer opportunities to IOM faculty to visit the Calgary campus to gain experience and greater confidence in teaching methods, to provide short-term Canadian faculty who would visit Kathmandu to contribute to the teaching programme and to offer advice on teaching methods.

This informal agreement in 1980 was the origin of the "Kathmandu connection." This limited relationship between the IOM in Kathmandu and the Faculty of Medicine in Calgary continued for six years before being superseded since 1987 by a more comprehensive agreement administered by the new Division of International Development (DID) of The University of Calgary.

The proposal to enter into this new institutional relationship gained the ready approval of the dean of the Faculty of Medicine, Dr. Lionel McLeod, and the senior University of Calgary administration, with the proviso that special funding should be found. Within a few weeks Julie and Kelly Gibson, residents of Calgary, offered to donate $25,000 annually. They subsequently continued this personal support for seven years, contributing a total of $183,000.

Throughout the eighties the government of Alberta showed leadership in Canada in its support of international development. This provincial initiative was the result of the foresight of the first director of the Alberta Agency for International Development, Mr. Ray Verge, and the encouragement which he received from Premier Peter Lougheed. The agency matched the Gibsons' donation in 1980. Over the decade of the eighties the province provided a total of $317,000 in support of the Kathmandu connection.

With this base funding in place, the first approach was made to the Canadian International Development Agency (CIDA). An initial three-year contribution agreement covered the period 1981 to 1984. This was followed by a second three-year award, extending the project to 1987. In that year, The University of Calgary signed a more ambitious five-year contribution agreement for a "Nepal Health Development Programme." Over the nine-year period from July, 1981, to July, 1990, CIDA contributed a total of $2,100,000 to our work in Nepal. The International Development Research Council (IDRC) provided $44,690 in support of related clinical research.

Two Albertan non-governmental organizations subsequently provided additional funds. Rotary District 536 Development Society, which coordinates international development assistance on behalf of over fifty Rotary clubs in western Canada, contributed $30,000. Childreach, a small

Calgary organization, donated over $17,000 in support of maternal and child health in Nepal.

This joint personal, non-governmental, provincial and federal funding made the Kathmandu connection possible. Over the decade it amounted to a total of over $2,500,000.

Faculty Exchange

The first two Nepalese faculty visitors, Dr. Gopal Acharya and Dr. Dibya Shree Malla, came to Calgary in the summer of 1980. The dean of the Faculty of Medicine and the chairman of the Department of Medicine in Calgary each spent periods of four weeks in Kathmandu in the spring of 1981. The president of The University of Calgary, Dr. Norman Wagner, also visited the project during the start-up period. During his time in Kathmandu, Dr. Wagner visited Dean Dixit in his office in Chetrapati. While they were in conversation, news arrived that students on the adjacent Ayurvedic campus were on strike and on their way to "lock in" the dean – along with his Canadian visitor! The dean and president were hustled to safety shortly before their student gaolers arrived on the scene.

In 1985, the succeeding dean of medicine in Calgary, Dr. Mamoru Watanabe, the president of the Foothills Hospital, Mr. Ralph Coombs, and the academic vice-president of The University of Calgary, Dr. Peter Craigie, also travelled to Nepal to review the programme. Other friends of the project, including Mr. Kelly Gibson, visited the IOM.

Between 1980 and 1986, eighteen Calgary faculty members spent periods of one to six months in Kathmandu to assist in various parts of the MBBS programme. They made contributions to the teaching of physiology, medicine, neurology, paediatrics, obstetrics and gynaecology, psychiatry, general practice and anaesthesiology.[1] Over that same period, ten IOM faculty visited the Calgary campus and shared in the work of various departments.[2] The University of Calgary assisted in a modest way with the provision of learning materials.

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1 Drs. Lionel McLeod, Clarence Guenter, William Whitelaw, Jeffrey Mellor (Medicine), Robert Haslam, Diane Morison (Paediatrics), Larry Bryan (Microbiology), George Carson, Jill Nation, Melville Kerr (Obstetrics), Robert Lee (Neurology), Roy McKenzie (Psychiatry), Ken Lukowiak (Physiology), Tudor Williams (Anaesthesiology), Tom Saunders, Wayne Elford, David Swann, Jim Noiles (Family Medicine).

2 Drs. Gopal Acharya, M.R. Pandey (Medicine), Dibya Shree Malla, Sanu Maiya Dali (Obstetrics), Hemang Dixit, Ramesh Adikhari (Paediatrics), Roshana Amatya (anaesthesiology), Bhisma Prasai (Pathology), Madan Upadayay (Ophthalmology), Mathura Shresthra (Community Medicine).

The Calgary Medical School also admitted a young Nepalese physician, Dr. Buddha Basnyat, for a two-year masters programme in clinical physiology in order to strengthen the teaching faculty of the IOM.

Calgary House

These crude statistics conceal a hidden world of personal interaction between Nepalese and Canadians. In 1981 a small house was rented to accommodate all visiting Canadians. "Calgary House" not only avoided costly hotel charges but also created a friendly environment which minimized the sense of being a transient. All Canadians were short-term visitors but Calgary House conveyed a sense of institutional permanence. Finding, furnishing and staffing Calgary House in 1981 was a heroic undertaking and a significant accomplishment given our relative penury and total lack of administrative support in Kathmandu. Those who worked to establish Calgary House made a major contribution to the friendship which has grown. For several years project transportation was restricted to cycling and pedestrianism! Vehicles were an unimagined luxury in these early years.

Calgary House, with its bicycles, was the temporary home for many Canadians – not only faculty but also spouses, families and friends of the project. One can speculate that the interaction of Nepalese and Canadian families, rather than merely a formal exchange of faculty, gave the Kathmandu connection a rare dimension of intimacy and informality.

Other Canadians working in Kathmandu gave invaluable informal support to Calgarians. The manager of a CIDA programme, Ms. Connie Swinton, became the trusted friend of all Calgarians in Kathmandu and an inexhaustible source of encouragement and advice. When her nursing campus project was completed she remained in Kathmandu as coordinator of the Calgary programme. She brought with her a Nepalese administrator, Mr. Arjun Dhiwan, a retired Gurkha officer, who has continued to administer the Health Development Programme. She later received the Order of Canada for her services to Nepal.

A surgeon from the Foothills Hospital in Calgary, Dr. Gerald Hankins, and his wife, who had worked in Kathmandu with the United Mission to Nepal since 1973, were another unfailing source of advice and comfort.

International agencies contributed to the growth of the IOM over these early years. The Japanese Government funded the construction and equipping of a new Tribhuvan University Teaching Hospital (TUTH) in Kathmandu. The IOM had been entirely dependent on the cooperation of physicians in government hospitals in Kathmandu for clinical teach-

ing. The IOM was unable to remunerate these teachers and was vulnerable to shifts in loyalty and commitment. The teaching hospital greatly strengthened the IOM's capacity for clinical teaching although the cost of its maintenance puts a heavy financial strain on a tight budget.

Other organizations, including WHO and the United Mission to Nepal, made faculty available to the IOM.

The MBBS Programme throughout the Eighties

The MBBS programme is now well established and is managed by Nepalese faculty. In 1991 the IOM employed 125 medical faculty and could sustain its own teaching programmes. It started with a class of twenty students and is currently raising its annual intake to forty-five. Over its first decade it has produced 154 doctors for the country, and a steady output of forty-five graduates annually will come close to meeting the projected needs of the health ministry.

In 1991, the IOM received an annual budget from the Ministry of Finance of 60 million Nepalese rupees ($150,000). This had to provide for the operation of the central campus, Tribhuvan University Teaching Hospital and eleven other campuses scattered across the country. Tuition fees for the MBBS programme were 400 Nepalese rupees per annum.

Despite several substantial challenges, the IOM has retained much of its original design for the MBBS programme. There have been significant changes in the admission policy and some curricular modifications designed to strengthen the basic sciences. The MBBS curriculum may have lost some of its original uniqueness and vigour and may be gradually merging into the homogeneity of international medical education. The latter stresses the common features of the medical profession rather than the uniqueness of health care in different societies.

The IOM's MBBS programme has already been recognized by the medical councils of Bangladesh and Pakistan. Under the South Asia Association for Regional Cooperation the IOM offers its programmes to the Maldives.

It is not within the scope of this chapter to evaluate the quality of the MBBS graduates. Although the IOM has its local critics, many doctors in Kathmandu in the late eighties claimed that the IOM's graduates were at least as effective as their counterparts from the other medical colleges of the subcontinent. Over 90 percent are still working in Nepal and can contribute to the manpower needs of the MOH.

Nepal's MBBS programme has been recognized both within the region and among the international academic community for the relevance and innovative nature of its approach to medical education. For example, it has been invited to join an international consortium of "Community Based Medical Schools."

The Generalist Programme

The Idea of the "Generalist" in Nepal

In 1981, my attention was drawn to the plight of young Nepalese doctors who were assigned to work in district hospitals as District Medical Officers. Most of these ten- to twenty-five-bed hospitals, especially those located in the middle hills, were isolated and it was impossible to transfer emergency cases to specialists in zonal or regional centres. District medical officers were expected to manage difficult clinical problems in conditions of extreme deprivation. They were the only medical resource for all the health posts within their district. They might be responsible for up to 250,000 people who were scattered throughout an inaccessible terrain and suffered from a high prevalence of preventable mortality and morbidity. Many district hospitals had too few facilities for handling common emergencies and were poorly coordinated with the health posts.

The reasons for this unfortunate situation were complex. Government hospitals were not adequately equipped nor regularly provided with essential supplies; nurses were often unwilling to work in rural areas; and there were rarely more than two doctors at any time in one hospital. The organization of health services tended to keep hospitals and health posts apart. In addition to these administrative obstacles, many young doctors who were posted to these isolated locations were unprepared for this responsibility. Their medical education had failed to provide them with the necessary technical knowledge, skills and appropriate attitudes to work in partnership with the people.

This problem was already well appreciated by health planners in Nepal. The original concept of Nepalese "generalists" dates back to 1974. In that year the MOH constituted a five-person committee to make recommendations for a long-term health plan. When the committee reviewed the needs of the 15- to 25-bed district and 50-bed zonal hospitals, they concluded that traditionally trained hospital specialists were inappropriate for these situations. They advised that these smaller hospitals should be designated as "general service hospitals" and that medical services at this level should be provided by "generalists." Fifty-bed hos-

pitals were at that time staffed by teams of three specialists – a physician, surgeon and gynaecologist. The committee declared that conditions in these hospitals were unsuitable for specialist practice and that the quality of health services was unacceptable.

The committee was aware that other countries were beginning to provide special postgraduate training for general practitioners. They recognized that new medical graduates were unprepared for the heavy responsibilities of staffing small isolated hospitals and recommended that the training of generalists should be incorporated in the 1976 Long Term Health Plan. This document observes that,

> in Nepal there is a greater need for generalists than specialists. Fifteen-, twenty-five-, and fifty-bed hospitals fall into the category of General Service Hospitals. Services will be given by generalists who have been trained in several disciplines. Arrangements for this type of training will be made in Nepal.

Over the next five years the MOH attempted but failed to find training opportunities for Nepalese doctors in general practice overseas. Consequently in 1981 Dean Hemang Dixit, and Dr. Bhisma Prasai on behalf of the IOM convened informal meetings with the MOH to consider how to provide this form of training in Nepal. The director general of health services, Dr. L. Paudyal, confirmed that the ministry intended to staff smaller hospitals with generalists and asked the IOM to prepare a suitable physician training programme.He suggested that the dean might pursue this idea with The University of Calgary. The MOH undertook to recognize formally the new generalists who would be produced.

Origin of the Generalist Programme

These discussions led to the introduction of the "Generalist" programme. Qualified generalists would become Senior District Medical Officers in charge of district hospitals and work in partnership with the MBBS graduates who would serve as Junior District Medical Officers. In this way the MBBS and Generalist programmes would be complementary and become the national source of doctors for rural health services. In order to facilitate planning and implementation, the IOM created its first Postgraduate Education Committee in January, 1982, under the chairmanship of Dr. L.N. Prasad, a senior otorhinolaryngologist.

All the categories, or "faculties," of doctors that were officially recognized by the MOH at that time fell within traditional hospital specialities. The MOH created a new Faculty of Generalists in April, 1984, in order to guarantee the status and career structure of the new generalists

within the government service whereby generalists could progress through the administrative hierarchy. This information was published in the *Nepal Gazette.*

These actions responded to policy statements emanating from the royal palace. Following an extended royal visit to the Mid West Region early in 1984, His Majesty's government issued a series of directives. These included an instruction to the MOH to "emphasise the training of generalist doctors."

The three years were arbitrarily divided equally between Alberta and Nepal. Of the eighteen months in Canada, the first year would be spent in teaching hospitals in Calgary under the supervision of the Department of Family Medicine of The University of Calgary. The last six months would be spent in a rural hospital in Western Canada. Of the eighteen months in Nepal, the first year would be confined to hospitals in Kathmandu. At least three of the remaining six months would be spent under supervision in a district hospital.

The time to be spent in central teaching hospitals was distributed among those clinical disciplines regarded as essential for the new generalists. In Calgary, blocks of two months were assigned to general medicine, surgery, paediatrics, obstetrics and gynaecology, family medicine and anaesthesiology. In Kathmandu the time was divided between medicine, surgery, paediatrics, obstetrics and anaesthesiology.

A new academic qualification was also required. The Department of Advanced Education in Alberta created a new diploma in general medicine specifically for this purpose. Tribhuvan University later awarded an MD degree to successful candidates. These steps were designed to assure the status of the new generalists.

The qualification MD in North America is equivalent to the European bachelor degree or Tribhuvan University's MBBS degree. The requirement of three years in an accredited educational programme determined the duration of training required of generalists. The latter's MD is a postgraduate qualification for an MD degree from Tribhuvan University.

The Generalist Curriculum

The planning committee had identified those competencies required of a senior district medical officer in rural Nepal. They emphasized the ability to manage common medical problems and cope with surgical and obstetrical emergencies. This implied the ability to manage acute and chronic infectious diseases, perform surgical and obstetrical proce-

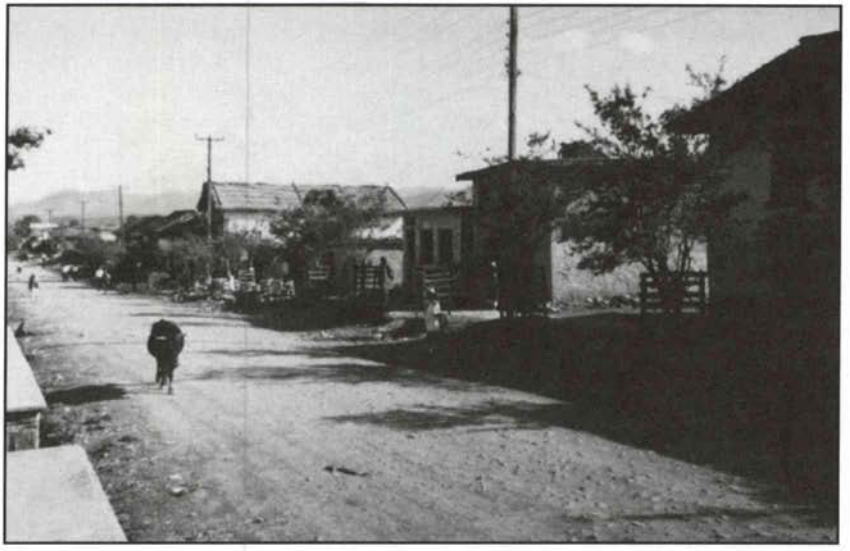
dures, and administer regional and general anaesthesia. The senior district medical officers were also expected to manage their hospital and work effectively with other health personnel in the district. The acquisition of these skills required a broad understanding of many aspects of clinical practice.

The first twelve months in Calgary were designed to serve the following purposes: to strengthen candidates' basic knowledge of clinical practice by interaction with faculty and fellow residents; to promote good doctor-patient relationships; to encourage habits of life-long learning; to prepare candidates for further experience in rural hospitals in Canada; and to offer the attraction of overseas experience. Only after completing this initial year would the provincial College of Physicians and Surgeons permit us to place Nepalese trainees in rural hospitals. During their final six months in Canada we hoped that they would gain first-hand clinical experience. Medico-legal constraints and the pervasive fear of litigation limited the extent to which we could provide hands-on clinical experience in Canada. We assumed that this deficit would be compensated when they returned home.

Back in Nepal they were required to spend twelve months within hospitals in Kathmandu. These could provide a sufficient volume of supervised clinical experience. We hoped that returning generalist trainees would be given appropriate opportunities to master the clinical skills which they would require – for example, to perform a laparotomy or cesarean section, reduce fractures and provide local and regional anaesthesia. Having gained this experience, trainees would work for three to six months in a district hospital where they could apply their clinical skills in a rural setting under supervision.

This plan envisaged a progressive acquisition of clinical understanding, increasing opportunities to gain practical skills and, finally, increased confidence with technical methods that would be appropriate for the rural districts of Nepal. The programme was managed in Kathmandu by Dr. Ramesh Adikhari of the Department of Paediatrics and in Calgary by Dr. Tom Saunders of the Department of Family Medicine.

The Foothills Hospital and the Calgary General Hospital accommodated the Nepalese doctors for their first year of training. Physicians in the communities of Pincher Creek and Camrose in Alberta and Hazelton in British Columbia also accepted these students into their hospitals and clinics. Overseas students are not easily accommodated within a busy practice, and the physicians and members of these communities who welcomed Nepalese students showed considerable generosity. Clinical



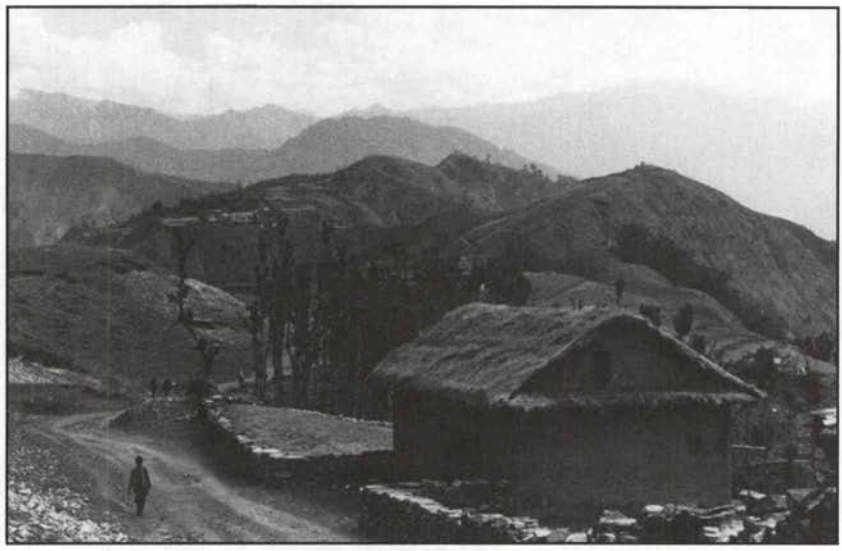
Birendranagar street scene

teaching in Kathmandu was provided within the Teaching Hospital, the Bir Hospital, the Maternity Hospital and the Children's Hospital.

Introduction to Surkhet

The requirement to provide learning experience in a district hospital in Nepal led us to Surkhet. Surkhet is a district located in the middle hills in the Mid West Region, about 500 km by road from Kathmandu. There was no year-round open road connection from the south until 1988, and Surkhet remained isolated, apart from air links. When the Bheri River ran high during the monsoon months, travellers between the Terai and the Surkhet valley faced a short but challenging crossing by ferry or dug-out canoe.

The hospital is situated in Birendranagar, the district centre. This town lies in a small fertile valley separated from the Terai by the Mahabharat range and rises in the north to the high Himalayas. The silence of the valley is broken only by the rhythmic clacking of rice mills and the cry of birds. A Ganesh temple overlooks the scene from a hillock beyond the river which threads through the town. For most of the eighties vehicles were a rarity in the town and the main street was used mainly by pedestrians and an occasional buffalo cart. Life proceeded at a walking pace. Chickens, goats, pigs and cows were free to roam in safety. How-



Surkhet valley

ever, since the road to the Terai was opened and some regional offices were moved from the Terai to Surkhet, traffic has increased and land values have soared. Beyond the valley, the remainder of the district remains inaccessible and lacking in most basic services.

Before the mid-sixties the Surkhet valley was mosquito-ridden and feared by local villagers because of the high risk of malaria. It remained uninhabited; villagers descended into the valley to farm by day and returned to the safety of the hills in the evening. Since the mosquito population was controlled by DDT, people have flooded in from adjacent districts. The Surkhet valley presents a challenge for community organizers since the villagers are recent incomers and have not yet achieved a sense of social cohesion.

CIDA has concentrated its assistance to Nepal on the Mid West Region and centred its efforts in Surkhet district. It operated a large-scale integrated rural development programme in Surkhet. Birendranagar was also the location of one of CIDA's campuses for the training of Auxiliary Health Workers and housing had been constructed to accommodate Nepalese staff. In addition to this Canadian presence, a maternal and child health programme, operated by the Save the Children Fund (UK), a tuberculosis control project, operated by the International Nepal Fellowship; an occasional American Peace Corps volunteer; and a community development pro-

gramme of the United Mission to Nepal were based in Surkhet district. These projects created a small expatriate presence in Surkhet.

The hospital had twenty-two beds, a small operating room and an obstetric delivery area. The basic facilities were in poor condition and the surgical and obstetric areas could not be used because of a lack of essential equipment and supplies. It was necessary to upgrade the basic facilities – sanitation, water supply, lighting, decoration and the provision of essential surgical equipment. A solar heating system was installed to provide warm water.

The subsequent fate of the Generalist Programme is outlined in the following account of the Health Development Programme.

The Health Development Programme

Origins

The Health Development Programme (HDP) was the logical extension of the MBBS and Generalist Programmes. It focused on the health needs of villagers in rural districts as its goal and recognized that the promotion of medical education is simply one means to that end. It was designed to enable the IOM to take over the training of generalists. Since doctors are only one element within the district health care delivery system it offered support to all health personnel. More fundamentally, it recognized the role that people can play in their own healing and proposed to foster community-based health initiatives. A quantum leap between the Generalist Programme and the HDP came in a more mature understanding of the holistic nature of healing and the limited role of health professionals in the process. The significance of the HDP is that it had the courage to attempt to translate this rhetoric into action.

The long-term goal of the HDP is "to assist the Government of Nepal (HMG/N) to improve its capacity to contribute to improvements in the quality of life of the rural poor in Nepal." Its immediate purposes are "to improve the health care delivery system in rural Nepal, focusing on Surkhet District; to enhance the capacity of HMG/N's institutions to provide health care more efficiently; and to design a rational model for a self-reliant, community-based health care delivery system in Nepal."

The HDP was based on ongoing partnering between the IOM and The University of Calgary. As with the Generalist Programme, the HDP included the MOH as an informal but essential partner. We intended to work together to establish a system in Surkhet District which would be replicable in the other hill districts of Nepal. Such a programme would

have to be sustainable within the resources available to the government of Nepal and within the communities themselves.

CIDA allocated a project budget of $4.67 million over the five-year period, 1987 to 1992. This was soon extended to 1993. By this new agreement The University of Calgary could access the resources of CIDA's bilateral country programmes rather than the more limited funding capacity of CIDA's Institutional Cooperation and Development Services (ICDS) which had supported our earlier activities. This allowed us to strengthen project administration in both Kathmandu and Calgary, locate four Canadians in Nepal on a long-term basis and extend support to the villages. A project office was created within the IOM with Dr. Bhisma Prasai as project coordinator and Mr. Arjun Dhiwan as administrator. Ms. Gloria Eslinger administered the HDP within the Division of International Development (DID), and I continued to coordinate the programme in Calgary.

Four faculty were recruited for initial two-year terms. Ms. Jean Garsonin, a community health nurse who had already worked in Ecuador, agreed to assist in the community work in Surkhet. Dr. Brian Cornelson, a family physician from Winnipeg, undertook to supervise generalist training in Surkhet. Both Jean Garsonin and Brian Cornelson were based in Surkhet. Dr. Stuart Harris, a family physician who has trained in international health, assisted with generalist training in Kathmandu. Dr. Sloane Dugan, a member of the Faculty of Management in Calgary who had previously worked in Nepal, assisted Dr. Prasai in managing the project and in strengthening the management of health services in Surkhet. Both Stuart Harris and Sloane Dugan were based in Kathmandu.

Although the funding and the agreement between Tribhuvan University and The University of Calgary were in place by August, 1987, the definitive memorandum of understanding, which required the formal approval of the MOH, was not signed until March, 1988. The work of the HDP team was stalled and the programme was fully active for less than two years during the decade under review.

As we approached the fifth year of the Generalist Programme it became necessary to rethink the conceptual and operational strategy of generalist training and the role of health professionals. Experience had shown that healing is intimately connected to developing and that health is the outcome of the social, economic and political conditions in which people live. It followed that "health" cannot be dissociated from other elements of developing. The hybrid expression "health development" was coined to capture this idea.

There were, therefore, two interdependent elements in the HDP. One concentrated on the support of formal health-care delivery systems. It

involved the training of health professionals who would contribute to health-care delivery at district level. This included not only the continuation of the Generalist Programme but also the support of district health management and health-post staff. The second focused on "community based participatory health development." This refers to the empowerment of village people to assume greater control over their own quality of life, of which health is only one aspect. The essence of the HDP was the attempt to bring these two elements into a synergistic relationship. The diverse activities which surrounded each of these two components incurred their own formidable problems. However, arguably the greatest challenge for the HDP was the commitment to bridge the gap between these two approaches to the healing of communities.

For purposes of description it is convenient to refer to each of these two elements separately.

The District Health Care Delivery System

In Surkhet, this system consisted of several elements – a district hospital staffed by one or more district medical officers, nurses and support staff; a Regional Health Director and his office; a District Public Health Officer and his office; nine health posts staffed by paramedical staff; and a network of village health volunteers. In addition to this formal health-care system there were others who offered informal health care. These included Ayurvedic practitioners, traditional birth attendants and healers, and pharmacists who dispense medicines.

Although HDP had the mandate to assist the Regional Health Director and the District Public Health Officer to strengthen their work in Surkhet district, preoccupation with the problems of generalist training distracted our attention temporarily from the other elements of the district health-care delivery system. Health surveys, needs assessment of health staff and subsequent in-service training were completed. Yet, progress was slow because of periods of political instability.

Expatriation of the Generalist Programme

A critical review of the Generalist Programme had been pursued synchronously in both Kathmandu and Calgary. In May, 1986, the third dean of the IOM, Dr. Gopal Acharya, constituted a special review committee. It included the Director General of Health Services together with senior members of the IOM, and it met on six occasions. Its mandate was to advise on the content and structure of the training programme and the future of generalists in Nepal. This committee recommended that the

duration of the programme should be reduced to two years and that the practice of combining training in Canada and Nepal should continue through to the end of 1990 when it should be repatriated entirely to Nepal. Parallel discussions in Canada led to agreement about a reduction in the duration of training. However, Calgarians recommended that the programme should be repatriated at the end of the initial five-year period as originally planned. Any difference of opinion about the timing of repatriation was resolved by the financial necessity to discontinue overseas training after 1987. Tribhuvan University's requirement of three years training as a prerequisite for an MD degree precluded a reduction of the programme to two years.

By the time the HDP management plan was completed in 1987 the decision had been taken to continue generalist training in Nepal. Details about the structure and content of training would be determined by consultation between the MOH and IOM. This same process of consultation would clarify such issues as recruitment policies, numbers to be trained, use of zonal and district hospitals for training and future career prospects for graduates from the programme. These consultations were protracted and inconclusive. By the end of 1989 this failure to define firm policies and to take essential actions was the source of keen disappointment.

Generalist Training in Nepal, 1982-89: A Review

In this section, I record our experience of generalist training, including both the original Generalist Programme and its subsequent incorporation within the HDP.

Students were recruited primarily by secondment from the MOH. Officials were expected to select candidates who had some experience of work in a rural hospital and had the capacity to benefit from postgraduate education. Other candidates could be seconded from the IOM. In practice, the MOH could exert little control over the doctors in its service; policies for selecting candidates for postgraduate training were not based on merit; older doctors were hesitant to accept training which was intended to return them to the rural areas; and little was known about the role and status of a generalist. As a result, recruitment proved to be difficult and an obstacle to orderly planning.

Our early projections had assumed an annual intake of four students for a period of three years' training. According to these expectations we should have recruited a total of thirty students and graduated twenty generalists by the end of the decade. In the event, we recruited only eleven

trainees and eight completed their training. Three withdrew for personal reasons and transferred to other disciplines. Of those who completed their training one failed to pass the qualifying examination and one left the country without sitting the examination. The remaining six gained an MD degree from Tribhuvan University and are currently employed by either the MOH or the IOM.[3] Since the end of the 1980s, six others have obtained an MD in General Practice and fourteen are still in training.

Of the many problems encountered by the Generalist Programme, some were of a general nature; some were specific to the logistics of training generalists; some stemmed from the ambiguity of the concept of "generalist"; and others were peculiar to conditions in Nepal. They are outlined below:

1. The non-specific problems included those of misunderstanding and miscommunication. We had to contend with exchanging information over wide distances and across cultures. Until 1987 we worked with minimal resources and without the benefit of fax machines or reliable telephone connections. Our financial situation was often precarious. Until the Health Development Programme was funded, project administration in both Calgary and Kathmandu was conducted on a voluntary basis by colleagues who already had busy full-time jobs. One of the challenges of leadership was to generate and maintain a high level of enthusiasm and resilience among the friends of the Kathmandu connection.

We relearned the painful limitations of offering training in an alien culture and at a remote distance from the security of family and home. The decision to bring young Nepalese doctors to Canada for training has been roundly, and perhaps rightly, criticized. However, in 1982 our options were severely limited. Tribhuvan University Teaching Hospital had not yet been constructed and the IOM relied on consultants in government hospitals in Kathmandu for clinical training. Past experience suggested that they could not cope with the additional load of generalist trainees. We also assumed, perhaps arrogantly, that the opportunity to gain experience in Canada would broaden the vision of trainees and would be an incentive for entrants. Given this decision, we were obliged to retain Nepalese trainees within the Calgary teaching hospitals for one year before the provincial College of Physicians and Surgeons would allow them to be assigned to rural hospitals.

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3 Drs. Ram Devi Shah, Sitendra Gupta, Manohar Gupta, Basanta Pant Amar Pradhan, Altaf Hussein.

2. The operational challenges of training generalists were almost insuperable. It is notoriously difficult to provide training for general practitioners or family physicians within hospitals in either Europe or North America. There has been a deeply engrained lack of respect and understanding between hospital specialists and community-based doctors. It remains a challenge to offer future generalist trainees a relevant experience within hospitals dominated by specialists. This problem, which still applies to Canadian family practice residents were multiplied when the generalist trainees were from overseas. Despite mutual goodwill and tolerance these logistic and attitudinal problems were not fully resolved by 1987, and the difficulty of accommodation was equally troublesome in Kathmandu and Calgary.

The supervision of trainees in Surkhet presented a challenge which was never overcome. Ideally there should have been two preceptors, one Nepalese and one Canadian. However, since we were creating a new category of clinician there were no existing role models in Nepal. Until the HDP was introduced we were unsuccessful in providing long-term Canadians to work in Surkhet and had to rely on a discontinuous series of short-term preceptors. Nevertheless, we were fortunate to be able to attract a number of excellent Canadian preceptors who worked effectively in difficult circumstances.[4] The HDP later enabled us to locate Dr. Brian Cornelson in Surkhet. The preceptors all worked in cooperation with the medical officers who were assigned by the MOH to Surkhet. The inability of the MOH to staff the Surkhet hospital with an appropriate senior district medical officer who could ensure continuity of supervision was a major handicap. Consequently, we could rarely rely on Surkhet as a rural training centre.

Uncertainty about the future of generalists in Nepal was particularly unsettling. Despite the explicit assurance of the MOH, young Nepalese doctors remained suspicious of the future career opportunities for generalists. Given the muttered questioning of some of their senior colleagues and the total absence of a role model in Nepal, their reservations were understandable.

When generalist (Family Medicine) programmes were introduced in Canada in the 1960s, they encountered similar problems. It took at least twenty years before these programmes became well established and attracted good candidates. It would have been surprising if the experience in Nepal had been different.

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4 Drs. Steven Bezruchka, Bill Hall, Clare Forestell, Brian Cornelsen.

3. The third category of problems relates to the concept of a "generalist" and its confusion with "general practitioner." During its planning debate in the seventies, the MOH wisely identified the need to replace traditional specialists by "generalists." It was clear that these generalists were required to operate district hospitals and provide for most of the health needs of a rural population. They required a formidable range of surgical, obstetrical, anaesthetic and other medical skills. Their role was roughly equivalent to that of a doctor who works in an isolated hospital in the Canadian Arctic, with the added complications that the prevalence of serious illness is higher, the prospect of evacuation of patients is even more remote and the resources available within the hospital are more limited. This role bears little resemblance to that of a modern general practitioner in either Europe or North America.

The MOH, however, fell into the trap of equating generalist with general practitioner. Their efforts to find training opportunities for generalists overseas were unsuccessful, and, given the confusion of terms, this is perhaps fortunate.

Our plans for training Nepalese generalists in Canada avoided some of these pitfalls. We devised a modification of a "rotating internship," a form of training which has virtually disappeared from Canada. The design of generalist training in Canada was appropriate in concept, if less than ideal in execution. Nevertheless, Canadians confused the Nepalese form of generalist with general practitioners. This resulted in a serious distortion of the direction of generalist training in Nepal. I will return to this issue in the following chapter.

4. The final set of problems derived from our decision to work through the MOH rather than as a non-governmental organization. The Kathmandu connection has been a process of partnering between Tribhuvan University and The University of Calgary. However, although formal agreements were established between these two academic institutions, the MOH was also an essential informal partner. The IOM/University of Calgary team acted in support of the health policies of the government of Nepal and did not try to function independently as non-governmental organizations. Although the partnership was legally between non-governmental institutions, the programme was deliberately dependent on government collaboration. Notwithstanding the principle that the most effective way to exert a lasting influence on health services and outcomes is by participating constructively within the official system, this strategy imposed severe restraints and delays.

The IOM/University of Calgary team regarded itself as acting strictly on behalf of the MOH. It agreed to create a new postgraduate education programme at ministerial request. This experimental programme was introduced in order to provide a new cadre of generalist doctors who were now required by the MOH to serve in government hospitals. The Generalist Programme was a response to the government's own perceived needs and not our own initiative. This was fundamental, yet uncertainties about this assumption plagued the programme over the years.

The MOH has not demonstrated a capacity to implement its own policies or to exert control over its personnel. It may assign staff to specific locations but is unable to enforce these assignments. Several hospitals are nominally "staffed" although they remain "unmanned" – that is, there is no doctor on site. This weakness lay at the heart of the failure to appoint an appropriate senior district medical officer to Surkhet. It also confounded attempts to recruit entrants to the generalist programme.

Despite these setbacks, it would be unwise to fail to recognize the progress which was made – although progress may have to be measured in terms of its future potential. The ingredients for an innovative and realistic approach to generalist training are in place. Four graduates from the Generalist Programme have been recruited by the IOM to constitute a department of general practice. This step is essential if the IOM is to be able to train generalists as senior district medical officers for the MOH. It will be crucial to ensure that this department is oriented towards producing generalists who will work in rural districts rather than creating conventional general practitioners for lucrative practice in Kathmandu or larger towns in the Terai.

This is no mean achievement. The Generalist Programme is the first of its kind to be attempted in the Indian subcontinent and, indeed, in Southeast Asia. It has attracted attention and the IOM has hosted a regional conference on the training of generalists in the region.

The Generalist Programme addresses one of the major issues which confront health planners throughout the region. It recognizes that rural hospitals need competent doctors; it has identified the competencies which are required; it has devised an appropriate curriculum; it has created a core of teaching faculty; and it can mobilize Surkhet as a site for rural training. The HDP has also recognized the importance of linking health professionals with the communities which they serve. It is difficult to conceive of any alternative solution to the problem of providing appropriate clinical care for the districts of Nepal.

The shortcomings of this programme stem from weaknesses in implementation and the fact that professional training cannot survive in isolation. We have already described the weaknesses in the operation of generalist training. More fundamentally, the MOH was ill-prepared to utilize generalists within its services. But to dismiss the MOH as simply obstructive or incompetent would be an arrogant disservice and fail to recognize the magnitude of the task which it faced.

It is foolhardy to train a new breed of health professionals and assume that their services will be automatically welcomed and fully utilized. It took many years before nurse practitioners who were trained in Ontario were integrated into that health-care system. Despite the massive resources available to health planners in Ontario, it took considerable time and effort to induce the necessary changes in attitude and practice.

The decision to train generalists in Nepal may have been taken too lightly and without full appreciation of these realities. We underestimated the inertia within bureaucratic and professional systems. Some will contend that the Generalist Programme was implemented prematurely or too precipitously. Others will insist that it was well timed but requires and deserves more time and patience to become accommodated within the health-care system. The Generalist Programme represents much more than the introduction of yet another postgraduate education programme. On the contrary, it was a brave effort to redirect energies and resources within a national health-care system.

We experienced little difficulty in introducing postgraduate programmes in anaesthesiology or obstetrics. These followed accepted norms and did not threaten the conventional role or status of doctors. From this perspective, we should be neither surprised nor disillusioned at the slow rate of progress. A wiser head would recognize the potential within the first tentative steps which have been taken. Generalist training should and can succeed in Nepal within the wider framework of health development policies provided, that it is given enough time and encouragement to evolve.

Participatory Health Development

The expression "participatory health development" is intended to convey two ideas which are fundamental to the work of the HDP:

1. **Healing and developing are indissoluble.** It is arbitrary and destructive to attempt to extract a package of "health" activities from the

more comprehensive content of socio-economic developing. This principle carries the corollary that the pursuit of improvements in health is fundamentally intersectoral. It also follows that the promotion of health is not the exclusive prerogative of health professionals.

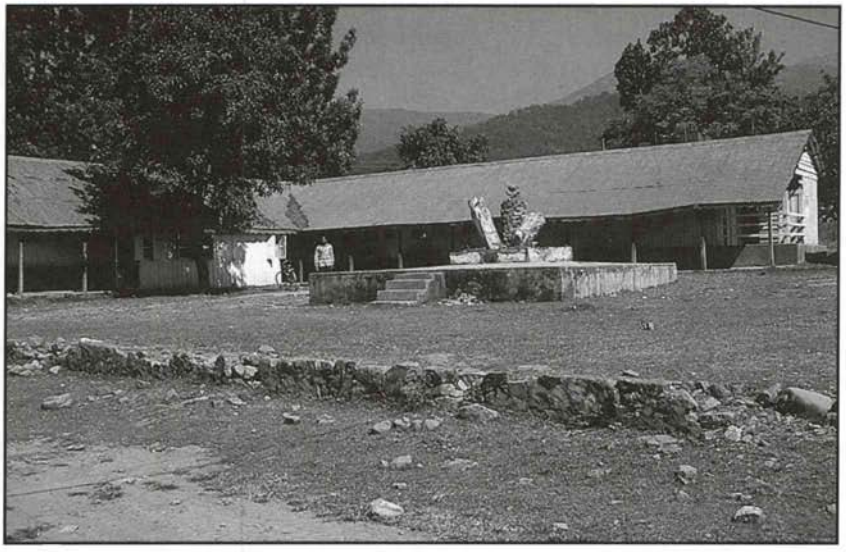
2. **Participatory developing is centred within communities**. Community participation implies that people are given greater control over their own developing processes. Community-based participatory health developing focuses on people making decisions about their own quality of life.

Introduction to Mehlkuna

The location of our efforts in participatory health development was Surkhet district. It is home for approximately 250,000 people distributed among fifty-one panchayats. It was decided to start the community programme in the panchayat of Mehlkuna which has a population of 7,000 people living in nine wards. Mehlkuna is reasonably accessible by road and track and is the site of a well-constructed health post. It was settled recently after the control of malaria encouraged hill people to come down into the valley to secure better land. Nevertheless, only fifteen percent of the people of Mehlkuna produce enough food to feed themselves throughout the year. This panchayat is particularly politicized and has taken an active and sometimes confrontational role in district affairs.

Work started in the spring of 1988 under the combined leadership of Mr. Padam Lal Devkota, a local anthropologist and community development worker, and Ms. Jean Garsonin, a Canadian community health nurse. Devkota lives in the Surkhet valley, farming a small holding on the western outskirts of Birendranagar. He is also a graduate of Tribhuvan University and holds a masters degree in anthropology from India. He is thus uniquely well qualified to guide the processes of community development among his own people. The participatory process which was followed in Surkhet was largely determined by Devkota's understanding of the possibilities of empowering local villagers. DID's later participation in health development in other countries was greatly influenced by the ideas which Devkota applied in western Nepal. This observation documents the opportunities for learning which Canadians enjoyed in Nepal. Jean Garsonin brought to the Asian context her experience of community health in Latin America.

This work progressed remarkably well, in accordance with the following strategy:



Mehlkuna health post

1. After a great deal of informal discussion over a period of several months of reflection and debate, the village people formed small ward committees.

2. These ward organizations were encouraged to identify their main areas of concern. Out of this discussion four priorities emerged – water for irrigation and drinking, road access, school buildings and health, in that order. These four priorities are interrelated and some other issues are implied – for example, the ability to generate income. These concerns have the inestimable merit that they represented the priorities of the people.

3. Working groups were formed to address these issues. These included a health group, an agriculture group, a forestry group and a women's group. Each of these collaborated on common issues although they also pursued special interests.

4. The health group carried out its own health survey using a questionnaire which they themselves designed. Although this instrument would not satisfy epidemiologists it had the unique value that it obtained information which the people owned and used for their own decision-making. This group also investigated the availability of loans from the Small Farmers' Bank to purchase seeds and fertilizers. They also

Surkhet District Hospital

sought ways to make their health post more accessible and responsive to their needs.

5. The women's group tackled the production of improved smokeless stoves, or *chulos*, for domestic cooking. They wished to reduce the health hazards of exposure to smoke and to conserve limited supplies of firewood. They found ways of constructing stoves from local materials. They also secured legal advice on the status of women.

6. Other groups took up the challenge of constructing schools. They built two premises and will soon complete a third.

7. All groups worked together on matters of common concern. They raised 35,000 Nepalese rupees towards an irrigation system and dug three water cisterns. Their pressure may also have contributed to the allocation of money from the district authorities to improve the local road. These groups also generated their own community fund which amounted to 30,000 Nepalese rupees.

8. Each of these interest groups sent representatives to a central coordinating committee which attempted to develop a unified set of policies.

9. Committee members were trained in advocacy methods, including the use of simple video equipment. They used this technique to promote their ideas with district officials.

10. The people of Mehlkuna undertook to exchange their experiences with the neighbouring panchayat of Sahare. This adjacent community has already adopted its own version of community-centred developing.

11. A second strategic community in a distant part of the district was selected for training in a similar process of participatory developing.

Over a brief period of less than two years, the participatory health developing element of the HDP has exceeded our original expectations. We had underestimated the readiness and ability of villagers to assume greater responsibility for their own lives.

It is too early to enter into the process of bridging the gap between the villagers' initiatives and the centrally planned health-care delivery system. However, if Surkhet District Hospital can function as a training site for generalists this process can begin without further delay. Given encouragement by the offices of the Regional Health Director and the District Public Health officer, Surkhet could become an important laboratory for creating a health-care delivery system that will be responsive to community needs.

The Anaesthesiology (DA) Programme

The MOH drew my attention to the acute shortage of anaesthesiologists in Nepal. A 1982 WHO Health Manpower Survey had shown that there were only seven trained anaesthesiologists in Nepal and all were based in two hospitals in Kathmandu. This posed a major obstacle to the provision of surgical services. With the experience of the Generalist Programme in mind, we debated how the IOM and The University of Calgary might collaborate with the MOH to train anaesthesiologists for Nepal.

There is ample evidence that postgraduate education of Nepalese trainees in Europe and North America has severe limitations. It tends to provide experience in technical methods that are not applicable to Nepal; it encourages dependence on support services which are not available; it requires Nepalese students to adapt to a foreign environment; and some trainees do not return to their own country if they obtain an internationally marketable overseas qualification. We had become acutely aware of all these problems with the Generalist Programme. Furthermore, the cost of overseas training was prohibitively expensive as we could not secure additional money for a new postgraduate programme.

We agreed that training should be provided in Nepal with its base in Tribhuvan University Teaching Hospital and with access to three other major hospitals in Kathmandu. The duration of training would be one

year. This would be followed by an examination to be conducted by the IOM and successful candidates would receive a Diploma in Anaesthesiology, or DA, from Tribhuvan University. Trainees could be nominated by either the MOH or IOM or could apply independently if not employed by either.

The new diploma programme started in January, 1985. Professor Roshana Amatya, who was designated head of the department of anaesthesiology in the IOM in August, 1985, directed the programme in Kathmandu. Dr. Roger Maltby, of the department of anaesthesia at The University of Calgary, accepted responsibility for coordinating the programme in Calgary.

Over the following five years a series of senior academic anaesthesiologists from across Canada spent periods ranging from three to twelve months to assist in the development of teaching, administration and research. Five department heads and other senior faculty from McGill University and the Universities of Western Ontario, Toronto, Alberta and Manitoba made this programme possible.[5] Some have served on more than one occasion. Dr. Tom McCaughey has spent a total of two years in Kathmandu in support of this programme. Nepalese anaesthesiologists have been entirely responsible for supervising clinical training. While Canadian preceptors initially organized and provided many of the systematic lectures, Nepalese faculty soon took over most of the didactic teaching.

Over the five-year period, 1986 to 1990, nineteen students were admitted to the diploma programme. With one exception all passed their diplomate examination at the first attempt and the other candidate passed on a second opportunity. External examiners from India, England and Canada have been consistently impressed by the high standards attained. The diploma programme produced nineteen anaesthesiologists for the MOH. Ten of these graduates are currently working in zonal hospitals, seven are employed in Kathmandu and two are taking further training in the United Kingdom. Other anaesthesiologists have returned to Nepal after completing training in India, Bangladesh and the United Kingdom. In 1992, there were thirty-four anaesthesiologists in the country, exceeding the original target set by WHO. A recent follow-up survey of anaesthesiology services has demonstrated that the DA graduates are

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5 Drs. Mary Ellen Cooke, Toronto; Tom McCaughey, Aylmer, Quebec; George Mooney, Edmonton; John Sandison, Montreal; Wolf Sporel, London; Arnold Tweed, Winnipeg.

providing a welcome service throughout the country. The DA programme continues to accept four candidates annually. The programme is firmly under the control of the IOM; Canadians ceased to provide technical assistance in 1994.

The DA programme is regarded by the MOH and IOM as an outstanding success. The reasons for this outcome include the fact that this programme was conceived and implemented in Nepal; it meets a well defined need; Dr. Maltby drew on clinical and administrative expertise from across Canada; the Canadian preceptors were all senior faculty and well respected by their Nepalese colleagues; and the programme was managed in a spirit of mutual understanding and respect.

We did not request any additional funds to support this new venture. It was simply incorporated within the existing Generalist and, later, the HDP budgets. This was done informally but with the tacit approval of the funding agencies. The costs were minimal, as the only expenditures have been for return economy air fares for Canadian anaesthesiologists and their spouses and a modest per diem. The total direct cost of this entire programme was approximately $150,000 spread over a five-year period.

The Obstetrics (DGO) Programme

The Alma Ata Declaration of 1973 proclaimed the goal of "Health For All by the Year 2000." Two of the major practical outcomes of this commitment were a greater emphasis on primary health care and a greater awareness of the significance of maternal and child health (MCH). Many countries pursued this new goal by evaluating the current status of the health of mothers and children in terms of conventional mortality and morbidity indices. In Nepal a maternal mortality survey in 1976 revealed that 850 out of 100,000 mothers died as a direct consequence of childbirth. This rate is open to underestimating because of incomplete reporting of maternal deaths in remote districts. The corresponding rate in Canada at that time was approximately two maternal deaths per 100,000 births.

The hazards of childbearing are complex in origin and cannot be reduced dramatically by any single intervention. However, one valuable ingredient in any programme designed to combat maternal mortality is the availability of trained obstetricians who can deal with complicated emergencies and can assist in training other categories of MCH workers. At that time there were approximately twenty obstetricians for a population of sixteen million people and all worked in the Kathmandu valley.

As early as the mid-seventies the need for more trained obstetricians was recognized. In 1981, the IOM expressed its intention in principle to train these specialists in Nepal. By 1985 the IOM had both the determination and the capacity to train specialists in anaesthesiology in Nepal. The combination of this perceived need for more obstetricians and the encouragement given by the success of the DA programme spurred the creation of a new programme directed towards the needs of mothers and children. This step was taken at the request of the MOH and with the support in principle of the WHO office in Kathmandu.

Dr. Dibya Shree Malla, then Superintendent of the Maternity Hospital in Kathmandu, took the initiative in drafting these ideas. Dr. Malla, a graduate of Lady Harding Medical College in New Delhi, and a British-trained obstetrician and gynaecologist, has been elected a Fellow of the Royal College of Obstetricians and Gynaecologists. She sets herself the highest standards and expects others to follow her example. The success of this programme owes everything to her determination and dedication.

Dr. Malla spent six weeks in Calgary in the summer of 1985 to draft a curriculum and broad logistic guidelines for a one-year programme leading to a new qualification, the Diploma in Gynaecology and Obstetrics (DGO), which would be awarded by Tribhuvan University. All training would be provided in Nepal and would focus on national priorities. Candidates would be physicians recruited from the MOH or others who fulfilled the admission criteria and they would be selected by examination. The goal was to train twenty obstetricians within the four-year period, 1986 to 1990. These ideas were clearly influenced by the experience of the DA programme.

However, the DGO programme introduced several progressive innovations. It would be operated entirely by Nepalese faculty; it would include one month training in a zonal or regional hospital; and it would require all successful recruits to sign an undertaking to work for at least two years in a designated hospital outside the Kathmandu Valley.

These proposals were approved rapidly by both Tribhuvan University and the MOH. A Calgary-based NGO, Childreach, provided seed funding pending the availability of more substantial funds from WHO. Dr. Dibya Shree Malla was appointed programme director and a small working committee was constituted.

The DGO programme started in 1986. By March, 1990, nineteen new obstetricians had received the new DGO qualification and all had been posted to referral hospitals outside the Kathmandu valley. The pro-

gramme has become established as a regular part of the IOM's postgraduate education programme.

The total cost of the DGO programme up until March, 1990, was approximately 575,000 Nepalese rupees ($25,000). The Nepalese teaching faculty did not receive any reimbursement for their work on behalf of this programme. It is too soon to assess the impact of the new DGO specialists in their areas but steps are being taken to measure this outcome.

The DGO programme was conceived, planned and implemented entirely by Nepalese faculty and was designed specifically for the unique circumstances of Nepal. The University of Calgary assisted in three ways. The DA programme, in which Canadians played a critical role, showed that the IOM had the capacity to operate postgraduate training in Nepal; Canadians helped to design the curriculum; and the initial NGO support from Calgary was invaluable in bridging the financial gap pending the availability of WHO funds.

Research Collaboration

We have made considerable progress in collaborating in clinical research. The keys to this initiative have been threefold. The chairman of the department of microbiology and infectious diseases at The University of Calgary, Dr. Larry Bryan, was fully committed to this cooperation. He spent some time in both Kathmandu and Surkhet. Dr. May Ho, a Calgary faculty member, was located in a research laboratory at Mahidol University in Bangkok. This gave her the opportunity to travel between Thailand and Nepal and ensure communication between the IOM and her faculty. The readiness of IOM colleagues to share research interests was equally crucial. The third and fourth deans of the IOM, Dr. Gopal Acharya and Dr. Madan Upadyay, had strong research interests and worked closely with Dr. Ho. Initial progress was slow and the determining elements in the eventual success were undoubtedly the enthusiasm and presence of Dr. Ho, the unequivocal support of her department head in Calgary and the reciprocal interests of senior IOM faculty. This experience strengthens the conviction that essential conditions for successful partnering include the quality of interpersonal relationships and the potential for mutual benefit.

Several studies have been completed on the use of antibiotics in typhoid fever. They have been published and are now being extended. The University of Calgary assisted the IOM in a study of fungal infections of the eye by offering technical training to key laboratory personnel. The results of this basic research are now being applied to the

prevention of blindness following eye injuries. A major comprehensive study of acute respiratory infection in children is under way. IDRC has contributed over $250,000 to the IOM for this purpose. Operation Eyesight International, a Calgary-based NGO, has provided funds for eye research. Other faculty members have joined in the collaboration and one Canadian medical resident has been able to gain clinical experience in Nepal.

A major effort was made to initiate collaboration in research in the social sciences. The work of the HDP in Surkhet provided opportunities to study the use of quality of life indicators to monitor the impact of the work in community development. An ambitious cooperative research programme which would have brought together various disciplines in both Tribhuvan University and The University of Calgary was prepared and submitted for funding to IDRC. This proposal was approved with enthusiasm and generous long-term funding was made available. Despite strong support from the IOM this proposal was eventually rejected by a high-level cabinet committee in Kathmandu for reasons which remain obscure.

The Engineering Education Programme

As early as the spring of 1986 I entered into discussions about the feasibility of assisting in engineering education in Nepal. The World Bank had been considering the status of the Institute of Engineering (IOE) for several years, and an abortive attempt had already been made to agree on an acceptable plan to enhance its infrastructure and education programmes. By 1986 the problem remained unsolved. The World Bank discussed this situation with the Association of Universities and Colleges of Canada (AUCC). The latter was aware of The University of Calgary's work in Nepal and invited DID to explore with our colleagues in Tribhuvan University ways by which Canadian universities could be of assistance in the field of engineering education.

The scope of work to be undertaken exceeded the capacity of one campus. It would require the support of a consortium of Canadian universities if we were to provide sufficient resources. In 1987 Professor Peter Vermuelen, a member of the Faculty of Engineering of The University of Calgary, visited Kathmandu to explore needs and opportunities. He joined a consortium team, Educansult, to study and recommend on engineering education in Nepal. This step was taken with the full support of the dean of the faculty of engineering in Calgary. The IOE had already determined its needs and had agreed with the World Bank on the type of resources required. In broad terms, the World Bank would

fund the construction of new infrastructure for the IOE and the Swiss government would accept responsibility for establishing training programmes at technician level. It was proposed that CIDA should support graduate-level education in several disciplines – civil engineering, mechanical engineering, electrical engineering, electronic engineering, architecture and rural planning.

Over the period 1987 to 1989, the IOE and The University of Calgary worked out a plan whereby the latter would establish and lead a consortium of four Canadian universities – the Universities of British Columbia, Saskatchewan, Manitoba and Calgary. This consortium would provide training programmes for support staff, postgraduate education opportunities at both masters and doctoral level for future IOE faculty, professional advice on curricular and laboratory design and consultation on institute administration.

CIDA assigned a budget of five million dollars over the six-year period, 1989 to 1995. The programme was initiated on schedule in the summer of 1989. Professor Gunnar Berg, an emeritus professor in the faculty of engineering at The University of Calgary, had led the planning process and became Canadian project manager. Mr. Pramod Shresthra, of the IOE, became coordinator of the entire engineering education project in Nepal.

This project is in its early stages and it is too soon to judge its progress. However, some significant trends are already apparent. The Canadian consortium has become a cohesive and efficient management organization. This experience gives confidence in the potential of academic consortia for undertaking this scale of responsibility. It has taken little time to establish a relationship of trust between the IOE and the Consortium. This new partnership with the IOE has been able to build on the strong links with Tribhuvan University which had been mediated through the IOM. Compromises have been required in both Kathmandu and Canada. Tribhuvan University has had to modify its selection practices in order to make available an appropriate group of future faculty for overseas training. The Canadian universities have had to adapt their programme criteria to meet the needs of Nepal. CIDA and the Canadian government are making policy changes to accommodate the legitimate needs of Nepalese families who must accompany their spouses overseas. The fact that substantial changes have been made quickly and relatively painlessly is a testimony to the adaptability of the partnership.

The ultimate success or failure of this project will be influenced by internal factors, some of which are under the control of the partner insti-

tutions. Equally critical will be those macro-economic, political and socio-cultural determinants which are beyond the control of the project.

Update

More than five years have passed since the end of the decade in which this narrative is set. Those years have witnessed a succession of political upheavals in Nepal. In the national election which followed the popular revolution of 1990 the Nepal Congress party rose to power. Public expectations of rapid economic growth and more efficient government were not fulfilled. Within a short time the Congress party was defeated in a national election and was replaced in November, 1994, by a minority Communist government. In its turn, this administration recently lost a vote of confidence in the national assembly and Nepal faced the prospect of returning to the polls yet again. However, in keeping with the new constitution, the king has invited the Congress party to form a new government without recourse to elections.

The economy remains stagnant and the quality of life has not improved for the Nepalese people. Rising costs of living, increasing unemployment and underemployment, further deterioration of the environment and persistent administrative ineffectiveness create a widespread mood of dissatisfaction and cynicism.

Tribhuvan University has been unable to free itself from bureaucratic inertia and has not found a clear sense of direction. Meanwhile, major changes in tertiary education are proceeding rapidly. Private universities and colleges are springing up across the country, some catering for foreign and Nepalese students who wish to enter medical school. A new medical college has opened in the Eastern Terai and private medical colleges are coming into operation in the West and Mid West regions. They represent a challenge for the Nepal Medical Council which has the responsibility to monitor standards of practice. It will also test the capacity of the medical profession in Nepal to provide teaching faculty and clinical facilities for those new institutions.

Throughout this turmoil, the HDP continued to operate. CIDA extended the duration of its financial support and the HDP finally came to an end in 1995. CIDA is negotiating a new contribution agreement with The University of Calgary to support rural health initiatives. More time is required to consolidate and expand the community base in Surkhet. CIDA will no longer fund Generalist training. Medical education has received continuous support from Calgary for fifteen years and the IOM has had time to build up a core of Nepalese faculty who should be able

to sustain undergraduate and postgraduate programmes. Canadians who shared responsibility for the anesthesiology programme decided that Calgary should not provide further assistance. They judged that, after nine years, they had more than fulfilled their mandate. The IOM has sufficient faculty to train anesthesiologists at the diploma level if more are required. The critical factor will be the will to proceed. The engineering project continues on course. It has been extended through to 1997 when it is expected to conclude. There is no present intention to request an extension of this programme.

The Kathmandu connection has evolved during a period of more than a decade and it may continue into the future. Over these years its focus has frequently shifted in response to changing circumstances. Perhaps it is time to divert attention away from professional training and concentrate on diversifying the work among rural communities. The time will also come – and should come – when The University of Calgary will cease to act as an agent on behalf of Tribhuvan University to secure financial and technical resources. Just as family roles evolve, so the IOM must be allowed to demonstrate its ability to operate independent of external assistance. The transition from dependency to autonomy is a challenge for all concerned but no good comes from delaying the achievement of independence.

Some question the fate of the Kathmandu connection when financial and technical assistance cease to flow through Calgary to Kathmandu. Only time will tell. A strong base of mutual understanding and respect will remain in Kathmandu and Calgary for many years. This feeling is spread widely enough to constitute genuine institutional friendship. It is likely to survive even after formal contractual ties are severed.

3

The Costs and Benefits of the Kathmandu Connection

Categories of Costs and Benefits

I will attempt to review as comprehensively and objectively as possible the costs and benefits of the Kathmandu connection over the decade of the eighties. There are many difficulties inherent in identifying and measuring the diverse inputs into these programmes. They include not only money and materials provided from a number of sources but also the use of scarce space and facilities and the time and energy of many people. It is even more challenging to appreciate all the diverse outputs or impacts not only directly on the partner institutions but also on the communities which they serve.

These impacts are both positive and negative. It is a matter of fine judgment to calculate their net effect. Even the best intentioned intervention has many impacts, not all of which are beneficial. No intervention is ever neutral. In this sense the "benefits" of a programme refer only to positive outcomes, whereas "costs" include both planned inputs and unintended negative effects.

The practice of working together is both an input and an output. The process of partnering has been both the vehicle of the projects and also itself an important product. It is not sufficient simply to catalogue quantifiable inputs and outputs only to underestimate the equally important but imponderable lessons of partnering.

Both time and energy are finite. The decision to undertake one programme implies that we decide not to embark on others. In a similar spirit, the decision to plan and implement a programme according to certain principles and policies necessarily means that we exclude other mechanisms and styles.

I have not been a disinterested observer and cannot offer other than a subjective impression of the balance sheet, which may not do justice to all the facets in our experiences of partnering. Nor can I hazard a verdict as to the overall success or failure of our joint efforts, since the selection of criteria as measures of success or failure is itself subjective. Perhaps it is sufficient simply to provide observations and information about the various factors and leave the solution of the final equation to others.

Costs and Benefits to Tribhuvan University

The following account focuses exclusively on the Institute of Medicine (IOM). Our collaboration with the Institute of Engineering (IOE) in this decade was too short-lived to allow for a meaningful analysis. My purpose is simply to consider the impacts on Tribhuvan University of the MBBS, Generalist, Anaesthesiology, Obstetrics and Health Development programmes as well as our collaboration in medical research.

In many ways the IOM acts on behalf of the Ministry of Health (MOH). In effect, the IOM has the responsibility for national health manpower development at all levels. It follows that any impact on the IOM has immediate repercussions on the capabilities of the MOH to provide health services. Consequently, this section will examine impacts on both the IOM and the MOH.

The goal of the Kathmandu connection is to improve the quality of life of the Nepalese people, and particularly those who live in Surkhet district. I will examine the extent to which this expectation has materialized.

The University of Calgary is only one of several agencies which have collaborated with the IOM. It is impossible and unnecessary to attempt to identify these outcomes which can be "credited" to The University of Calgary. In most instances, the Canadian contribution has been complementary to that of others, and it would be unprofitable to attempt to dissect apart a synergy simply in order to claim a unique element of

success for the Tribhuvan University/University of Calgary alliance. I am content to offer an understanding of the various impacts of those programmes in which we have shared without assuming sole responsibility for either successes or failures.

Costs

1. **Money.** Neither Tribhuvan University nor the MOH has been required to contribute any funds to the operation of our collaborative programmes.

2. **Space and Facilities.** After the Teaching Hospital (TUTH) was opened in 1985 the IOM allocated space for the administration of our various programmes – in particular, the Health Development Programme (HDP) and the Anaesthesiology Programme. Office space within the Teaching Hospital is in short supply and has been in great demand. Despite this pressure, our programmes were assigned an administrative area of approximately 100 square metres and two other personal offices in prime locations.

In order to accommodate Canadian preceptors and generalist trainees in Surkhet it was necessary to allocate four houses on the IOM residential compound to the Generalist and HDP programmes. This accommodation was in high demand and these programmes received priority.

Accommodation in both the teaching hospital and Surkhet was provided at no cost to the programmes and constitutes a significant contribution in kind from Tribhuvan University.

Since 1983 the MOH has made Surkhet District Hospital available to the programme. This has in no way compromised the clinical work of the hospital and it offers convenient access to a valuable clinical facility for training purposes. The MOH also permitted use of government hospitals in Kathmandu for training postgraduate students.

3. **Personnel.** Over the decade the time commitment of Nepalese faculty to this programme has been substantial. In comparison with the level of staffing in Canadian universities, there are few faculty members in the IOM and they are required to perform a wider range of tasks. The IOM employs only 125 faculty members on the Maharajgunj campus. They have the responsibility to implement not only the MBBS and postgraduate medical programmes but also nursing and several certificate-level paramedical programmes. Furthermore, the IOM is responsible for the management of a 250-bed teaching hospital and for the supervision of eight campuses outside the Kathmandu valley. It follows that the commitment of faculty time to our joint programmes has the inevitable

consequence that it makes them less available for other critical duties. It is against this background of the high value of faculty time that one has to assess the contribution of IOM personnel. It represents a significant cost to the IOM in terms of the negative impact on its other activities.

The equivalent of the time of one senior faculty member was spent in Calgary over the decade. In addition, the programmes required the service of senior faculty for their administration in Kathmandu. This applied particularly to the HDP which, in many ways, lies outside the main stream of routine IOM business. From the summer of 1987 through to November, 1988, it required the full time of the HDP coordinator in Kathmandu, Dr. Bhisma Prasai. At that time he was appointed dean of the IOM and had to combine these onerous duties with his commitment to the HDP. It also required a half-time manager of the community component in Surkhet and another senior manager to take responsibility in Kathmandu for planning Generalist training. Many other faculty have generously given their time to committee work.

It is impossible to measure the value of all these faculty inputs over the years. It certainly exceeds the equivalent of one full-time faculty position annually. Given the modest size of the IOM's faculty and the magnitude of its responsibilities, this represents a substantial contribution of scarce and valuable human resources.

One can add to this catalogue the involvement of MOH staff. Several senior administrators have taken time to visit Calgary and this distracted them from departmental responsibilities. They have made themselves available to meet with programme staff and to serve on committees. It would be unfortunate to underestimate this contribution and to ignore the cost to the MOH.

4. Neglected Opportunities. The decision to introduce specific programmes automatically excluded other opportunities. The selection of the MBBS and the various postgraduate programmes made it less likely that alternative educational systems would be introduced in Nepal. This has not been an absolute bar and the Kathmandu connection has not impeded opportunities to establish profitable linkages with other institutions.

5. Unintended Negative Impacts. Some Nepalese individuals suffered inadvertently as a direct consequence of our programmes. This was most evident among the Generalist students in Calgary, some of whom were recruited without due consideration for their suitability for education in Canada. Those who did not complete the course experienced disappointment and distress to an extent that is hard to exaggerate. The stress level was high for many of the Nepalese students in Calgary. Some discomfort and tension was unavoidable, given the na-

ture of the programme, but it might have been reduced by better screening and orientation of candidates.

The impact of Canadians on the design and style of the various programmes in which we have collaborated is imponderable and yet significant. On the one hand, Canadians have been sensitive to the hidden dangers of exporting ideas and stereotypes from the North to Nepal. Calgary faculty have consistently tried to restrict themselves to the subservient role of assisting the IOM to plan and implement programmes tailored specifically for the unique needs of Nepal. All of those programmes in which we have worked together were based on the expressed needs of the MOH as interpreted to The University of Calgary through the IOM.

On the other hand, despite this sincere intention to avoid imposing Canadian preferences, it is not difficult to detect a heavy Calgary imprint on all our joint programmes. In most instances this impact was appropriate and can be a source of legitimate satisfaction. Indeed, if a Canadian influence was totally lacking one would have to question the need for Canadian collaboration. However, it is instructive to be alert for Canadian impacts that could be interpreted as injudicious.

It takes little imagination to trace the conceptual origins of the MBBS programme. The process of identifying learning objectives by the analysis of health priorities and desired competencies is based on sound principles which have universal application, although they are rarely employed. However, the choice of pedagogic methods reveals a strong and perhaps uncritical predilection for North American educational fashions. The type of integrated curriculum which I recommended demands a great deal of flexibility from faculty, especially if they have been accustomed to traditional teaching methods. My advice to introduce clinical experience at an early stage in the curriculum and to emphasize community experience imposed a heavy burden on the IOM. My proposal to use a problem-based learning strategy was even more ambitious. Students in Nepal have been schooled in a strictly didactic tradition and their teachers are unfamiliar with the problem-based approach. Despite a willingness and enthusiasm to adopt this principle, one can legitimately question if this suggestion was entirely realistic. It is not an approach which can be mastered in a few short workshops on teaching methods. The mixed experience of Canadian universities in introducing problem-based learning in medical schools gives weight to this reservation.

This introspective self-criticism is not intended to represent an abject confession that this early advice was ill-conceived. It does reflect an acute awareness that advice given enthusiastically and vigorously carries the risk of unintentionally imposing personal enthusiasms and opinions on

others. On reflection, one can argue that this risk has been justified by events. Faculty and students have energetically defended the MBBS curriculum against serious challenges, including the interrogation of a Royal Commission. External observers have commented favourably on the relevance and innovativeness of the MBBS curriculum.

The MBBS programme was initially regarded outside Nepal as suspiciously avant garde and falling short of international academic standards. This was a risk which had been anticipated during initial planning. At that time a calculated decision was taken to give priority to the educational needs of Nepal over the expectations of the international community. The programme has since been formally approved by the medical councils of Bangladesh and Pakistan.

The Canadian influence on the Generalist programme has already been acknowledged but deserves closer attention. From the onset, the IOM/University of Calgary team believed that it was following the expressed intention of the MOH. The early planners fully intended to design a programme which would meet the special needs of Nepal. They recognized that their goal was to train future senior district medical officers. These had already been designated as Generalists by the MOH in its early discussion papers. The plan was to provide a predominantly clinical training programme which would help Nepalese doctors to acquire the various competencies which they would need in order to provide good clinical services in the rural districts. It was inevitable and excusable that the actual programme would fall short of our intentions. There were many practical considerations which conspired to limit our capacity to provide the range of clinical opportunities we wished to offer. This experience is no different from many other educational programmes where circumstances force compromise.

Values and stereotypes are more insidious and subversive. One can find evidence of an unconscious Canadian perspective which crept into the Generalist programme with unfortunate effects. The expression "Generalist" was a given and is entirely appropriate. However, it is reminiscent of "general practitioner." The Canadian equivalent of this European term is "family physician." It was easy to assume that the Generalist programme was intended to train a Nepalese version of the Canadian or European general practitioner. This assumption carries a logic which leads to a focus on the career development of general practitioners in Nepal and a concern to strengthen their national status by linking them with general practitioners across the world. One is led to adopt strategies which foster professional status through solidarity with the world community of general practitioners.

These concerns emerged early in the HDP. While such a preoccupation is acceptable within the context of general practice as it is understood in many countries with a sophisticated infrastructure, one can question if it is relevant to the current situation in Nepal. The Generalist in contemporary Nepal is the senior district medical officer and faces challenges which have no parallel in Canada today. The situation did exist in Canada fifty years ago when one or two doctors worked in isolation in remote communities without access to specialist referral. They were obliged to provide for most of the medical needs of their communities. These conditions have virtually disappeared. However, this historic situation in Canada is parallel to that of the new Generalist in Nepal. The counterpart of the Nepalese Generalist is not the modern general practitioner or family physician, who fulfils an entirely different role. Canadians may have unwittingly distracted generalist training away from its focus on the districts of Nepal toward a preoccupation with fashions in medical services in North America.

The expectations of individuals or institutions may not be compatible with the needs of society at large. The assumption that social needs take preference over individual rights is rarely applied in the North. In particular, doctors have legitimate personal ambitions for themselves and their families. They look for an income commensurate with their living standards, access to good education for their children and social amenities. These opportunities are sadly lacking in the districts of Nepal. Consequently, there is likely to be a wide gap between personal expectations and realities in the rural districts.

The needs of society are likely to require the assignment of personnel where they are most needed and the diversion of most resources to the people who are in greatest need. In the context of health services in Nepal this implies an unequivocal emphasis on the allocation of resources towards the rural areas and away from the centre in Kathmandu.

The HDP found itself sandwiched uncomfortably between divergent personal and social goals. Where individual and social goals are incompatible, the HDP had the obligation to give priority to the needs of the people. Yet, the HDP temporarily strayed away from its programmatic goal to improve the quality of life of the rural poor in favour of protecting professional interests.

As the HDP recovers its sense of direction, a western stereotype and vocabulary could again deflect energies away from its objective to produce medical officers who will provide an effective service in district hospitals. One can rephrase this objective of the HDP by declaring that

it aims to provide better medical services to rural communities, or to "train community doctors for Nepal." An immediate association may be made with "community medicine" or "community health," terms that suggest a model of community health as it has evolved in the North in recent decades. This model, which has facilitated the improvement of health care in the North, it has an equally valuable role to play in the evolution of health services in the South. However, it would be dangerous to misinterpret the role of district medical officers whose duty it is to provide clinical services to people in their communities and thus to impose on them the model of community medicine specialists as they function in the North – that is, concerned with whole populations (epidemiology) rather than direct patient care.

These harsh reflections have been described at length. They illustrate the inescapable hazard that when foreign "experts" offer advice overseas, they carry within themselves their own vocabulary and values. This hazard is inescapable and, indeed, the object of partnering is to share ideas and experience.

There is no doubt that the Canadian influence created unintended negative impacts that should appear on the debit side of the balance sheet of the Kathmandu connection.

Benefits

We may look for evidence of benefit in terms of individuals, institutions and the people of Nepal. There have been 154 graduates from the MBBS programme; nineteen graduates from the DA programme; nineteen graduates from the DGO programme; and twelve graduates from the Generalist programme. All of these individuals have benefited from the opportunities which have opened for them by obtaining this education.

The IOM has gained from the partnership in several ways. The Kathmandu connection has contributed to its capability to train basic doctors for Nepal. It has also resulted in the establishment of postgraduate training programmes in general practice, anaesthesiology and obstetrics, disciplines which are critical for the country. Finally, the Calgary linkage is continuing to strengthen the IOM's research capacity.

While it is easy to catalogue these outcomes, it is more instructive to examine the nature of the impacts of the Kathmandu connection. The initial input to the planning of the MBBS programme in 1977 provided a timely impetus and offered a sense of direction which has influenced its subsequent course. The contribution of Canadian faculty to the teaching

programmes in Kathmandu and Calgary was also valuable, as were the opportunities for Nepalese faculty to learn from their Calgary colleagues.

However, perhaps more significant than these direct personal contributions of individual Calgary faculty was the unfailing friendship of The University of Calgary as an institution, especially during the critical formative years. During this period the IOM was exposed to constant criticism from within the country and to scepticism from beyond its borders. It was difficult for inexperienced Nepalese faculty to maintain their confidence and enthusiasm within this atmosphere of uncertainty and negative attitudes. The fact that an established Canadian university stood by steadfastly to offer advice, support and encouragement may have been more important than any more practical input. This is the essence of genuine institutional partnering.

As new challenges or opportunities emerged, the IOM's Canadian partner was always available to contribute ideas backed up, when appropriate, by resources and action. The practice of partnering was understood to mean that The University of Calgary would act as a friend and advocate on behalf of the IOM to secure additional resources as required. This partnering had a genuine institutional dimension. The individual friendships included within this wider relationship were crucial and the institutional connection would have disintegrated without the cement of family ties. However, personal commitment by itself could not have provided the quality of support required. The level of institutional commitment was openly demonstrated by the personal support of the president of The University of Calgary and senior administrators. The practical contributions of many senior Calgary faculty also made it clear that partnering extended beyond the enthusiasm of a few individuals.

The unequivocal demonstration that a credible Canadian university was actively supporting the IOM has been Calgary's greatest single contribution. A display of solidarity would, of course, have been hollow without its expression in practical intervention. These actions comprised the substance of the Kathmandu connection.

The impact of Tribhuvan University – University of Calgary partnering on the MOH has been significant. Since the IOM is assigned the responsibility of training health manpower for the MOH, it follows that to strengthen the IOM is automatically to strengthen the MOH. The IOM now has the capability to train all the doctors that the country will need in the future. Furthermore, the MOH now has the services of sufficient anaesthesiologists and obstetricians. Even more significantly, the country has the capacity to train additional specialists as they are required. There is

also a mechanism in place to train Generalists to provide clinical leadership at district level whenever the MOH elects to initiate the process.

Given the nature of the HDP, one can already demonstrate a positive impact on rural people. Although there are as yet no statistical data to document any improvement in health indices, the formation of action groups and subsequent promotion of the process in an adjacent *panchayat* is unequivocal evidence of a change in the attitude and behaviour of the people of Mehlkuna and in adjacent villages. This direct impact of the HDP on village people is perhaps the most satisfying as it reaches to the ultimate goal of the programme. There are encouraging signs that the process of participatory health developing is both sustainable, at least in the short term, and replicable, at least within one district. One can question if the process which has been initiated in Mehlkuna is sustainable in the long term unless much more time is allowed for the process of participatory developing to take root among a critical mass of the people of Surkhet. The clear evidence of the latent power which lies within rural communities is encouraging. However, it is a fragile bud which needs careful tending if it is to survive and blossom. The benefit to the people of Surkhet is still potential and not yet realized.

Costs and Benefits to The University of Calgary

Since our work with the IOE started only in 1989 I will deal here exclusively with the collaboration between the IOM and The University of Calgary.

Costs

1. **Money.** The funds which were used for the operating and capital costs of our various projects between April, 1980, and March, 1990, came from CIDA, IDRC, the Alberta Agency for International Development, individual donors and non-governmental organizations in Alberta. Over the decade of the eighties this amounted to a total of approximately $2,500,000. Until CIDA funded the HDP in 1987, none of the money which we raised was used for administrative purposes in Canada, and the Calgary campus received no overhead allowance. All of the funds were used for direct project purposes. No Canadian received more than travel costs and a modest daily living allowance. Apart from one short-lived exception, none received a salary. Furthermore, the funds were divided approximately equally between Nepalese and Canadians.

The contribution which we received from CIDA in 1987 for the HDP was of a different magnitude. The HDP was eventually extended to seven

and a half years and over this period expenditures totalled $4.66 million. Of this sum, expenditures in Canada amounted to $1.05 million, or 22 percent of the total budget. The cost of maintaining Canadians in Nepal was $2.04 million, or 44 percent of available funds. The remaining $1.57 million, or 34 percent, was spent in Nepal on project activities.

This budget allowed DID to maintain a full-time administrative organization in Calgary. The University of Calgary received an overhead allowance to cover its institutional costs. Money was provided for Canadians to travel to Nepal. However, the largest single budget item was the cost of maintaining Canadians overseas. Initially we placed four Canadian's in Kathmandu and Surkhet but this number was gradually reduced over the life of the project. Money was provided for the IOM's administrative purposes in Nepal, for the support of Nepalese personnel and for community activities in Surkhet.

As I reflect on the disbursement of funds over the life of the project, troubling questions surface. Expenditures required to maintain Canadians overseas consumed 44 percent of the total available funds. To put this in a Nepalese perspective, this expenditure is equivalent to the total money which is available to the ministry of health to provide health care to the 250,000 people of Surkhet district for twelve years. Furthermore, The University of Calgary did not pay all the overseas allowances which CIDA would approve. Consequently, the costs of sending Canadians overseas can be even higher than our figures suggest. It will be necessary to return to questions raised by the distribution of development funds in following chapters.

2. **Space and Facilities.** Since DID was created in 1986 the University of Calgary has provided approximately 150 m^2 of office space and essential services free of charge. This has an estimated value of $30,000 per annum. The university also contributed $25,000 in 1986 for the purchase of capital equipment to help to establish the office, and an additional $30,000 for the purchase of special equipment.

3. **Personnel.** This programme has required contributions from several categories of Canadian faculty: programme managers; visiting Canadian faculty in Nepal who were temporarily released from their university duties for periods of one to six months; faculty who were specifically recruited for long-term assignments in Nepal; and faculty who contributed to teaching Nepalese students in Canada. Although most of these Canadian faculty were associated with The University of Calgary, there are many important exceptions to this generalization. Physicians in hospitals in rural Alberta and British Columbia assisted in

teaching Nepalese doctors; academic anaesthesiologists from across Canada made the anaesthesiology programme possible; and four faculty were recruited from across the country to serve as long-term workers in Nepal.

The responsibilities of the programme coordinator required twenty-four visits to Nepal over the decade for periods ranging from four days to three months, or an average of five weeks each year. In addition, administrative duties in Canada involved a minimum of five hours each week, or an annual total of 250 hours – that is, the equivalent of about six working weeks each year. This last approximation must be qualified insofar as much of this management work in Calgary was done outside regular working hours. The work of the programme coordinator both at home and abroad occupied at least eleven weeks each year. This represents a total of over two years throughout the decade.

Over the period 1980 to 1990, twenty-four faculty members spent periods raging from one to six months in Nepal in connection with the MBBS, Generalist and HDP programmes. These individual contributions add up to a total input of approximately 72 months or six years.

It is more difficult to measure the faculty time involved in the supervision of postgraduate Nepalese doctors during their training in Canada. Twelve Nepalese students each spent eighteen months in Alberta over a five-year period in various types of postgraduate clinical training. Their supervision required the equivalent of forty percent of a faculty member's time for each of these five years. This represents a total of two years' faculty time.

In summary, these three categories of faculty input into the MBBS, Generalist and Health Development programmes add up to a total of ten years, or the equivalent of one full-time faculty position for each of the ten years of the programme. The university received no financial compensation for this input. This constitutes a significant and sustained contribution in kind throughout the decade.

The anaesthesiology programme merits special mention. It required the presence of a full-time Canadian anaesthesiologist for the five years, 1985-90. All of these anaesthesiologists were senior academic faculty members from faculties of medicine across Canada. None of these institutions received any financial compensation and all these anaesthesiologists, while they worked in Nepal, received from the programme only their travel costs and a modest per diem to defray living costs. This voluntary contribution of time was a major input into this programme. Over the decade this constituted the equivalent of a total of approximately five years' faculty time, or half an equivalent faculty position annually if this were distributed over the decade.

It is important to acknowledge the essential role played by physicians in rural hospitals in Pincher Creek and Camrose in Alberta and Hazelton in British Columbia. They accommodated Nepalese students in their offices and hospitals for periods of six months. Hospital administrators, physicians and local people made considerable efforts to offer hospitality and supervised clinical experience. It is a difficult and sensitive challenge to fit overseas trainees into a busy clinic or the routine work of a hospital. All of this work was undertaken on a voluntary basis and the programme could not have continued without this community cooperation.

One has also to consider the invaluable input of the many others who supported the programme. For the first six years one administrative assistant, Ms. Danielle Sikander, managed the secretarial, administrative and accounting work on a voluntary basis. During the last two years of this initial period it became necessary to recruit an experienced administrator, Ms. Jenny Whitelaw, to manage the complex logistics of the Generalist programme. After the creation of DID in 1986, this work was transferred to DID's office. From this time onwards, administrative support for the programme has been provided by DID staff under the leadership of Ms. Gloria Eslinger. The university has continued to contribute the salary of the Assistant to the Director of DID.

It would be a serious mistake to overlook the remarkable contribution of many friends of the programme. Spouses and friends of faculty have played an invaluable role over the years. A characteristic of the Nepal programme throughout the decade has been the willing participation of families and friends in all aspects of its operation. It is impossible to put a value on the hospitality offered by many Calgary families or the work they have performed in a variety of essential tasks – for example, in the herculean efforts required to establish and sustain Calgary House. It is very doubtful if the Kathmandu connection would still be viable today without these voluntary efforts from its friends. It was always possible to rely on the enthusiastic support of the "Friends of Nepal." A large body of colleagues were always available for meetings and a formal Nepal Friendship Association was organized. This is an example of the truism that the most important factors are often imponderable whereas the least critical elements are the easiest to measure.

In brief, the planned inputs required from Canada to implement the Canadian component of our joint efforts over ten years amounted to the following: $2,500,000, 1.5 equivalent full-time faculty positions each year, access to shared campus space and facilities together with the crucial but imponderable input of goodwill expressed in voluntary action.

4. **Neglected Opportunities.** Preoccupation with the Kathmandu connection consumed a great deal of the time and energy of many people in Calgary. It could be argued that this preoccupation came close to an obsession. For several years we did not seek other interests beyond the Himalayas. As a consequence, Nepal may have blinkered us to other opportunities.

There is an instructive analogy between institutional and interpersonal relationships. The focus on our intimate friendship with Nepal blinded us to other attractions. I will argue later that this analogy is valid and relevant. It suggests that an institution may be able to form only a few intimate relationships such as this Kathmandu connection. Meanwhile, the acquisition of the expertise of new colleagues with different experiences and interests has allowed DID to break out of a strictly "Nepalophile" orientation.

5. **Unintended Negative Impacts.** Our efforts over these last ten years had some effects which were unexpected, unintended and unequivocally negative. These adverse side effects were most evident among those engaged in the conduct of the programme in Nepal for long periods. One could have anticipated that the health of some would suffer. However, we have been fortunate to have escaped serious illness or injury, although few avoided minor ailments.

Some faculty feel that their contributions to this programme have not been adequately recognized by their faculties in terms of merit or promotion. There are some exceptions to this generalization; some, in fact, advanced their academic careers as a direct result of their work in Nepal. However, there is a general sense that time devoted to this programme has had at best a neutral impact on their careers. This can be considered as a cost to individuals.

Many of those who volunteered their time in Nepal relinquished their income. This was most significant for those who did not continue to receive a regular base salary and were entirely dependent on their own earning capacity. None of those in this category who went to Nepal for periods of up to six or even twelve months received more than a token living allowance from the project. They incurred a substantial financial loss.

The most serious negative outcomes affected some of those Canadians who were specially recruited to work for the programme on a long term basis in Nepal and who subsequently found that their experience did not meet their expectations. The need to follow wise and sensitive recruitment policies deserves greater recognition and attention. The fault need not lie within individuals. It may simply be a mismatch between aptitudes and requirements.

Benefits

The Kathmandu connection has been the collective responsibility of an entire academic institution, albeit conducted on its behalf by many individuals. The university is itself an integral part of its local community, and partnerships should be based on the pursuit of mutual benefit. Evidence of benefit may be found in individuals, the institution and its local community.

Over this decade, at least eighty Canadians spent some time in Nepal in connection with various aspects of these programmes. Some visits were for as little as one week and others for as long as three years. Some went there to teach, some in company with teaching faculty. Some went as administrators and others as interested and committed friends of the programmes.

For most of the Canadians this was their first intimate contact with one of the lowest income countries in the world. It gave them an opportunity to gain some insight into the origins and consequences of poverty. Although each had a unique experience and perception, this learning was regarded by all as a valuable experience. It has had a profound impact on the subsequent career interests of some and has resulted in an ongoing commitment to the problems of developing either at home or abroad. None has been untouched by the experience.

The University of Calgary has gained in several ways from its partnering with Tribhuvan University. The experiences gained by many faculty in Nepal should have enriched their teaching and had a positive impact on the educational life of the campus, but it is hard to document this effect.

Students were not encouraged to participate directly in the work overseas. It was considered that the involvement of Canadian students had to take second place to the needs of Nepalese students and the local community. The few Nepalese faculty were fully occupied in their own duties and it was felt that they should not be distracted by having to supervise foreign students. Consequently, any beneficial impact on our student body has had to be mediated through those faculty who have participated actively in the programme.

Some opportunities for joint research have been pursued. Collaborative research has been undertaken in clinical medicine, as already detailed. This has allowed members of the department of clinical microbiology in Calgary to benefit from these research opportunities. It is unfortunate that the intensive effort which was made to initiate collaborative research in the social sciences was frustrated.

The pursuit of scientific research has not been a high priority to date. This apparent relative lack of enthusiasm for research was due to the perception that the conduct of the programme itself was the highest priority. Given the limited available time of both Nepalese and Canadian faculty, and financial constraints, it was felt that concentration should not be diverted. It would be easy to subvert the goal and participatory strategy of the programme if it were to be combined with the demands of scientific experimentation. In retrospect, some observers will conclude that this is an area which might have been exploited more vigorously without prejudice to the outcome of the programme.

The major benefit for The University of Calgary has undoubtedly been the growth of its active involvement in developing. Collaboration with Tribhuvan University led directly to DID's introduction to the Institute for Primary Health Care in Davao and its subsequent participation in the Davao Health Development Programme. The contact with the department of education in Bhutan also arose directly from the links with Kathmandu. It was largely the initial experience in Nepal and subsequently in Davao which led to the request that DID should become a partner with the Pan-American Health Organization in a perinatal programme in Latin America. The decade of experience in Nepal laid the foundations on which the Canada Asia Partnership was later constructed. The friendship with Tribhuvan University and the diverse range of activities which arose from this relationship have played a crucial role in the evolution of DID. In this sense, it also contributed to the stabilization of the university's International Centre during its formative years.

It would be unrealistic to claim that the Kathmandu connection has yet begun to make any significant impact on our local community in southern Alberta. A Calgary non-governmental organization, Childreach, and Rotary District 536 Development Society have made valuable contributions to Nepal. However, we have not yet found a formula whereby these donations can become reciprocal in the sense that there is a sharing of experience between Nepal and Alberta for mutual benefit. The facilitation of direct community-to-community partnering is a long-term goal. It may be a sufficient achievement for this first decade that our experience of partnering with Tribhuvan University has opened our eyes to the possibility of this form of mutual learning between people.

4

Davao Medical School Foundation, Mindanao

The purpose of this chapter is to trace the origin of Davao Medical School Foundation (DMSF) and its Institute of Primary Health Care (IPHC) and describe the conditions in which they operate. This is necessary in order to appreciate the relationship which came to connect Davao and Calgary. It is an inspiring story which has not been well documented. DMSF has many roots within the Davao community and few of those who are directly engaged in its activities today are fully aware of the richness of their heritage. Even those who played a part in its creation from one direction are not well informed about its other sources. Many of the founders have died or have moved away from Mindanao without leaving a written record of their achievements. Their collective history could be irretrievably lost. I have had the good fortune to talk at length with many of those who played a prominent part in the conception and birth of the foundation and feel an obligation to tell their story.

It is impossible to grasp the nature of DMSF, or the significance to Calgary of the Davao connection, without some knowledge of the environment within which it evolved. In the following pages I have sketched pictures of the island of Mindanao and Davao City as I have known

them. I have not adopted the style of photographic realism. What follows are impressions of places and events as they affected the Filipino people in an effort to create a fair image of the historical situation out of which DMSF emerged.

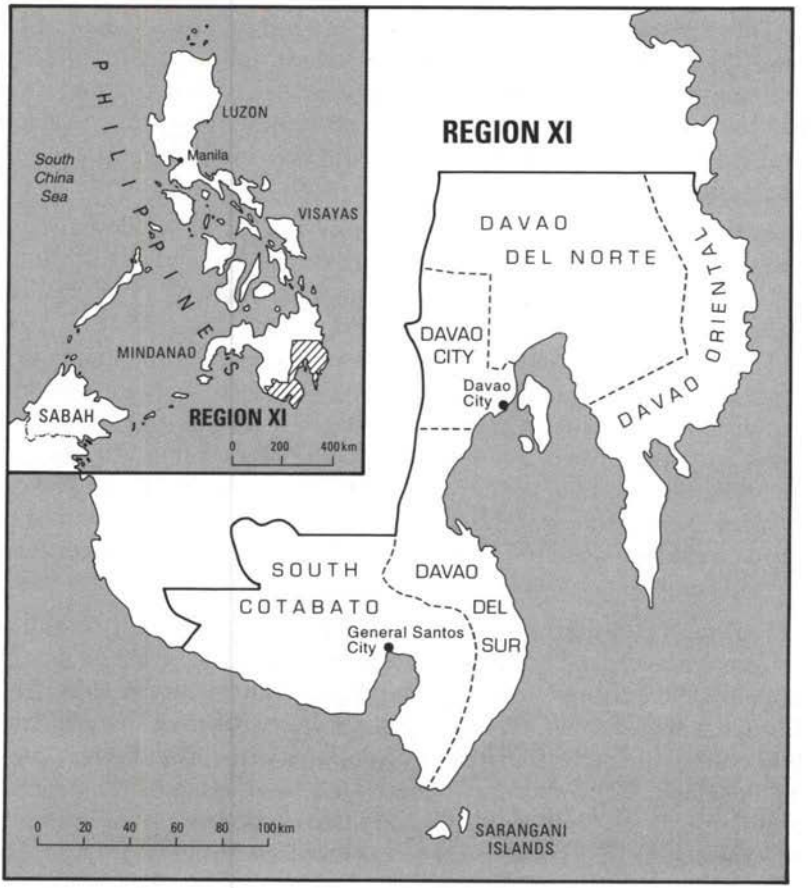
A full account of the Philippines is far beyond the scope of this chapter. North Americans may find life in Nepal strange and incomprehensible but they are much better equipped to appreciate the Philippines of the twentieth century. During that period, Filipinos have been dominated by the United States. Many aspects of contemporary Filipino culture, systems of government and patterns of education and health care will be familiar to Americans. The following account targets recent events in the Philippines and those elements which are unique to contemporary Mindanao – its relationship to Manila, its experience of oppression and exploitation, the confrontation between Christianity and Islam and the clash between insurgents and counter insurgents.

The Philippines

Overview

Just as Belgium has unhappily found itself the "cock pit of Europe" where its neighbours fought their bloody battles throughout the twentieth century, so the archipelago of the Philippines has been the setting for the competing ambitions of Europe and North America for over four centuries. In 1565 a Spanish force undertook the systematic conquest of these islands in the name of Philip, son of the Emperor Charles V. This followed the brief and fatal landing of Ferdinand Magellan in Cebu in 1521. Since then, the Filipino people have been the objects of the rapacity and whims of foreign powers.

This Spanish colony became a pawn in the war games between Spain, the Dutch Netherlands and England. Dutch fleets ravaged Spanish coastal settlements and the British controlled Luzon from Manila for a brief period. A century ago the Philippines became embroiled in the Spanish American war and was ceded to Washington by the Treaty of Paris in 1898. Within more recent memory, it became snarled in Japanese expansionism and reluctantly hosted the confrontation between Japanese and American forces during the Pacific war of 1941-45. The peoples of Southeast Asia suffered grievously during the Japanese occupation. However, the temporary success of the Japanese armies had the positive effect of inspiring national resistance movements and expedited the dismissal of Americans, Dutch, French and British from the Philippines, the Dutch East Indies, Indo-China and the Malay states.



Map 2. Region XI, Mindanao

During the late sixties and early seventies, it became entangled in the Vietnam war. It was a base for American bombing missions to Vietnam and a temporary haven for Vietnamese refugees. This experience made many young Filipinos acutely aware of the harsh politics of their region and contributed to their radicalization.

The Philippine archipelago comprises over 7,000 islands. The island of Luzon, where the capital, Manila, is located, lies to the north. The large island of Mindanao is to the south, in close proximity to the Malaysian state of Sabah on the northern coast of Kalimantan. Luzon and Mindanao are separated by a sprawling cluster of smaller islands known collectively as the Visayas.

These islands are volcanic in origin and are part of an unstable land mass. The Philippine islands are at the mercy of disastrous earthquakes and active volcanic eruptions. Typhoons rise in the south and sweep northwards across the western Pacific striking the eastern coastal areas of Luzon and the Visayas before crossing the South China Sea to reach the mainland.

Within the twelve-month period from June, 1990, to May, 1991, the country was devastated by a major earthquake and a volcanic eruption in Luzon and a destructive typhoon which struck the Visayas. Typhoons are part of the annual weather cycle and a regular feature of life in this region. They have recently taken on a more ominous form. In late 1991 a typhoon of only moderate intensity wrought havoc in Leyte in the eastern Visayas and resulted in over 7,000 deaths. The combination of heavy rains and soil erosion due to deforestation caused flooding and mud slides that were out of proportion to the severity of the storm. The combination of environmental damage and perhaps a shift in weather patterns could increase even further the vulnerability of the Philippines to a cruel combination of natural and man-made disasters.

During the period of Spanish rule colonizers penetrated deeply into southern and central Luzon and the Visayas. They have left an indelible imprint on the culture, language and architecture of these regions. Those European settlers who were born in Spain were known as "peninsulares," while those of Spanish origin who were born in the islands were known as "insulares." The aboriginal inhabitants were referred to, somewhat ambiguously, as "indios." Insulares intermarried with the indios and this mestiso people became known as Filipinos.

The country is divided into 72 provinces, each administered by an elected governor. Provinces are subdivided into municipalities which are managed by elected mayors. Within the municipalities, the smallest administrative units are the barangays, each led by an elected barangay captain. Barangays may be separated into smaller units, sitios or puroks, the latter of only minor significance.

Resistance to External and Internal Tyranny

Resistance to colonial rule never died, and intensified in the latter part of the nineteenth century. Under the leadership of reformers such as Jose Rizal, and revolutionaries like Andres Bonifacio, the Filipino people finally threw off the yoke of Spanish rule in 1898. However, middle class intellectuals, or "illustrados," redirected the people's drive for independence to their own selfish purposes, with the result that power

was simply transferred from Madrid to Washington. The government of the Philippines remained under the control of the United States until the independent Republic of the Philippines was proclaimed in 1946 under the presidency of Manuel Rojas.

Unfortunately, the Filipino people have been abused ruthlessly not only by foreign invaders but also by national leaders. The behaviour of the illustrados is a painful historical example of this pattern. Since the achievement of independence in 1946, the country has continued to be exploited by foreign commercial interests and plundered by corrupt and incompetent administrations.

In 1965, Ferdinand Marcos was elected as the seventh president of the republic. He was the son of a middle-class politician from Ilocos in central Luzon and generally respected as a brilliant lawyer. He brought to this office not only an enviable legal reputation but also a criminal record. He had been charged and convicted of the murder of a candidate who had challenged his father for a seat in the senate. During his time in prison he wrote the bar examinations and took first place in the country. He was subsequently acquitted of murder on a technicality.

Marcos was the first president to be elected for a second term of office. In 1972, towards the end of his second – and constitutionally his last – term, he declared martial law. By this strategy he was able to continue in office indefinitely, and suspend the constitution, the senate and house of representatives. He appointed a prime minister and created a new constitutional body. He introduced a new layer of government, the regions. The seventy-two provinces were aggregated into thirteen regions. This greatly diminished the power of the provincial governors and was a significant step towards centralization and dictatorship. The right to freedom of speech was abolished; imprisonment could be made without trial; and the police and military could control the country without hindrance.

The Emergence of Filipino Communism

Reaction to the suspension of the constitution was immediate and coalesced around the Communist Party of the Philippines. Filipino socialism traces its roots to the popular fight for independence against Spain in the late nineteenth century. The Russian Revolution of 1917 and the subsequent spread of communism throughout Asia inspired the formation of a national Communist Party of the Philippines (CPP). This step was facilitated by a communist leader exiled from Indonesia and the active support of the Communist party of the United States. Much of the resistance against Japanese occupation during the Pacific war was

coordinated by the communists and their success greatly widened their popular appeal. Following the establishment of the republic and its apparent adoption of American capitalism, the Communist party directed its efforts against the national government in Manila.

Filipino communism was modeled on the Stalinist proletarian system and rapidly lost its attraction for the largely rural Filipino population. New dynamic and charismatic leaders replaced the old party hierarchy. They espoused the Maoist form of communism based on the power of agricultural workers. A young university lecturer, Jose Maria Sison, and a peasant leader, Bernabe Buscayno – who adopted the *nom de guerre* "Commander Dante" – formed the New Communist Party of the Philippines, or the National Democratic Front. They won the allegiance of a wide spectrum of disaffected students and workers. A military wing, the New People's Army (NPA), became active under Dante and led the fight for justice against the Marcos administration. The government eventually suppressed these guerrilla activities and, within a few years, both Sison and Dante were in prison.

Restoration of Democracy

A dramatic event in 1983 hastened the demise of the Marcos administration. Ninoy Aquino returned to Manila from the United States where he had fled for asylum. As he stepped from his plane in Manila airport he was gunned down by a rifle shot. The finger on the trigger and the mind behind the plot have never been publicly identified. The murder of Ninoy Aquino further enraged the people and heightened their resistance to Marcos. Eventually, in February, 1986, the people rose in rebellion. After a brief series of skirmishes in Manila, Marcos fled the country to Hawaii accompanied by his family, "cronies" and, allegedly, several billion dollars which he had purloined from state funds.

Ms. Corazon Aquino, widow of Ninoy Aquino, reluctantly accepted appointment as the eighth president for a period of six years. The Constitution of 1935 was reenacted and, in effect, the country returned to the conditions prevailing before 1972. An important exception is that the regional governments which had been created under martial law were retained.

The Aquino administration released many political prisoners, including Sison and Dante. The latter has returned to community work in central Luzon; Sison and some colleagues took refuge in the Netherlands from where they mobilized support for the Communist party. However, there is growing evidence that Filipinos are rejecting violence in favour of constitutional democracy. The recent legalization of the Communist party and the demise of communism in Eastern Europe have under-

mined Sison's ability to attract resources in Europe. Under these pressures, the party leadership has become bitterly divided between those who wish to continue armed rebellion and those who prefer to work within the constitution. A small but committed rump of rebels persists and will undoubtedly continue to resist as long as extreme poverty and social inequity persist.

The six-year tenure of the Aquino presidency came to an end in 1992. The subsequent elections were generally regarded as fair and free from corrupt practice. General Fidel V. Ramos was appointed as the ninth president. Some of the early initiatives of the new administration are encouraging – improvement in peace and order, further decentralization of authority and radical innovations in health care.

A new Local Government Code had already been introduced in 1992. It has the potential to revolutionize the distribution of political power throughout the country. It abolished regional government and effectively returned authority to the provinces and municipalities. Responsibility for health services, social work, agriculture and highways devolved to local government. While control over the infrastructure of schools passed to the provinces, the central government retained control over education. Decentralization has the potential to transfer power closer to the people and provide for greater accountability. It may also lead to abuse. There is particular concern over the fate of social services which are now at the discretion of provincial governors and municipal mayors.

Filipino Society

The Philippines is the only Christian country in the region. The Catholic Church claims the allegiance of 85 percent of the population – a proportion exceeded only in Malta where 90 percent of the people are Catholic. However, a rapidly growing minority has been attracted to fundamentalist forms of evangelical Protestantism. Churches are well attended and television evangelists dominate the media. Filipinos are characteristically spiritual, although this often takes the form of pragmatic religious practices rather than an uncritical conformity with traditional dogma. Community development in the Philippines has to be understood in terms of this spiritual dimension.

Filipino culture is a curious blend of remnants of the original Malay traditions, the influence of Spain, particularly on the older generations, and the overpowering impact of American pop culture and consumerism. This mixture is expressed vividly in the common vernacular which is basically Filipino but switches incongruously into American English in mid-sentence.

The Filipino economy is poor and income is failing to keep pace with inflation. Consequently living standards are deteriorating, especially for urban dwellers who cannot produce their own food.

Early American administrations introduced a form of public education. Many of the older generation of Filipinos express gratitude for the opportunities which this gave them. There is now a comprehensive system of public education which extends from primary schools through to state universities and colleges. An extensive private education sector is run by Catholic, Protestant and Muslim religious institutions as well as by secular organizations. Private education, however, is expensive and beyond the means of most Filipinos.

American administrators also introduced a public health system. It is still inadequate to meet the needs of the public and is poorly funded. As a consequence, an extensive private health sector has grown, and many hospitals are operated by religious orders and private investors. Many doctors work outside the government service and most remain clustered in towns and cities, far beyond the reach of rural villagers. Private health care is too costly for most Filipinos.

The "projected" population of the Philippines in 1993 was 67,822,000. This figure is based on the "actual" total of 60,684,887 which was recorded at the last census and on estimates of subsequent population growth.

The budget for the Department of Health in 1993 was 7 billion pesos. According to "actual" population data, the Department of Health spent 115 pesos per head in 1993. However, on the basis of the higher "projected" population, the annual sum spent on each Filipino was closer to 100 pesos (US$4.00). This compares with annual per capita expenditures on health of 35 Nepalese rupees (US$0.70) in Nepal and $1,500 in Alberta.

The Philippines in Perspective

In the earlier years of this century Manila rivalled Bangkok, Singapore, Kuala Lumpur and Hanoi as a "pearl of the Orient." The country had excellent natural resources in terms of a fertile land, rich forests and mineral deposits. It had an educated people with a wealth of talent. In 1946 one would have forecast a prosperous future for the newly independent Republic.

Events have proved otherwise. It is tempting to assume that the wide gap between potential and reality is simply due to incompetent leadership and corruption on a massive scale. However, the roots of political ineptitude may be traced to the vulnerability of a fragile national economy to the competitive pressure of rich countries, more than four

centuries of colonial rule by both Spain and the United States, and to an inappropriate political structure.

Whatever the causes, the economy of the Philippines has declined dramatically in relation to many of the other countries of the region, with the sole exception of Indo-China. The people of Manila look enviously towards Singapore, Bangkok, Kula Lumpur, Jakarta, Seoul, Taipei and Hong Kong.

This bleak picture of general deprivation conceals a pattern of inequitable distribution of wealth and resources. Manila is home for families of immense wealth and it is generally conceded that some of this wealth is the product of corruption. The coexistence of great wealth and overwhelming poverty speak to the need not only to expand the national economy but also to achieve some semblance of social equity. The early years of the Ramos administration may be a turning point for the Philippines. If Manila can eradicate corruption and introduce efficient and socially responsible policies, the country could be poised for a promising future. Conversely, if it slips into irresponsible incompetence, then Filipinos expect to return to widespread insurgency and social decay.

Mindanao

Mindanao is the second largest island in the country with an area of 96,430 km^2, representing 33 percent of the total land mass. For administrative purposes, it is divided into four regions, the Autonomous Region of Mindanao and twenty-three provinces and includes the islands which comprise the Sulu archipelago.

Many areas, especially in the southeast, are mountainous and have been heavily wooded. However, poorly controlled logging has caused extensive deforestation. It is estimated that only ten percent of natural forest remains. There are few good roads and poor transportation across the island is an obstacle to economic growth. Many rural and coastal communities can still be reached only on foot or by boat. One can begin to understand Mindanao only against the background of more than four centuries of colonial oppression and exploitation. The island has played a special role in this national tragedy.

The Muslims of Mindanao

In the early centuries of this millennium, Islam spread from its origins in West Asia across the Indian Ocean to reach the Malay peninsula and advanced on into the islands of modern Indonesia. By the fifteenth century a Sultanate had been established on the southern coast of Mindanao and the

adjacent islands of Sulu. Mindanao formed an integral part of the Muslim trading, religious and cultural society of Southeast Asia. To this day, the Moros, as the Spanish disparagingly called the Muslims of Mindanao, claim solidarity with their Islamic friends in neighbouring Sabah.

When the Spanish arrived in the Philippines in the following century, having only recently ejected the Moors from the Iberian peninsula, they found themselves engaged again in the same conflict between the crescent and the cross. Mindanao became the interface between the competing ambitions of Islam and Christianity.

The Spanish governor dispatched expeditions against the Muslims but these served only to harden resistance. Muslims and Christians remained enemies throughout the three centuries of Spanish colonial rule. This religious conflict has never ceased. While Spain could not conquer the Muslims, it did succeed in containing the spread of Islam to southern Mindanao. Under the influence of Spanish priests, those Indios who became Christians learned to look down on the Muslims, despite the fact that they were of a common ethnic stock. A stalemate existed between the Christians and Muslims of Mindanao until the mid-nineteenth century. At that time the Muslims were in the majority. However, the Spanish encouraged internal migration from Luzon and the Visayas into Mindanao in order to relieve population pressure in the north and to take advantage of the promise of the southern island.

Spanish cession of the Philippines to the United States in 1898 included Mindanao, although Spain had never conquered the Muslims. The Americans had no religious agenda but were determined to integrate Mindanao into the Philippines for economic and commercial purposes. They imposed on a traditional Muslim society American systems of land settlement, justice, local government, public schools and hospitals, and abolished slavery. Muslims continued to resist assimilation and it took American military forces ten years to achieve a modest degree of pacification.

The Filipino Commonwealth Government, which was constituted in 1935 under President Quezon, regarded Mindanao as a land of opportunity. The Muslims, in turn, considered Filipino Christians no less foreign and unwelcome than the Spanish and American colonizers.

Following the worldwide resurgence of Islam after the end of hostilities in 1945, new mosques, schools and Islamic organizations multiplied throughout Muslim provinces. Many young Muslims went to the Middle East for higher education and Muslim preachers visited Mindanao. Wealthy countries in the Middle East provided financial support for Filipino Muslims. The government in Manila responded by accelerating the

process of modernization and expropriation of land. Whereas Muslims had once been in the majority, by 1982 they owned only 17 percent of their ancestral lands. Manila interprets this paternalistically in the language of planned development. Muslims call it legalized land grabbing.

This clash of interests led to a virtual Muslim war of independence between 1972 and 1975. In reaction to this sustained aggression Manila signed the Tripoli Agreement in 1976 by which it agreed to offer autonomy to 13 Muslim provinces in Mindanao in exchange for the cessation of hostilities. President Marcos later revoked this agreement.

Muslims do not constitute a homogeneous cultural or linguistic group. They reflect the ethnic diversity of the original Malay peoples. They embrace thirteen distinct ethnic groups, the largest being the Maranaos, the Maguindanaos and the Tausugs. They are also divided ideologically in terms of the form of Islam which they embrace and the political goals which they pursue. Several competing Muslim organizations were formed to represent these special interests. The most prominent resistance organization, the Muslim National Liberation Front (MNLF), is led by Nur Misuari, previously a member of a Marxist student organization and thoroughly secular in outlook. The MNLF is recognized by the Organization of the Islamic Conference (OIC) and currently represents Muslim interests in negotiations with the Manila government.

This ideological conflict has been a defining feature of Mindanao and remains a fact of life for its people to this day. The Muslims, supported by the OIC and financed by wealthier Muslim countries, have never abandoned their fight for independence or autonomy.

In 1991 the Aquino administration attempted to fulfil its commitment to the Muslims under the terms of the Tripoli Agreement by conducting a referendum on autonomy in these provinces. Only four opted for autonomy. Although those provinces are not contiguous, they have been grouped together as a new region, the Autonomous Region of Mindanao (ARM).

The Muslim problem remains unresolved. Although many Muslims have willingly merged into mainstream Filipino society, the majority, especially in the rural areas, remain opposed to assimilation. While Filipino Christians look towards the west for their models, Muslims look east towards their Islamic brotherhood for their values and identity.

Meanwhile, the four Muslim provinces which have become autonomous are dissatisfied with their new status. The various Muslim political organizations are divided among themselves. Most have abandoned the goal of a separate state and wish to negotiate a form of limited autonomy. However, a fundamentalist minority remains committed to

achieving independence – by violent means if necessary. It continues to perpetrate acts of terrorism in an attempt to destabilize the country.

Mindanao in Perspective

Partly because of Muslim resistance, Spanish colonizers failed to penetrate the interior of the island and were contained within a few coastal settlements. The tribal peoples of Mindanao, like similar bands in northern Luzon, vigorously resisted Spanish attempts at pacification and retained their cultural identity. They are now succumbing to the attractions of western culture more readily than to the advances of priests or soldiers.

Because of the intransigence of the Muslims and the tribal people, Mindanao has been less exploited than Luzon and the islands of the Visayas. It is still significantly disadvantaged in terms of roads, communication, energy supplies and social services.

Mindanao has been the last frontier of the Philippines. Although it began to attract pioneers from the more northerly islands late in the nineteenth century, the pace of internal migration has accelerated over the last forty years. The population has virtually doubled in the two decades between 1973 and 1993. The official "projected" population of Mindanao in 1993 was 15,086,000.

Mindanao is distanced from Manila by many miles, sea channels, its Islamic and ethnic heritage and by a growing sense of alienation. In this last sense, the attitude of Mindanao to the capital is uncannily reminiscent of that of Western Canadians or Scots to Ottawa or London.

Mindanao has considerable potential as part of a new international regional growth centre. The neighbouring large islands of Mindanao, Kalimantan and Sulawesi represent the last area in the region still to be exploited. Each is remote from its capital city – Manila, Kuala Lumpur and Jakarta. The opportunity to exploit their collective potential is under intense discussion by the governments of the Philippines, Indonesia, Malaysia and Brunei.

Davao City

Davao City lies at the base of a natural harbour, the Gulf of Davao, and at the foot of Mount Apo, the highest peak in the Philippines at 3,000 metres. The region is fertile, well-watered and has been densely forested. It enjoys a tropical climate and escapes the typhoons which regularly ravage the northern islands. For centuries, the region has been the ancestral home for several tribal groups. By the early nineteenth century,

Muslims had penetrated throughout the region from the Sultanate in Maguindanao. The Spanish did not venture into the Gulf of Davao with serious intent until the middle of the nineteenth century. Settlement and Christianization were characteristically imposed on the reluctant Muslims and tribal peoples by the concerted efforts of soldier, priest and trader. A settlement was established at the mouth of the Davao River, which drains the foothills of Mount Apo into the Gulf. However, it had made relatively little progress by the time American forces arrived in 1897 to challenge Spanish authority.

The early growth of Davao was spurred by an unlikely accident of fate. The first American settlers found it difficult to cultivate the land and recruited for the purpose Japanese workers, who had recently completed construction of the mountain road from Manila to Baguio and needed employment. The early history of Davao is the story of the industry of these Japanese indentured workers – particularly in cultivating the abaca plant and manufacturing hemp to produce nets for their fishing fleets; the entrepreneurism of omnipresent Chinese traders; the efficiency of the early American administrators; the evangelical zeal of Catholic and Protestant missionaries; and the energy of the early pioneers who migrated to Davao from the crowded islands to the north.

During the first four decades of this century, Davao City emerged as the centre of small scale agricultural and fishing interests. The land is fertile and the surrounding ocean teems with fish. Davao attracted the attention of Manila as having considerable economic potential. On 1 March 1937, it received its charter as a city.

By 1941, the city was home for 15,000 prosperous Japanese settlers. Shortly before the attack on Pearl Harbor, the Japanese abruptly left Davao to return to their homeland. Tales persist that some of these "settlers" reappeared wearing the uniform of officers of the Imperial army. Throughout its Japanese occupation the people of Davao suffered hardship and ignominy. Davao City was heavily damaged, particularly during the American invasion and war of liberation.

Today, Davao City is part of Region 11. This region consists of six provinces: Surigao del Sur, Davao Oriental, Davao del Norte, Davao del Sur, South Cotobato and the new province of Sarangani. The region also includes two cities, General Santos City in South Cotobato as well as Davao City. Since 1945, Davao City has grown rapidly, although its economy has never flourished.

The educational system has grown and diversified. Schooling is compulsory for six years at primary level and for four years in high school.

Public education is free. An extensive private-school sector made up of religious and lay institutions is too expensive for most Filipino families. The Society of Jesus, which already ran primary and high schools in Davao, opened the first university, the Ateneo de Davao, in 1948. Two other private campuses have since opened – the University of Mindanao, owned by a local family, and the University of the Immaculate Conception, run by the Sisters of the Immaculate Conception. The University of Southern Mindanao is the only state-run university in Davao City.

The first hospital in Davao was opened in 1906 by an American Protestant mission and became known simply as Davao Mission Hospital. It was followed in 1920 by the first government provincial hospital. Another was soon added to cater specifically for the large Japanese community – it was destroyed during the war of liberation. Since the end of hostilities the original Protestant mission hospital has moved on several occasions. It was renamed the Brokenshire Memorial Hospital in memory of its prewar American medical director, Dr. Herbert Brokenshire, who was drowned off the Surigao coast in a naval encounter during the Pacific war. It is now managed by the United Church of Christ in the Philippines. The church still operates a College of Nursing, but the hospital was closed in 1985 as the result of an industrial dispute.

San Pedro Hospital was opened in 1948 by a Dominican order which has its mother house in Montreal. The order opened the first College of Nursing in Davao in 1956. Other hospitals are operated by local entrepreneurs, the most prestigious being Davao Doctors' Hospital. Private hospitalization is expensive, and institutions such as the Doctors' Hospital are far beyond the means of all but the wealthy.

The department of health operates a public hospital, Davao Regional Medical Centre, as well as a small twenty-bed district hospital. Each province has its own hospital and small health centres cater to some municipalities. Health care in government hospitals is free, although patients are required to purchase all necessary medical supplies.

As throughout the Philippines, religion dominates the lives of many Davaowenos. Catholic churches predominate and embrace a wide range of traditions. However, Protestant denominations are flourishing in bewildering diversity. As an example, there are four variants of Baptist churches in Davao – General, Independent, Southern and Bible Baptists – and there are fifty-seven Southern Baptist congregations within the city. Some sects, such as the Eglisia Kristo, are highly disciplined and electorally powerful, favouring right-wing political parties.

Davao City lived through trying times throughout the turbulent years of the seventies and eighties. In reaction to the repression of martial law, the New People's Army (NPA), became particularly aggressive in Davao City and adjacent provinces. Encounters between the NPA and the military occurred regularly within and around Davao City – some neighbourhoods were effectively controlled by guerrillas. The military organized counter-insurgent paramilitary forces, the Alsa Massa, recruiting defectors from the NPA. They were trained to protect their communities from the demands of guerrillas, frequently using violent measures. It is difficult for an outsider to ascribe virtue or vice to these opposing forces.

Davao City became a virtual war zone with fighting between guerillas and both military and paramilitary forces. Violence reached a peak around 1985. The rule of law has since been restored – albeit sometimes with excessive force. Whereas Davao City was regarded as the danger spot throughout the eighties – one poor neighbourhood, Agdao, was known whimsically as "Nicaragdao" – its streets are now quieter than Manila.

Davao City in Perspective

To the casual observer, Davao City has all the appearances of a province rather than a city. It includes a typical urban centre but this is surrounded by an extensive hinterland of coastal villages and a hilly interior, including the foothills of Mount Apo. However, it is administered as a city by a mayor rather than a governor and is subdivided into twelve districts rather than municipalities.

Today, Davao is the most populous city in Mindanao and the third largest in the country, after Manila and Cebu. In 1993, it registered a population of 939,623. It occupies a sprawling area of 2,440 km^2 and claims to be the largest city in the world in terms of land area.[1]

As a young city, Davao evokes the atmosphere of the frontier. It conjures images of interconnected rural villages rather than an urban metropolis. There is no defined commercial centre and no clusters of office blocks, and hints of spontaneous evolution rather than urban planning. Threats of hidden violence lurk in the shadows. In recent years banditry has escalated and members of wealthy families are at constant risk of kidnapping for ransom. There are few curbs on the excesses of entrepre-

1 By comparison, the new city limits of Calgary enclose an area of 671.75 km^2 to accommodate a population of 727,719.

neurial speculation. Despite a wide difference in relative affluence, Davao City and Calgary share some common features. They are of comparable age and population size. More significantly, behind urban facades, they are still essentially restless, pioneer settlements of migrants, suspicious of central government and retaining a fierce sense of independence. It is unlikely that Davao Medical School Foundation could have emerged in any other city in the Philippines, in the same way that the Kathmandu connection could not have been forged in any other Canadian city than Calgary.

If plans for regional cooperation between the Philippines, Indonesia, Malaysia and Brunei come to fruition, Davao City is strategically well placed to play a major role in the region. Air links between Davao and other cities in the region are opening and the natural harbour of the Gulf of Davao is ideal for transportation. Davao City may soon enjoy the prosperity which it has long been denied.

Davao Medical School Foundation

The origin of Davao Medical School Foundation (DMSF) is unusually complex. The roots of medical education in Davao are not to be found in the deliberations of government planning commissions or academic councils but rather in the minds and hearts of a handful of Davaowenos. Their concerns were expressed not in terms of curricular content or pedagogic principles but rather as a moral response to the predicament of local people who were trapped in the grip of grinding poverty. Medical education was seen explicitly only as a means to a social end.

In these circumstances, individuals are more significant than committees. The evolution of DMSF has to be understood as the product of a group of concerned citizens. The following account is consequently biographical and I make no attempt to conceal my admiration for those who had the courage to follow the logic of their convictions despite apparently impossible odds.

Development of People's Foundation

In the late sixties, a small group of physicians and nurses, members of the Christian Family Movement, were deeply concerned about the plight of the poor in the urban slums of Davao. Economic conditions were steadily deteriorating and they were distressed by the lack of access to health care for the indigent.

In 1967, they opened a "charity clinic" in the grounds of a Redemptorist Monastery in Davao City. This started as a free clinic operated twice weekly and offered consultation and treatment at no cost to the poor.

The clinic was staffed entirely by volunteers and occupied space made available by the order. Over the next two years, it grew in popularity and clearly addressed at least some of the needs of the local community. However, some disquieting trends soon became apparent. Many patients appeared repeatedly with the same complaints and there was an increasing and often inappropriate demand for free medicine. The volunteer group became acutely aware that they were responding to deeply ingrained health problems at only a very superficial level. They were treating symptoms of deep-seated social malaise in a way that was ineffectual. They had the choice either to discontinue these goodwill gestures or to intensify their efforts and take a more radical approach. They would have to address the problem of poverty alleviation, foster sustainability by encouraging active community participation and facilitate greater community autonomy. But for the strength of character of these pioneers, their decision to take the latter course would have been inconceivable.

The Marcos administration was becoming increasingly repressive and the introduction of martial law was only a few years in the future. The NPA was active and attracting the allegiance of many students who were enraged by social inequity and saw no alternative to political resistance. These tensions did not escape Davao and the Redemptorist priests took an unequivocal populist stance. The populist interpretation of the national situation was not congenial to the clinic volunteers and they became uncomfortable with their squatter status on the monastery grounds.

All these circumstances conspired to bring about the creation in 1969 of the Development of People's Foundation (DPF). Land was donated by Dr. Jesus de la Paz for a twenty-year term. The Davao Light Company was in the process of disposing of a staff house and offered this property to the new DPF. Under the constant supervision of Engineer Alfonso S. Ibanez, the house was dismantled piece by piece and reconstructed on the donated land. It became the home of the DPF and it continues to serve this purpose today.

DPF discarded the concept of a charity clinic in favour of a health cooperative. Families could join the cooperative at a monthly cost of 50 centavos per family. For this outlay they received free consultation and treatment. Within a few years 2,000 families from neighbouring poor housing areas had joined the DPF cooperative. In order to augment the income of members a sewing workshop was established and soon gave employment to 100 women. They could produce and sell their products within DPF – a practice which still continues.

DPF's most significant innovation was the decision to train community health volunteers who would provide health care to their neighbours. These health workers were named "Katiwalas," or "trustees of health," by the community. The training of Katiwalas started in 1972 and, over the next five years, 166 Katiwalas were trained.

Dr. Jesus de la Paz, a member of an academic medical family in Manila and a graduate of the University of the Philippines, was the driving force behind this initiative. After completing training as an obstetrician he moved with his wife to the remote city of Davao to become the first qualified obstetrician in the region. He was a man of unusual charisma and generosity and is fondly remembered by his many friends and patients.

His vision was the creation of teams of local people who would be trained to provide for most of the health needs of their community. He believed that Katiwalas were capable of providing health services to a high level of sophistication and developed an ambitious curriculum and training programme. They learned not only conventional first aid but also preventive care, and acquired diagnostic and therapeutic skills. Katiwalas were unpaid volunteers but gained considerable respect and status within their communities. This programme attracted considerable attention within Mindanao and also financial support from overseas. As the Katiwala programme became better established it soon required more resources than the facilities of DPF could offer. It also strained the commitment of its still-volunteer staff.

Out of this experience emerged the concept of a new model of health training whereby local community health volunteers could receive a more systematic and rigorous education. A visionary element was the idea that this paramedical training should be combined with more formal medical education for doctors. That medical students and local people could learn together and, indeed, from each other was a revolutionary concept, but entirely in the spirit of idealism in which the Davao Medical School would be founded.

Dr. de la Paz expressed his vision in notes for a lecture delivered in 1978. He emphasized his concern over the lack of health services for urban slum dwellers and rural poor as well as his enthusiasm for primary health care (PHC). These were his twin driving motives. He hoped to find a solution to the problem of inequitable health care by a new approach to health manpower development.

The following are excerpts from his handwritten notes.

> This goal is to be accomplished by a two prong thrust – one, the education of a new person in medicine – a family, community orientated doctor; and

two, the education and training of PHC workers. Within the structure of Davao Medical School, the Board of Trustees has established an Institute of Primary Health Care. Two candidates for PHC training should be accepted for each medical student who will be admitted.

Whenever possible, the PHC candidates should be selected from the point of origin of each medical student.

In the first year, IPHC shall organise communities and conscientise the people. Some candidates for PHC training shall be selected by their own community. Education and training in PHC shall start in the second year. Second and subsequent year medical students shall be involved in the training of PHC workers under the supervision and guidance of the faculty.

During semester breaks and summer breaks, both medical students and PHC workers are to engage in community health projects in their towns and barrios. These projects shall increase in extent and complexity as the medical student progresses through his medical education and as the PHC workers become more competent in their jobs. The faculty shall be intimately involved in these projects – whenever possible, to the extent of living among the people part of the time.

Why start a medical school at all? Why not just an IPHC? The reasons are:

1. A PHC worker cannot stand alone. The PHC worker is part of the health care delivery system. The PHC worker stands at the base of a pyramid above intermediate level health workers and at the apex are doctors and nurses.
2. Graduates of medical schools are, by and large, unfamiliar with PHC and are indifferent to, or feel threatened by, other tiers of health workers. Hence the need for a new person in medicine – a student, a teacher, a researcher – but whose laboratory will be the living laboratory of our communities as much as the laboratory on the medical campus.
3. If we expect our graduates to engage in promotive and preventive health care as well as be skilled in curative medicine, early on the medical student has to come into contact with PHC workers with which the future doctor will have to work.
4. The doctor who trains PHC workers cannot feel threatened by the latter. On the other hand, the doctor becomes more aware of his responsibility to the community, his leadership in service and his fulfilment as a doctor in the service of teacher/leader.

Dr. de la Paz had been influenced by studying the works of Paolo Friere and by observing at first hand the Chinese experiment in training "barefoot doctors." He was enamoured of the Cuban approach to health care and was enthusiastic about the promotion of primary health care as advocated by WHO. His ideas could easily be dismissed as unrealistic and impracticable. In fact, he was soon overtaken by a painful and fatal

illness from which he died in 1981 at the age of 57. He never had the opportunity to put his ideas into practice nor to share his vision with his colleagues. I am particularly attracted by his idea of bridging the gap between doctors and communities, his unswerving commitment to his people and his willingness to take a radical approach to medical education. In the event, his dreams have not yet been fulfilled.

Davao Medical School

A parallel stream of events began around San Pedro Hospital. In 1975, the recently appointed director of the hospital, Sister Florida Manzano, widely acknowledged as perhaps the key activist in the formation of Davao Medical School, now nursed serious reservations about the nature of medical education. Her observations as a nurse had convinced her that the practice of medical education was focused far too narrowly on the management of disease and neglected the wider concept of health. She had recently completed a masters degree in hospital administration in the College of Public Health of the University of the Philippines in Manila where she had been the only nurse in a class dominated by doctors. With these experiences in mind she was interested in the possibility of creating an alternative system of medical education which would foster a greater sense of social responsiveness and a more holistic understanding of health. Sister Manzano has subsequently left her home country and is now working with her order in Burundi.

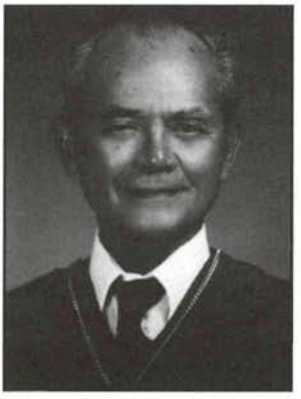
San Pedro Hospital had already established the San Pedro College of Nursing in 1956 – the first nursing school in Davao. The Dominican order which operated both the hospital and the nursing school was in the process of constructing a new library and laboratory complex and was heavily committed to the provision of both health services and training.

Sister Manzano required the services of an external auditor and in the summer of 1975 hired an accountant, Mr. Adolfo Miguel, for this purpose. He was studying for a masters degree in business management and selected as the topic for his thesis "A Feasibility Study on a Medical School in Mindanao." He undertook a survey of the health status of the people of Mindanao and related it to the demand for and the supply of doctors. At that time Mindanao was home for over eight million people, or twenty-two percent of the total population of the Philippines. There were fifteen medical schools in the country at that time, half of them in Manila and none in Mindanao. Mindanao had only one doctor for 5,000 people, whereas the national average was one doctor for 2,500 people. Apart from this absolute shortage of physicians, those

who had come to the island were concentrated in the cities whereas 80 percent of the people lived in villages. It was estimated that there was only one doctor for 50,000 people in the rural areas. He concluded, perhaps too optimistically, that a new medical school in Mindanao would offer some substantial benefits. It might encourage those doctors who would be educated in Davao to settle in the island. As well, a radically reformed medical curriculum might produce doctors who would be more socially responsible.

Sister Florida Manzano

What may have been initially conceived as a theoretical exercise for an academic degree rapidly became an urgent matter of real concern. Mr. Miguel needed advice on the content of medical education and was referred to several doctors. It is significant and characteristic that the idea of creating a medical school was not guarded secretively as the exclusive property of San Pedro Hospital. The Superior of the Dominican Sisters in Davao had already expressed cautious reservations about the practical implications for her order of assuming this level of responsibility. Consequently, a group of doctors, nurses, hospital and academic administrators and community leaders came together to try to bring these ideas to fruition.



Dr. Alex Panuncialman

Dr. Alex Panuncialman, Medical Director of San Pedro Hospital, accepted the leadership role with characteristic energy and enthusiasm. He was a native-born Davaoweno, son of one of the early migrants from the Visayas, a medical graduate of the University of the Philippines in Manila and an American-trained general surgeon. He was elected as the first dean of the proposed new Davao Medical School, a post which he eventually held for twelve years. He died in 1993.

Brokenshire Memorial Hospital cooperated willingly and Dr. Virgilio Durban Sr., a general surgeon on the medical staff, accepted the onerous responsibility for recruiting the founding medical faculty. The process of recruiting faculty was challenging. It was already clear that the new school would have a meagre budget, and the new faculty were invited

to volunteer their services. As events transpired, all the senior medical faculty agreed to give their services free for the first five years and, in effect, donated their time and energy as a contribution in kind. The feasibility study had predicted that these faculty costs would amount to 215,000 pesos annually. The design of a new curriculum and the innumerable teaching and administrative responsibilities required to initiate a new medical school are demanding and all those early faculty pioneers made considerable financial sacrifices.

Furthermore, none of these doctors had any previous experience in teaching or academic planning. Dr. Herrera, dean of the faculty of medicine of the University of the Philippines in Manila, mounted a special course on medical education for the new faculty and several Davao doctors attended this workshop in Manila at their own expense. It is a tribute to the persuasiveness of the first dean and his closest advisors that they overcame all these difficulties and assembled a core of committed faculty.

The founding faculty offer several significant observations about these early days. There was no conflict or competition between the various institutions or their senior staff. Nor was there any interest in academic rank. Several senior physicians willingly accepted relatively subordinate positions. The importance of family participation was important. This was demonstrated by the active participation of spouses in planning activities and the involvement of entire families in such activities as the "Walk for a Cause."

This group of physicians was greatly strengthened by several churchmen. In addition to the Dominicans of San Pedro Hospital and the Protestant Brokenshire Memorial Hospital, the Ateneo de Davao University, operated by the Society of Jesus, played a crucial role. The active participation of an accredited university was required in order to grant degrees, and the president of the Ateneo de Davao University, Father Emeterio Barcelon, S.J., became an energetic member of the planning committee. He played a key role as a skilled entrepreneur on behalf of the new institution. His hand can be detected in many of the subsequent developments – in particular, the addition of a dental school. Father Bustos, SJ, Procurator of St. Xavier's Seminary, served on the committee and advised on financial matters. Leading members of the Davao business community, who had already played a crucial role in DPF, became members of the Board of the Davao Medical School Foundation (DMSF).

DMSF was formed in 1976 with five founding partners – Ateneo de Davao University, Brokenshire Memorial Hospital, Development of

People's Foundation, San Pedro College of Nursing and San Pedro Hospital. Alfonso S. Ibanez, an engineer, became the first chairman of the board.

Dra. Trinidad Conchu de la Paz, known affectionately simply as "Doctora," was appointed as treasurer, a post which she held until her death in December, 1991. She was a member of a legal family in Manila, a graduate *magna cum laude* of the University of the Philippines and a qualified paediatrician. She had moved with her husband to Davao immediately after completing speciality training and they worked together in clinical practice. Her financial acumen and tenacity of spirit were essential ingredients in the team which founded the new Medical School. She later accepted responsibility as Director of the Institute of Primary Health Care. Doctora was widely respected and loved as the strong moral leader of IPHC and one of the most resilient and dependable pillars of DMSF. She died on Christmas Day, 1991.

Drs. Trinidad and Jesus de las Paz

DMSF is a Christian health institution whose stated goal is "to contribute to the improvement of the health conditions of the people of Mindanao." Its aim is "to develop a graduate who is a responsible and competent person for others, of high calibre, person-oriented and imbued with a sense of personal worth." As an institution it is committed to health-care research, health policy formulation and community health service in addition to its educational role.

On 22 September 1976, the Board of Trustees of the new DMSF formally submitted a request to the director of the bureau of higher education of the department of education and culture for the establishment of Davao Medical School. Within a few weeks a three-person review team visited Davao on behalf of the department to prepare a recommendation.

They were satisfied with the academic plan and the commitment of potential faculty. However, three conditions were of concern to them. They asked to visit the laboratories that would be used for the medical school and to examine the library facilities. They were shown the newly constructed laboratory of San Pedro Hospital and the library of the college of nursing and drew the understandable but incorrect conclusion that these facilities had been designed for medical students. The team was also interested in the financial status of the new institution. They

Davao Medical School

estimated that approximately seven million pesos would be required as initial capital. Father Bustos described a vision of a series of pledges from wealthy corporations and families in Davao which amounted to eight million pesos. This presentation satisfied the visitors although they may not have appreciated that these pledges were entirely hypothetical and, in fact, never materialized.

The accreditation team was satisfied with the description of the proposed Davao Medical School. A telegram confirming official approval for the proposed institution was received on 24 December 1976.

In reality, at that time there were no committed funds; there was only limited available space and few facilities. The key ingredient was a core of volunteer faculty backed up by a group of committed local people. Even by the time the school opened its doors to the first class, its total capital did not exceed 50,000 pesos.

A group of Davao doctors set off at their own expense to visit towns across Mindanao and the Visayas to recruit students for the new Medical School. San Pedro Hospital offered the use of disused dormitories to accommodate lecture rooms. Sister Manzano purchased fifty microscopes and obtained donations to purchase eight cadavers for the dissecting room.

In January, the community organized a sponsored twelve-kilometre "Walk for a Cause" from the airport to San Pedro Hospital and raised

40,000 pesos for the new medical school. Doctora approached the Asia Foundation in Manila and they provided 5,000 textbooks which constituted the core of a new medical library.

An American charitable organization, the Nellie Kellogg Foundation, was already active in Davao. Nellie Kellogg had been the wife of an American military officer stationed in Luzon prior to the outbreak of war. In 1941 she was interned by the Japanese and witnessed the courage of the Filipino people during the occupation. As a token of her respect, she subsequently established a foundation to encourage health education in the Philippines. It had supported the Katiwala programme and Dr. de la Paz encouraged the trustees to look sympathetically towards the new school. The foundation also supported an outreach programme at Brokenshire Memorial Hospital and its medical director recommended the new school as a worthy cause. The dean convinced the American visitors of the potential of the new programme and a proposal was rapidly drafted and submitted. In 1977 it committed $18,000 per annum for scholarships and faculty development. This foundation has continued to provide consistent support and has steadily increased its contribution.

Davao Medical School was the first medical school to be established in Mindanao. It opened its doors to the first class of sixty-six students in June, 1977, only six months after it had obtained accreditation. It is significant that the feasibility study had anticipated that it would require seven years before the programme could be implemented.

The space allocated to the Medical School within San Pedro Hospital rapidly became inadequate and alternative land was sought. A member of the San Pedro Hospital Board offered at a modest cost three acres of land in a convenient location close to the city centre. Using this land as collateral, a mortgage was obtained to construct the first school building. A member of the Board of the DPF was personally connected to a family foundation in Cebu and an approach to the Ramon Aboitiz Foundation resulted in a donation of 750,000 pesos to the future IPHC towards construction costs.

In the decade following the first graduation in 1981, Davao Medical School graduated 648 doctors. It is thought that 80 percent are in practice in Mindanao and that most of these are in general practice. However, no formal follow up of graduates has been conducted. There are only three medical schools in Mindanao to train doctors for a current population of approximately fifteen million. The Davao School is the largest of these.

DMSF later opened a Centre for Education and Research Development on Health (CERDH). This unit has the mandate to undertake faculty development in medical education and conduct health-care research with the goal of creating alternative strategies that can be field tested and evaluated. It offers a three-semester masters degree in community health. The majority of students are physicians from the department of health. To date, it has graduated thirty-five physicians.

A faculty of dentistry was opened in 1980. It has already graduated over 200 dentists, most of whom are thought to be in practice in Mindanao. It is still the only dental school in the island.

The Institute of Primary Health Care

In order to meet its commitment to community service the Board of DMSF decided that the school must have an organization designed specifically for this purpose. This new body was named the Institute of Primary Health Care (IPHC). It began operations in 1978 under the directorship of Dra. Trinidad Conchu de la Paz, who carried this responsibility until her death in 1991. IPHC started its work within the DPF house with a staff of only five. By 1990 this number had swelled to over 100 and it occupies its own premises on the grounds of Davao Medical School Foundation.

Part of IPHC's original mandate was to expand the training of katiwalas (or "trustees"), and, between 1978 and 1982, it trained 525 additional katiwalas. This programme attracted national attention, and in 1980 it received presidential recognition for its services to women and children. In the early eighties the systematic training of katiwalas within IPHC was discontinued. By that time the department of health had recognized the value of these Community Health Volunteers (CHVs) "as an alternative system of regional development" and accepted responsibility for their ongoing training.

Within a few years it became clear that the experiment of trying to integrate the training of katiwalas with medical students was not succeeding. The latter understandably focused narrowly on conventional "medicine" on which they would be examined and evaluated. Both faculty and students found it difficult to see a realistic connection between their professional expectations and the amateurism of the people's efforts to control their own health. This experience illustrates the wide gap which separates professional health-care systems and community health initiatives. This experience is particularly significant since it occurred in a most favourable environment where there was a strong and sincere commitment to integrate medical care with community-based

health programmes. IPHC, however, is still active in the promotion of primary health care.

It was anticipated that IPHC would play a key role in providing experience for medical students in health care in the communities. This expectation was never fully realized. IPHC had hoped to send students out to the rural barangays to learn directly about the conditions which determine the health of the people. Within a few years this practice ceased, due partly to the dangers associated with the unstable peace and order situation but was due at least as much to a lack of interest and motivation among the students. IPHC still provides opportunities for medical students to experience health care in rural areas.

The wider role which IPHC has actually come to fulfil is a logical extension of its understanding of the nature of health. DPF had upheld a broad view of health and appreciated the intimate connections between the health of people and their social, economic and political situation. In pursuit of their commitment to participatory, community-based health development, IPHC embarked on such programmes as community leadership training, popular theatre for education in nutrition and family planning, assistance to small local organizations for livelihood projects, and management training. As IPHC began to recruit new staff in order to undertake field programmes, it is significant that an institution devoted to primary health care did not recruit a single nurse or doctor – apart, of course, from its director. Its employees are graduates of universities and colleges in Mindanao and have been educated in the social sciences, business management, agriculture and related disciplines. This policy clearly reflects IPHC's tactical approach to health.

IPHC defines its mission as follows: "To stimulate the improvement of the quality of life of our Filipino people by building organized, caring communities capable of transforming their own situation through participatory processes for change and eventual national transformation." It adopts the following strategies:

> To promote community-managed development programmes utilising participatory approaches leading to people empowerment and directly contributing to the realisation of national goals; to actively seek out alternative sources of funds (external and internal) to enable the Institute to strengthen the NGO sector in the region as it works in partnership with government organisations; to provide continuing staff development opportunities to its personnel; and to support efforts to recognise community medicine/dentistry as a vital thrust of the Medical School.

IPHC emphasizes its commitment to "participatory action research" (PAR). It defines PAR as based on the conviction that

Mindanao Training and Resource Centre

research is not the monopoly of professional social researchers and that research can be made more relevant and responsive to the needs of communities. PAR aims at demythologising traditional research in which people are treated as objects of development and are therefore mere respondents to questions of outside agencies and as mindless beneficiaries of goods and services. Thus, PAR strategy is an alternative form of social research in which the people themselves are the main actors in the entire research process – from the decision to investigate, to formulate research tools, to collect and analyse data and finally to disseminate and utilise the data. This strategy should result in the formation and mobilisation of local research teams or core groups which can systematically diagnose the existing and changing conditions of their community, and validate those with the majority. The final outcome is an informed people whose increased social awareness should move them towards taking concerted and well planned actions for problems or issue resolution.

IPHC describes its concept of institutional capability-building as follows:

> The task of assisting communities to work for social change is a great challenge. The problems that beset these communities are multi-faceted and therefore call for an integrated/coordinated solution. The task cannot be the monopoly of any one institution but must be the joint responsibility of as many organisations and institutions as are engaged in development work. This strategy aims to develop a broader NGO sector supportive of

the efforts of government and responsive to the development needs of the communities in the region. This strategy should result in NGO's with capable and caring staff manifesting a clear vision of the NGO's role in national development, functioning, efficiently with viable systems in place and implementing well defined and planned programmes resulting in bringing about significant social change.

IPHC's understanding of community organising is based on the belief that "people whose lives are directly affected by prevailing social, economic and political conditions should take the lead in determining the direction that their own development should take. This strategy aims at providing communities with opportunities to learn how to act on problems that confront them in an organized, collective, systematic fashion. It should result in the emergence of caring community groups (confident, articulate, credible, vibrant, creative) which are able to address the changing needs of their constituents through well planned programmes and projects carried out and supported by a broad base of the community.

Shortly before her death, Doctora spoke to IPHC staff and shared her reflections on her thirteen years as director. She expressed her satisfaction that IPHC had come "to excel in several areas – community organization, participatory action research, community training in participatory processes, primary health-care training, and linkaging and networking." She stressed her belief in continuing to work with government, NGOs, national foundations and overseas organizations. She identified the strengths of IPHC as "our dedicated, idealistic staff; our willingness to listen to our communities' needs and seek ways to address them; our flexibility and innovativeness; our harmonious relationship with government and other NGOs; and our openness to change." As a close observer of IPHC, I can fully endorse Doctora's assessment of her organization and underline the prime importance of the quality of her young field staff. Their idealism combined with a realistic knowledge of their own communities represents IPHC's single greatest asset.

The relationship between Development of People's Foundation, Davao Medical School Foundation and the Institute of Primary Health Care is complex. In organizational terms, IPHC is a component part of DMSF, of which DPF is one of the five founding members. DPF has a particularly intimate relationship to IPHC since the creation of IPHC was largely the initiative of DPF. Indeed, DPF secured the necessary funding for the construction of the institute's first building. In the early years, it was DPF which was registered with the United States Agency for International Development (USAID) as a Private Voluntary Organization and DPF was the recipient of USAID grants, although the programmes were implemented by IPHC.

DPF/IPHC received its first major grant from USAID in 1983 to allow it to help thirty-six villages with trained katiwalas to improve their management of farm production and health activities. In 1986, USAID awarded $2 million to DPF/IPHC, in partnership with the National Economic Development Authority, the Department of Health, the Population Commission and the Development Academy of the Philippines, to undertake the CHILD project – Community Health through Integrated Local Development. This five-year programme combined three elements: one assisted the Department of Health to augment health services to underserved areas; another focused on capability building within municipal councils; the third, implemented by IPHC, targeted 280 communities in the region. In 1988, USAID provided one million dollars to allow IPHC to offer small grants for sixty-one micro-projects managed by fifty-two NGOs in seventy-five communities. In 1990, USAID gave a further grant to allow IPHC to replicate the CHILD process in Zamboanga in the southwest corner of Mindanao. In addition to this regular support from USAID, IPHC has attracted project funding from many other overseas and multilateral agencies, including UNICEF, the United States, Australia and Japan. Although Canada withheld bilateral aid throughout the Marcos years, the Ministerial Administered Fund managed from the Canadian Embassy in Manila provided a small grant to support the katiwala programme. Since 1988 CIDA has supported two major collaborative projects between Davao and Calgary – the Davao Health Development Programme and the Canada Asia Partnership. These will be described in detail in the following chapter. More recently, as overseas sources of aid are shrinking, IPHC is attracting internal funds from national foundations and government agencies.

USAID recently provided funds for the construction of the Mindanao Training and Resource Centre (MTRC). The Davao Health Development Programme also transferred some project funds to assist in the equipping of the MTRC. This complex is situated in the grounds of DMSF. It houses most of the IPHC staff and provides dormitory accommodation for up to 150 trainees, and contains cafeteria facilities, classrooms, library and information services. It is designed to allow IPHC to function as a learning resource for community leaders and other NGOs throughout Mindanao. It has the capacity to create and produce learning materials and its staff can provide consulting services as required.

5

The Davao Connection

Origins

Throughout the years of the Marcos administration Ottawa maintained diplomatic relations with Manila. As an expression of its distaste for martial law it did not provide bilateral aid. CIDA contributed only to agricultural and fishery cooperatives in Luzon and the Visayas and provided small grants to NGOs. Prime Minister Trudeau avoided any direct contact with the Marcos administration, although he did visit Manila in 1983 to attend an ASEAN regional meeting. After the 1986 revolution a member of parliament was asked to assess aid needs while he attended a meeting of the Asian Development Bank in Manila. The United Nations had declared the island of Negros Occidental in the Visayas the first "man-made disaster" by virtue of the extreme poverty and starvation that had resulted from the collapse of the sugar industry. The member of parliament was impressed by the widespread need for assistance and recommended that Canada should review its aid policies towards the Philippines. The Secretary of State for External Affairs, Mr. Joe Clark, visited the islands in the summer and promptly announced that Canada would commit $100 million as bilateral aid over a five-year period.

In the late summer of 1986 a team of Canadian aid representatives visited the Philippines in order to identify development projects which might be funded by CIDA. These funds would be used in several ways. Some aid would be provided in the form of Canadian commodities, such as potash from Saskatchewan; bilateral aid would be used to offer direct assistance to high priority communities, such as the sugar workers of Negros Occidental; and Canadian NGOs, such as the Canadian Co-operative Association, would be enabled to collaborate with sister Filipino organizations. CIDA also decided to encourage institutional linkages between Canadian and Filipino universities. These would target three key sectors – environmental protection, food storage and primary health care. CIDA identified three Filipino institutions regarded as leaders in these sectors. These were the University of the Philippines at Los Banos in Luzon, the University of the Philippines at Iloilo in the Visayas, and the Institute of Primary Health Care (IPHC) of Davao Medical School Foundation in Mindanao. CIDA selected a Canadian partner for each of these campuses – Dalhousie University for Los Banos, McGill University for Iloilo, and The University of Calgary for Davao.

IPHC was chosen on the basis of its international reputation in primary health care, its ability to attract and manage international funds, and the success of its initial links with CIDA, which had started during the Marcos years. IPHC's katiwala training programme had received funds from CIDA's Ministerial Administered Fund in Manila as well as from IDRC. It was anticipated that IPHC's innovations could become a prototype for the entire country. The University of Calgary was selected as a partner for IPHC because of its track record of partnering with the Institute of Medicine in Kathmandu. It was anticipated that DID might serve to facilitate the exchange of experience between Mindanao and Nepal. CIDA put considerable weight on Calgary's apparent ability to achieve a sound partnering relationship as well as its health-care orientation.

It was anticipated that the new Health Development Programme was essentially a "health" project. It was therefore reasonable to assign its management to Davao's Institute of Primary Health Care. It was equally logical to involve Calgary's Division of International Development which had the experience of associating in a health development programme with another institute of medicine in Asia. It was expected that IPHC would contribute its considerable expertise in community organization and training as well as in primary health care. IPHC had already built up an experienced administrative organization which supported approximately fifty staff and managed a substantial budget.

In response to a request from CIDA, I visited Davao in October, 1986, in order to meet with Dra Trinidad Conchu De La Paz, the Director of IPHC, and explore with her the feasibility of future collaboration between Davao and Calgary. DID had been in operation for barely three months and its overseas experience had been limited to partnering with the IOM in Kathmandu. We had not yet reached a systematic understanding of the nature and conditions of partnering and relied on our instinctive optimism about the prospects for this new liaison. I recognized that our Filipino colleagues had much greater understanding and field experience of both community development and primary health care, and I welcomed the opportunity to learn from this new association.

The Davao Health Development Programme

Against this background, a proposal to CIDA for the Health Development Programme was drafted during the course of 1987. The preparation of this plan was coordinated by a CIDA project officer. Both the broad strategy and the detailed content of the project were conceived by IPHC, while DID contributed ideas to the design of the project and prepared the detailed documentation and management plan for submission to CIDA. The project which emerged from these discussions was originally named, with typical Filipino flair for acronyms, the SHIELD project – that is, Sustained Health Improvement through Expanded Livelihood Development. It was later rechristened, rather more prosaically, the Davao Health Development Programme, or HDP.

The proposed HDP was a logical extension of the USAID-funded CHILD project, Community Health through Integrated Livelihood Development. This had started in 1986 and continued through to 1990, operating in parallel with the first phase of the HDP. That component of CHILD which was the direct responsibility of IPHC targeted 280 communities in underserved provinces of South East Mindanao (Region XI) – a region with the third highest infant and child mortality rates in the country. IPHC was engaged in community organization and training in health-related activities and had assisted in introducing an innovative health information system. This not only allowed the project team to monitor health outcomes but also assisted communities to generate and utilize for themselves simple health indicators – such as the growth of children, rates of immunization, use of family planning and access to reliable sanitation.

The goal of the HDP was to improve health, nutrition and quality of life in 100 communities within these same depressed areas of Region XI.

This was consonant with the policy of the government of the Philippines to focus on rural-based development in an attempt to increase family incomes and, as a consequence, improve living conditions. The HDP was designed to ensure that the community-managed health initiatives which CHILD had facilitated would be sustained by parallel local economic development. In essence, the HDP aimed to link health development with business development.

The HDP addressed two distinct aspects of sustainability. First, it recognized the need to encourage the long-term sustainability of IPHC as a national institution. Our earlier discussions had identified two areas where IPHC could be profitably strengthened. The Institute was relatively weak in some aspects of research which were regarded as critical for its evolution as a leader in community development – in particular, expertise in social research, evaluation methods and social impact analysis. Our intention was not to generate scholarly research but rather to encourage the emergence of an attitude of critical enquiry which could be applied to the analysis of practical problems. The organization was also vulnerable in terms of middle-level management.

The second aspect of sustainability was the weakness of communities in terms of their capacity to maintain their own health initiatives. The HDP addressed three elements of community sustainability – financial, managerial and organizational. It proposed to encourage financial self-reliance by raising family incomes and creating a community-managed fund for the support of health-related initiatives. It planned to provide systematic management training for communities, with a particular emphasis on project design and implementation, including financial control. Organizational strength would come from leadership training and the formation of multi-purpose federations. These would exercise greater power in purchasing and marketing. A key, and perhaps unique, feature of the HDP was the intention to require project communities to commit a proportion of profit from funded projects to a Social Development Fund (SDF). This would provide a pool to be used to sustain health-related activities and seed new income-generating projects.

The peace and order situation in the region was a stumbling block for CIDA. The provinces around Davao were, at that time, a stronghold of the NPA, as well as being the home of a powerful counter-insurgency organization, the Alsa Massa. Muslim activists were also present in some provinces. Communal violence was a daily reality, even within some parts of Davao City. However, the IPHC staff were familiar with local conditions and were well able to minimize risks.

Consequently, the HDP Management Plan was finally approved for a five-year period in the spring of 1988.

CIDA awarded a contribution of $3,480,282 to be spread over a period of five years. By the time the HDP was terminated in 1993, a total of $2,182,651 had been disbursed. Of this sum, expenditures in Davao totalled $1,399,775, or sixty-four percent of available funds. This included the expenditure of $591,652 on the support of over fifty HDP project staff in IPHC, $94,812 for staff training, $254,691 for livelihood loan assistance and $154,190 for community organization. Total expenditures in Calgary amounted to $782,876, or 36 percent of the budget. Of this sum, personnel costs consumed $330,951; travel costs amounted to $175,660; $156,403 was spent on operational costs; and The University of Calgary received an overhead allowance of $119,861.

The proportion of the budget allocated to Davao increased as the project proceeded. Some funds originally assigned to Calgary were transferred to Davao. Furthermore, the modified work plan which was rejected by CIDA in the fall of 1992 would have made further transfers.

IPHC's project manager for the HDP was Ms. Sony Chin, Administrator of IPHC. DID's project manager was Dr. Jeff Jacobs, a member of the Faculty of Education in Calgary. They had collaborated with the CIDA project officer to prepare the management plan.

This took the form of agreements between CIDA, The University of Calgary and DMSF, whereby each institution contributed substantial resources to the project. The management structure of the HDP merits attention. The University of Calgary, through DID, was designated the Canadian Executing Agency and the contribution agreement was strictly between CIDA and The University of Calgary. The latter subsequently signed a memorandum of understanding with DMSF on behalf of IPHC. This clarified their respective roles and responsibilities. According to these agreements, The University of Calgary accepted from CIDA full responsibility for the outcomes of the programme, for managing the budget, for acting as a "conduit" for the transfer of funds from Ottawa to Davao and for acting as the "interface" between CIDA and IPHC. This general responsibility for project management was additional to DID's obligation to provide technical assistance to IPHC in social research and middle-level management training.

DMSF, through IPHC, was referred to as the "implementing agency," with immediate responsibility for all field operations. Given IPHC's unquestioned reputation for project implementation and its track record

in managing overseas funds responsibly, the idea of locating a Canadian project manager in Davao was never contemplated. The heavy expense of maintaining a full-time expatriate in Davao would have been unjustifiable. Indeed, it is doubtful if the project should have been approved if this degree of direct Canadian supervision had been regarded as essential. The project budget was constructed with provision for only two annual visits to Davao, each of three weeks duration, by DID's HDP manager.

DID provided a Canadian public health physician to IPHC for an initial period of two years. Dr David Swann was selected by both IPHC and DID and his mandate was to assist in the promotion of primary health care and to assist Davao Medical School in its community health programmes. He was also designated as Calgary's on-site coordinator to liaise between the IPHC and DID project managers. He did not exert any direct authority in the management of the project. Nor was it anticipated that this position would be required beyond the first two years.

The HDP required the services of an additional thirty-five local staff, all of whom had to be oriented to the philosophy of IPHC as well as to the general purposes of the HDP and their own specific duties. Eventually the number of HDP staff would reach fifty-five, or half the total personnel complement of IPHC.

The HDP in Concept

The HDP was designed as an orderly sequence of action steps:

1. IPHC would select 100 project communities in five provinces in Region XI. Criteria for selection included the stipulations that they must be "CHILD" communities, that the level of peace and order was tolerable, that they should be located no more than five kilometers from the nearest public transportation and that they were sympathetic to the purposes of the project.

2. IPHC would collect baseline social, economic, political and health data derived from samples of these project communities. Since they were a sub-set of the larger CHILD project, it would be possible to collect comparative data from both HDP and non-HDP communities.

3. IPHC would prepare a series of training manuals for the guidance of project staff and community leaders. These manuals would cover those topics which would form the content of community training.

4. IPHC would organize each of the 100 project communities into ten clusters or Quality of Life Circles (QLCs). Each QLC would recruit, on average, 7.5 families. Since average family size was six, it follows that

the HDP would directly affect 45,000 individuals. At least in this early stage of the project, the QLC would represent the basic unit of organization. The field staff would then embark on a sequence of systematic training for QLC members, which would focus primarily on four themes – the QLC concept, community organization, project planning and implementation (including financial management), and small business practices. Each QLC would appoint a leader and it was anticipated that most of these would be community health volunteers, some of whom would have been original katiwalas. All would receive leadership training. Project staff would assist QLC members to prepare micro-business proposals for subsequent review by their QLC, the provincial project team and community representatives.

5. When project proposals were approved, the HDP would provide small loans, commonly of the order of 2,000-5,000 pesos, in support of these projects. Two alternative credit systems were offered; loans were repayable without interest within an agreed time frame; profit would be divided between individual proponents and their QLC; and loans were granted to QLCs rather than directly to individual members. QLCs would act as a conduit for credit, supervise projects and act as guarantors for the repayment of loans. The project team would provide not only credit but also technical assistance in the implementation of the project. It would facilitate linkages with other agencies that could provide additional support.

6. That proportion of profit diverted to QLCs would constitute their Social Development Fund (SDF). This SDF would be managed by QLCs partly to support their own health-related initiatives and partly to recycle the money to fund other income-generating projects.

7. Projects funded by the accumulated SDF would then be implemented, monitored and evaluated systematically by representatives of the local community as well as by project staff.

8. Once QLCs were established and functional, they would be encouraged to coalesce into larger cooperative units, or federations. The latter would create larger units, which could exert greater power for both purchasing and marketing.

9. As experience was gained through the work of the QLCs and federations, IPHC would be responsible for disseminating this information widely to others within and beyond the project communities.

10. IPHC would establish demonstration farms or centres for appropriate technical innovations in order to share experience between villagers.

In parallel with this entire process, IPHC would continue to train villagers in the essentials of primary health care. In line with the focus on self-reliant health, QLCs would be encouraged to monitor the health status of their communities and display this information on public data boards as the basis for community health planning.

In essence, the HDP represented an attempt to link two complex ideas – community-based health development and business development. Each of these ideas is complex in concept and challenging in implementation. There are now many models of "People's Banks" and cooperative movements based on the pioneer work of the Grammene Bank of Bangladesh, and many variants of that initial system are being explored in every continent, including North America. The HDP may have been unusual in its attempt to fuse all these elements within a single programme. As a further complication, the HDP was to be operated through a partnering arrangement between Filipino and Canadian institutions which had no previous experience of working together. On reflection, it is doubtful if those of us who shared in these plans fully appreciated the enormity of the task we would undertake. It is likely too that those who have subsequently criticized the HDP have not fully understood the complexity of the undertaking.

The HDP in Operation, 1988-93

In tracing the course of the HDP from its inception in the early summer of 1988 until its termination early in 1993, I will attempt to indicate our successes and failures without entering into unnecessary detail. Rather than describe specific events or the actions of individuals, I will be content to identify general trends and broad issues. As one follows the course of events, it would be wise to bear in mind the distinction between two features of the HDP – the process of partnering and the technical content of the partnership.

Progress in the first four action steps was encouraging, despite inescapable problems which caused early delays. For example, the original intention was to focus on those provinces closest to Davao City. However, peace and order concerns in Davao Oriental required IPHC to relocate to the more northerly province of Surigao del Sur. Within the first year, the time frame of the HDP was extended from five to six years and the available funds were redistributed accordingly. By the end of 1990, 100 project communities had been selected; baseline data had been collected; the necessary training manuals had been completed; the projected number of QLCs had been formed; and the sequence of community training was well advanced. This laid the necessary foundation of

Davao HDP field staff on location. Mindy Antopina is in the centre foreground.

organized and trained communities on which the project team could proceed to provide livelihood assistance in the form of loans to individual proponents through their QLCs.

I became DID's project manager for the HDP in the summer of 1990, a position I retained until the end of 1992. At this same juncture, and for unrelated reasons, the responsibility for project management within IPHC was transferred to Ms. Mindy Antopina, a young member of the HDP field staff. We enjoyed a harmonious working relationship during what proved to be two stressful years. A few months later the CIDA project officer in Manila was changed following a reallocation of personnel. Ms. Antopina resigned from IPHC in September, 1992, and Ms. Luz Canave took over her responsibilities.

Recognizing DID's commitment to offer a range of technical assistance, a project team was constituted on the Calgary campus. It included a sociologist, an economist, an adult educator and a civil engineer from our campus, together with DID administrative staff. We also attracted a community health nurse who works with the Department of Indian Affairs and is herself a member of the Siksika Nation. She could offer not only her professional expertise in primary health care but also her personal experience of being a member of an indigenous community. All of these team members visited Davao to learn more about the programme at first hand.

In the late fall of 1990, we conducted an exhaustive internal review in Mindanao to examine the operation of the HDP in detail. Several concerns surfaced and corrective steps were taken. In order to fulfil DID's requirement to strengthen IPHC's research capabilities, a research team was created within the HDP; a local consultant was hired to support the research team; new questionnaires were drafted and the survey plan expanded; and training opportunities were found locally in Davao. Subsequently, the DID team organized a special three-week workshop on research methods in Calgary for the HDP research team. In response to continuing concerns about the weakness of middle-level management, a schedule of training opportunities for HDP staff was planned, making full use of the programmes of the Canada Asia Partnership. The management of a complex credit system was a source of concern and we agreed to conduct an audit of the programme. The focus on primary health care had become blurred as a result of preoccupation with business development. Steps were taken to recover the emphasis on health in community training. A local consultant was recruited to advise on primary health care and our civil engineer subsequently visited Davao to advise on the provision of potable water. A grant from the Alberta Agency for International Development allowed the HDP to assist some communities with water projects.

The HDP in the Field

So far, this account of the HDP in practice has been impersonal and has focused narrowly on management concerns. It fails to do justice to the vitality of the HDP in action among communities.

Over fifty new staff had been recruited to IPHC to implement the programme. They came from Davao City and surrounding provinces. Most were in their twenties and were graduates of universities and colleges in Mindanao, mostly from the disciplines of the social sciences, commerce and agriculture. None had been trained in the health sciences. They were selected by an exhaustive participatory process on the basis of their professional education, their suitability for work among rural communities and their capacity for team work within the ethos of IPHC.

The project was spread widely across four provinces and Davao City. Five provincial teams were formed, each with seven project officers. Each project officer was responsible for three project communities, comprising thirty QLCs and approximately 200 members. Each team was managed by a provincial coordinator and supported by a central administrative core within IPHC.

Project officers spent most of their time living within their communities, reporting back to the IPHC offices for a few days each month. They sometimes found themselves in potentially violent situations. They devoted their time to organizing and training their project communities for microbusiness and health activities. Later they operated loan assistance and supported and monitored the small projects for which loans had been requested. They maintained close working relationships with local government agencies and other nongovernment organizations in order to facilitate cooperation. Every effort was made to encourage effective linkages among all the resources available to communities.

It would have been impossible to appreciate the essence of the HDP without sharing time with field staff among their communities. They were enthusiastic and effective community organizers and the trust which grew between project officers and QLC members was almost palpable. The effectiveness of project officers in organizing their communities cannot be challenged. Filipinos seem to have an intuitive capacity for collaboration.

The responsibility of project officers expanded exponentially when they began to extend loans and QLC members began to use these funds to implement small income generating projects. Most loans were requested by individuals and recipients were equally represented by women and men. Some secured loans to purchase seeds and fertilizer to plant corn or vegetables and sell their produce. Some set up a corn mill to process locally produced grain. Some raised poultry for sale. Some engaged in small vending operations to sell fish or other products in the local market or opened a small shop in their barrio. Some produced goods for sale – simple sandals were a profitable commodity. Some entered into small cooperatives to secure a larger loan.

Many of the micro-projects undertaken proved to be profitable and provided opportunities to those who had been denied access to financial assistance. However, the failure of some projects and loan delinquency caused concern. Some projects failed because of natural hazards such as drought, which devastated corn harvests in some regions. Some vending operations were simply poor market prospects. More serious problems arose when projects supported by larger loans failed.

One example haunts my memory and illustrates the unfortunate consequences of well-intended but ill-conceived loan assistance. A small group of fishermen on the Surigao coast obtained a loan to purchase a used fishing boat. However, the leadership of the group was weak and unreliable and their choice of boat was ill-advised. As a result, they found themselves the owners of a useless unseaworthy vessel and saddled with

a debt they could not repay. Their loan, rather than being a valuable asset, became an additional liability.

The HDP under Stress

The process of extending loans had started early in 1990 and appeared to be progressing as anticipated. However, by March, 1991, it became clear that the loan system was not operating satisfactorily. Disparities between various estimates of the amount of loans extended, the amount which had been repaid and the time scale for repayment of outstanding loans led to a detailed review of loan policies and the financial monitoring systems then in place. We realized that the record system could not provide reliable information. As a consequence of this discovery, we promptly halted the processes of new QLC formation and provision of new loans until corrective actions had been taken. CIDA/Manila was informed immediately of the situation and of the actions which we had taken.

Project officers continued to assist their communities in the implementation of existing projects and in the financial management of loans. However, the team was diverted to the following tasks: to review each loan file in order to retrieve accurate information about the amount of money released, the amount repaid and the agreed time frame for repayment of outstanding loans. It emerged that, of those QLCs which had been formed and completed their training, only 228 had received loans. Out of a total of 7.5 million pesos which had been assigned for loans, 4.3 million pesos had already been disbursed. Only 3.2 million pesos remained for distribution to the remaining QLCs. This sum would, of course, be augmented by recycling those loans which would be repaid. In the summer of 1991, the low rate of loan repayment was disquieting.

These disturbing findings led to a detailed examination of the loan policies in operation, the reasons for non-repayment of loans and the financial control systems. It transpired that the current loan policies were ill-conceived. Even if implemented faultlessly, they were unlikely to result in effective economic benefits to individuals or a viable collective Social Development Fund (SDF). The SDF was the foundation of the sustainability of the HDP. The preferred "venture capital" loan mechanism was complex and poorly understood by project officers. Not surprisingly, there was an even greater degree of confusion in the barangays. Some QLCs believed that they were receiving grants rather than repayable loans. Some assumed that the HDP was entering into a "joint venture" with them and would share in both their successes and failures. Others did not appreciate that loans were repayable irrespective of the outcome of their projects.

Some of the projects which had been approved and funded had been high risks – for example, those resulting from natural disasters, such as drought – and others were simply poor market prospects. The project staff studied this situation in detail and did not flinch from acknowledging failings in our own attitudes and behaviours as well as those of project communities.

The financial management system for documenting and monitoring loan assistance and providing data to the management team required a thorough overhaul. With the assistance of the CIDA/Manila project officer, a local accounting firm was contracted to examine the existing financial systems and recommend changes. Within six months the missing data on loans was retrieved. On the recommendation of the consultant firm and with the approval of CIDA/Manila a new computerized financial management system was introduced; additional trained accounting staff was hired; and HDP management personnel were trained in the use of the new systems. Although there was clear evidence of weak management there was absolutely no suggestion of misuse of funds.

The HDP team in Davao met to review existing loan policies and to share experience and opinions. Advice was taken from others in the region who had pertinent experience to offer. All of these explorations were shared with the DID team and Calgarians and Davaowenos worked harmoniously to find a solution to the problem.

In retrospect, these discussions did not challenge sufficiently radically the basic assumptions of the business development component of the HDP. Given our previous collective experience of community-managed development, we did not bring to our deliberations a practical understanding of banking or business practice. Nevertheless, by the end of 1991 we had completed a draft work plan which could recover control of the HDP.

This new work plan did not meet with ready acceptance from CIDA/Manila because of shortcomings, none of which was insuperable. More significantly, it failed to gain acceptance by the IPHC administration. A period of six months' stalemate followed, characterized by miscommunication between Davao, Calgary and Manila. At the time, this period seemed to be the nadir of the HDP.

Further correspondence and conversations in Manila indicated a new direction which might transform the HDP. We agreed that the entire business development aspect of the HDP required radical surgery rather than minor adjustments, and the expertise required to undertake reconstruction was close at hand in the Philippines. Within a few weeks, a new Filipino team of consultants was recruited to strengthen the techni-

cal capabilities of the HDP in three areas. Mr. Jose Deles, an experienced and highly respected Filipino development planner, agreed to act on behalf of DID as its on-site representative in Davao in order to strengthen the HDP management team. Mr. Cresente Paez, who had an enviable track record in business development within the Philippines, undertook to advise on the credit systems; and Dr. Mila Viacrusis, an experienced Davaoweno physician with an intimate knowledge of community health issues in the region expressed willingness to supervise the health component of the HDP. DID recruited this new team and the plan met with full approval from both IPHC and CIDA/Manila.

The intensive review of the HDP which ensued highlighted three areas which had to be addressed and a revised work plan was proposed to remedy these deficiencies:

1. Evidence of failure of the business development policies could be seen in the low rate of loan repayment, the high rate of project failures and the slow accumulation of the Social Development Fund. A major factor contributing to this situation was the lack of a community organizational structure capable of sustaining local economic growth. The respective roles of QLCs and federations had become confused. It was deemed that QLCs should be reactivated as informal groups which would facilitate collective health and livelihood initiatives, constitute units for requesting loans on behalf of their members and act as their guarantors. However, they should not receive funds directly from the HDP or manage credit facilities. Federations should be assigned the key role of managing credit and administering loans. They would also become responsible for proposing broad business and health strategies. In order to support their own health care, federations would generate and manage the SDF, or "Katiwala Bank," on behalf of their entire community. The pace of accumulation of SDF would be accelerated by charging a small rate of interest on loans for this specific purpose. In order to strengthen their business capabilities, these "Community Health and Financial Associations," or CHFAs, as federations would be renamed, should receive further training on the appraisal of projects based on the match between market opportunities and local resources. The HDP should hire a marketing officer to find new business outlets. Savings and investment would be encouraged by incentives in order to break dependency on external funds. As soon as possible these federations, or CHFAs, would be coalesced into larger provincial associations in order to achieve greater efficiency and benefits of scale.

2. Community Health Volunteers would be brought together into associations of CHVs. They would retrieve their former "katiwala" role

and provide leadership in the health activities within their QLCs and, collectively, within their communities. They would draw on the resources of the Katiwala Bank for this purpose. They would link with the government midwives and other health workers and function as intermediaries between their communities and the official health-care system. Using their past training, they would assist their QLCs and the larger associations to plan and implement health action plans.

3. Project management was addressed by restructuring the HDP Management Committee and ensuring that it had both the responsibility and authority to make decisions, in appropriate consultation with DID and IPHC. Lines of communication between the HDP team in Davao and DID, IPHC and CIDA/Manila were clarified.

By October, 1992, after a painful but productive hiatus of eighteen months, the HDP appeared to be back on track – a repaired and upgraded track – with a new management team backed by experienced Filipino consultants in whom DID had complete confidence. We had reconstructed the budget in order to be able to extend the project for an additional two years – that is, through to 1996. By virtue of changes in the peso value of the dollar, the transfer of funds from administration to the communities, the use of contingency funds and realistic anticipated rates of repayment of outstanding loans, we could identify over nine million pesos for loan assistance – that is, two million pesos more than had originally been provided for this purpose.

We submitted this new workplan and budget in the belief that the revised HDP could achieve its original purpose by 1996. The new concepts and logistics were well accepted in both Davao and Calgary and appeared to have the support of the CIDA project team in Manila. Official approval was denied. Instead, it became clear by the end of 1992 that the HDP would be terminated, which it, in fact, was in 1993.

The HDP in Retrospect

It is distressing but instructive to reflect on the experience of the Davao HDP – a project in which I have been intimately engaged and for which I am accountable. My personal understanding of developing and partnering owes an immeasurable debt to Filipinos – not only to the leaders of DPF, DMSF and IPHC whom I came to admire and love but also to the young staff of the HDP team and members of the project communities. They have been my patient mentors.

The mixture of joy and sadness which has characterized the process that brought Davao, Manila and Calgary together needs to be explored

as dispassionately as possible. Failures are at least as instructive as successes – by whatever criteria these outcomes are judged.

In reflecting on the fate of the HDP in order to weigh its strengths and weaknesses, one should distinguish between the technical content of the partnership and the practice of partnering which sustained it. Each of these elements combined to determine the fate of the HDP.

The Content

In terms of the content of the partnership, one can analyze the efficiency of the operation in terms of the technical competencies which IPHC and DID contributed. Successful partnering requires that partners should bring to the enterprise those skills that allow them to fulfil their obligations. The content of the HDP fell into three sequential and interrelated parts – community organization, business development and health development.

The process of community organization progressed well and demonstrated the ability of IPHC's field staff to work effectively within their communities. Their success in organizing QLCs and federations and conducting community training reflects IPHC's considerable experience.

However, the business development phase of the HDP proved to be seriously flawed in both concept and execution. Although the HDP team mobilized communities with characteristic sensitivity and skill, it did not create a structure capable of accommodating the needs of business development. Project staff had spent years protecting communities from the social inequities of the world of commerce and acting as their unfailing advocates. It required a major shift in the ideological orientation of field staff to insist that their communities should adjust to business and banking practices and confront such problems as loan delinquency, interest charges and market forces. Staff, who had defended the rights of individuals to control their own developing and who cherished New Testament ideals of love between neighbours, now found themselves required to become advocates of entrepreneurism and market competition.

Business development was the central core of the HDP. It generated the financial resource which was a crucial element of sustainability. Reaching the goal of sustainable health development depended on success in achieving the means of stimulating the local economy. IPHC has an outstanding reputation in the practice of participatory health development. Although it was not fully recognized in 1987, a key to the success of the HDP lay in the central core of business development, and this was beyond IPHC's

previous experience or known aptitude. DID's previous experience in Nepal had not prepared it to compensate for this deficiency.

The solution to this predicament lay close at hand within the Philippines. When the problem was identified and its resolution understood, it took remarkably little time to find national resources which could reinforce the weaknesses of the HDP team. The fact that it took eighteen months to take corrective action requires explanation.

The Process

The quality of the partnering process was at least as critical to the outcome of the HDP as technical competence. In practice, the HDP was a triple rather than a dual relationship. It included not only IPHC and DID but also CIDA/Manila. A *ménage à trois* is necessarily more subtle and challenging to sustain than a more conventional two-person "household." The relationship was further complicated by the unequal distribution of authority and power among the three participants. Dominance declined from the funding agency through the Canadian executing agency down to the local implementing institution. It is difficult, although not impossible, to build respect and trust when control is unequal and the limits of power are ill-defined. It may be argued that a funding agency only monitors and does not interfere directly in project management and that the executing and implementing agencies are fully accountable for their actions. In practice, there is a fine line between monitoring and managing, and concerns were expressed at times about the perceived degree of intrusion of monitoring into management. Given this interpretation of events, one can analyze our experience of cohabitation in terms of the prerequisites for successful partnering (see Chapter 8).

1. IPHC and DID were well matched in terms of their values and their pursuit of social justice. They agreed on participation as a means to that end and their institutional ambitions were not in conflict. This can be stated more positively: through the experience of the HDP, Filipinos and Canadians enriched each other's understanding of their goal, purpose and objectives.

CIDA initially endorsed our vision by approving the goal and purpose of the HDP and by contributing to its cost. However, CIDA's enthusiasm for participatory developing probably declined in response to changes in the political and economic climate in Ottawa. These nuances of shifts in attitude are subtle and impossible to document. However, it would be foolhardy to underestimate the harmful impact on a long term

project of unpredictable swings in the political priorities and preferences of those agencies which "pay the piper."

2. It will be argued in a later chapter that progression from understanding through respect to trust is the obligatory path to successful partnering. Anything which undermines these attitudes has an immediate and lethal impact on the quality of the relationship. In retrospect, the partnering process within the HDP proved to be vulnerable. It is difficult to reflect on this experience with any pretence at objectivity. I can do no more than venture some general observations which are pertinent to understanding the fate of the HDP.

There was an abrupt and coincidental discontinuity in project management in Davao, Calgary and Manila in the second half of 1990. None of these transitions was smooth. It was unfortunate that this coincidence occurred at a critical point in the HDP. The process of building mutual understanding was interrupted at a time when solidarity was crucial.

Around that same time, misunderstandings within IPHC led to internal dislocation between the HDP and other parts of IPHC. This created an atmosphere of misunderstanding and miscommunication which confounded the process of restructuring the work plan and rethinking the philosophy of the HDP.

A concomitant loss of cohesion within DID prejudiced its effectiveness and allowed miscommunication to flourish. On occasion, relationships between Calgary and Davao had been tense and uncomfortable. The strength of interpersonal relationships weakened in the latter part of 1991 and throughout 1992 – at the very time when mutual confidence was urgently required. Perhaps due to the difficult transition in leadership in late 1990, at the time when cracks in the loan system surfaced, the level of understanding between CIDA/Manila and its two partner institutions also deteriorated. Misunderstanding was compounded by the inadequacy of communication between Manila and Calgary. With more frequent meetings and greater awareness of differences in style and perspective, the trust relationship between DID and the project team in Manila was restored. Indeed, the preparation of a new work plan in the summer of 1992, which appeared to have resolved the checkmate, was the direct product of improved communications between Manila and Calgary.

This sad litany of miscommunication and misunderstanding may be interpreted to demonstrate that the failure of partnering was irreversible and that the fate of the HDP was sealed. However, sporadic and occasional tension did not threaten the warmth of the institutional friendship between DID and IPHC or compromise the respect of Calgarians for our

Davaoweno friends and colleagues. By late 1992, the HDP was advancing rapidly along the path to a recovery of understanding and trust. It is sad to realize that events conspired to terminate this process of healing.

3. The experience of the Kathmandu connection coloured DID's relationship with IPHC. DID interpreted partnering to mean that friendship cannot be fenced off within the confines of a legal contract. Calgary extended assistance to Davao Medical School. Four Calgarians spent periods ranging from four weeks to eighteen months teaching physiology, biochemistry, pathology and community medicine.[1] None received a faculty salary – two were unpaid and one was paid at local peso rates. DID drew the attention of the Alberta Agency for International Development to Davao and it contributed over $30,000 to improve the provision of potable water in some communities. Childreach, the same Calgary NGO that had funded maternal and child health activities in Nepal, also supported a "child to child" approach to the welfare of children in Davao. DID facilitated an exchange of experience between Nepal and Mindanao. A Filipina visited Surkhet and a member of the Nepal HDP team returned the visit to Davao. Through the agency of the Canada Asia Partnership, Nepalese and Davaowenos were able to learn together.

After a short period of little more than four years, there were encouraging signs that the process of partnering was alive, despite the very real difficulties which we had encountered. It is hard to accept that the story of the Davao HDP will remain a fragment, an account of a relationship that came to an untimely end.

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1 Drs. Irene Wanke, Keith Cooper, Ian Robertson and David Swann.

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The Division of International Development, The University of Calgary

This chapter introduces the Division of International Development (DID) of The University of Calgary. Although the Faculty of Medicine was the birthplace of Calgary's association with Nepal, DID assumed parental responsibility for both the Kathmandu and Davao connections. DID later forged similar relationships both at home and abroad. DID has struggled, with limited success, to practice at home the gospel of partnering that it has preached overseas. In effect, DID merits attention not only as a participant in overseas partnerships but also as a case study of partnering within its own community.

DID was the child of its times. Its pattern of behaviour was imprinted during a period of brimming confidence and apparent stability. This inspired a fondness for long-term planning and wide-ranging horizons. DID was also the product of its immediate environment. It is the progeny of a young campus with the typical self-assurance and restless energy of adolescence, led by a campus administration which encouraged expansive dreams and creative energy. The city of Calgary is built on self-reliance; the province of Alberta values entrepreneurism above all other virtues – even in the cause of international development. A simi-

lar organization evolving in other circumstances would necessarily have taken a different form. It is unlikely that phenomena such as the Kathmandu or Davao connections would have emerged on any other campus or in any other city in Canada.

The Division of International Development

During the early 1980s, The University of Calgary made several abortive attempts to create a new centre for international business with the express intention of providing greater support to the local business community. A need was also perceived to coordinate the wide diversity of student and faculty exchanges that had multiplied over the years. The administration was aware of several small CIDA-funded development projects which were being managed by various faculties. Consequently, the motivation to create an international centre was threefold – determination to establish an international business centre, the need to coordinate overseas academic programmes and a desire to support small development projects. It was assumed, perhaps too uncritically, that all these activities would benefit from being integrated under a single umbrella organization.

The first steps were taken by a senior academic administrator, Dr. Peter Craigie, who brought to his purpose unusual sensitivity and breadth of vision. However, his leadership was rudely terminated by his sudden and untimely death in the fall of 1985. Perhaps in reaction to this tragedy, the administration moved with unaccustomed haste. Debate on the issue among faculty and the usually protracted process of seeking approvals were condensed into less than three months. The normal administrative mechanism for the management of academic centres was bypassed and the new organization was placed directly under the control of the president's office.

After this abbreviated gestation period, the birth of a "Centre for International Education and Business" (CIEB) was announced to a surprised campus in January, 1986. This title was subsequently changed to the "International Centre." It was constituted for an initial period of five years with a broad mandate and the specific requirement that it should become financially self-sufficient within that time limit. It was to be composed of three divisions – a Division of International Business, a Division of International Relations and a Division of International Development (DID). DID's role would be to enhance the university's contribution to international development in ways that remained to be defined.

The following account will focus on DID's first five years. Prior to the public announcement, I had been appointed director of DID for a five-year term, on half-time secondment from the faculty of medicine. My qualifications for this responsibility were limited to my experience in Nepal. In practice, this proved to be a full-time position.

It was not until September that DID secured office accommodation on the main campus, recruited an administrator and received an operating budget. In effect, it was only in September, 1986, that DID became fully operational.

The first challenges were to find a meaningful role for DID, to build an organization and to establish a funding base. A small group of sympathetic senior faculty formed an interim advisory committee.

At the beginning of 1986, the only project which DID could claim to manage was the institutional linkage between the IOM and the faculty of medicine. The faculty fully supported this transfer of responsibility. Other CIDA-funded projects were being conducted from the campus but were managed by individual faculty members from their departments or faculties – a practice which DID warmly endorsed. At that time, programmes were being operated in Gaza, South Africa and Sri Lanka. Since that time other programmes in the Windward Islands, Egypt and Thailand have been introduced and are managed independently of DID. We had no ambition to claim an exclusive role as manager or even coordinator of all campus development activities. While committed to responding positively to requests for advice or assistance, DID sought to establish a complementary role as an alternative source of broadly based campus programmes.

DID's interim advisory committee met early in March and on three subsequent occasions before the summer. It was agreed that DID should aim to serve three functions: to undertake development education in order to heighten awareness of development issues; to support, when requested and appropriate, development initiatives from the campus; and to promote and operate carefully selected projects overseas. We recognized that DID should play a role in developing activities both at home and overseas. It is doubtful if, at that time, we could have articulated precisely how these two spheres of interest would intersect. We attempted to attract wide representation and mobilize resources from all disciplines within the campus in order to enrich our collective understanding of developing and strengthen our capacity to act as a collective body.

The first DID council met in late September, 1986, with representation from most of our sixteen faculties. Throughout DID's first five years,

attendance at monthly council meetings rarely fell below eighteen, out of a total membership of twenty-five. This is some measure of the level of support for the division, not only from experienced development workers but also from enthusiastic neophytes. A pattern of dividing the council agenda between home and overseas interests soon fell into place.

DID's Home Mission

In pursuit of our responsibility to the campus, we invited visitors to address the campus on developing; we embarked on what proved to be an interminable and inconclusive debate on "globalization" of the curriculum; we created study groups to further our understanding of such themes as "moral dilemmas in developing" and "business cooperation in developing"; we invested considerable energy in generating a data base of people with past experience and current interests in developing; and we debated how to assemble a resource library. The habit of inviting the campus to an annual open house in DID was instigated. A quarterly bulletin was produced and distributed widely.

The Council proved to be too large a body to handle more than broad policies. A five-member executive was constituted to advise the director on management decisions and continued to meet in an expanded form at monthly intervals. Within a few months, the director's travel habits indicated the need for a deputy director – a position which Ms. Carol Rogers of the faculty of nursing accepted on a voluntary basis. Two years later, Dr. David McGinnis was seconded from the department of history to DID on a half-time basis as deputy director. Dr. Ralph Miller was also released from the faculty of education to coordinate the Canada Asia Partnership. These positions and membership of the executive or council were never sinecures. I recall with surprise the substantial time and energy that many faculty members contributed voluntarily to the multifarious activities which soon spawned around DID. By the end of its first quinquennium, we could identify over 100 faculty who had contributed to DID in some significant way.

The roles and responsibilities of the director, deputy director, executive, council and administrative staff remained issues for debate or dispute and were never fully resolved, despite the efforts of successive *ad hoc* committees. It will be necessary to return to concerns about "participatory management" within DID.

DID explored how it could contribute to the awareness of development issues on the campus and within our community. We recognized the untapped resource of knowledge and experience of our overseas

students and their relative isolation within the student body. Many Alberta citizens knew little about conditions in these students' countries of origin. Ignorance and parochialism are a fertile breeding ground for intolerance and racism and create an inhospitable environment for the multicultural society which we hope to create in Alberta.

We recruited both overseas and Canadian students to form teams that would visit schools or community organizations throughout southern Alberta to share their experience of other continents. This strategy had the potential to encourage closer partnering between Canadian and foreign students; to enable foreign students to reverse their role and become our teachers; and to encourage students to play an effective role in DID. Funding was secured, a student coordinator was hired and students joined the DID council. Those early ventures in development education have continued and diversified.

The question of DID's solvency was ever present, given the admonition to achieve financial self-reliance by the end of 1990 – and only four years remained. Although DID was fortunate to achieve this target, it did not do so without considerable effort. Many advances were made to local, national and international foundations, most of which were courteously and thoughtfully declined. "Funds" appeared with monotonous regularity on the agenda of every DID council meeting. Despite many disappointments, DID attracted support for its work overseas from the Calgary-based Kahanoff Foundation, Alberta Rotary societies and a Calgary NGO, as well as from CIDA, IDRC and the Alberta Agency for International Development. Channelling consultation fees into DID and the matching of donations by the provincial government satisfied DID's internal financial needs.

By our second council meeting in October, 1986, the idea of a DID "retreat" was raised and approved. We needed time and a congenial environment in which to share ideas and create a spirit of mutual understanding. The first retreat took place in Banff in February, 1987, and this set a pattern for future years. Retreats were opportunities for those who were involved with DID to share experiences with colleagues from other campuses, Alberta NGOs and development agencies. The principal benefit of retreats was that they helped to build a consensus on such issues as the nature of developing, participating and partnering; the role and management of DID; and DID's relationship to other organizations. Some were frustrated by what they perceived to be a lack of focus, inconclusiveness of debate and the sense that recommendations from retreats were rarely translated into action. On balance, many of the pioneers of DID might agree

that these early retreats exerted a positive influence on the growth of internal cohesion and the maturation of DID's collective identity.

DID's Overseas Mission

Throughout these early years DID was preoccupied with establishing its role overseas. Much of the time and energy of the DID administration was devoted to forging connections with sister institutions in Asia and Latin America. As early as March, 1986, several possibilities had emerged as potential arenas for DID.

At the suggestion of the Association of Universities and Colleges of Canada (AUCC), I had already begun to explore the feasibility of a link with the Institute of Engineering of Tribhuvan University – we had shared ideas with our colleagues in the Institute of Medicine about extending our horizon beyond the limits of medical education to embrace a wider concept of health – and I was nursing the notion of a link with Bhutan. The council worked hard to bring these speculations to fruition.

By the end of October, 1986, the first visit to Davao had taken place; a request had been received from the South East Asian Ministers of Education Organization (SEAMEO) in Bangkok for assistance in planning new links between ASEAN centres and Canadian universities; and proposals for programmes in Nicaragua and Peru had been prepared by two members of the DID council. In effect, with the exceptions of the Canada Asia Partnership and recent initiatives in India and Latin America, the seeds of all the overseas programmes that would dominate the attention of DID had been planted before the end of 1986. Decisions taken during these first few formative months set the agenda for DID for the rest of the quinquennium.

More mundane questions followed automatically and have never ceased to tantalize. How should DID intervene to ensure that work carried out overseas on behalf of DID's programmes would be "legitimized" or rewarded when departments annually assessed the "merit" or promotion prospects of their faculty? The issue of academic recognition of service to the wider community remains unresolved, although the problem may be more perceived than real.

As the prospect of DID's wider participation overseas became a closer reality, new administrative questions surfaced. Guidelines for project management were required. A manager was identified for each project, invariably on a part-time basis – either voluntary or remunerated, sometimes with time release negotiated from faculties, and sometimes recruited from beyond our campus. Managers were encouraged to form

project teams of both academic and community members who could contribute the spectrum of expertise and experience which their projects required. Project managers enjoyed a high degree of autonomy. They carried considerable responsibilities and were given commensurate authority. There is no reason to regret this unwritten policy although it posed a challenge for a director who could not escape accountability but had relinquished direct authority. DID itself represented a microcosm of the new world of participatory management.

Troublesome questions about details of travel and living expenses surfaced. DID adopted a broad policy, difficult to define with bureaucratic precision, that those who worked on behalf of DID should neither suffer nor profit financially from their efforts.

Given our predilection for regions of political instability and insurrection, DID had to confront the risks of terrorism and satisfy our administration about institutional liability – an issue which was never fully resolved.

We debated endlessly how DID should integrate research into its development activities since a campus might conventionally be expected to apply its research capability and methodologies to the developing programmes in which it was involved. On occasion we submitted proposals to research agencies in order to match development activities with research. After the management plan for the Nepal HDP was approved by CIDA, we submitted a parallel research proposal to IDRC. Unfortunately, although this proposal was approved and funded by IDRC, it was rejected by a cabinet decision in Kathmandu. A member of the DID executive set a Canadian precedent by persuading both IDRC and the Medical Research Council of Canada to collaborate in funding a research project, part of which would be conducted in Calgary and part in Thailand.

DID did not formulate general policies for blending developing with research. Each project dealt with the challenge in its own way. Thus, by the terms of the management plan of the Davao HDP, DID agreed to strengthen the research capability of IPHC. The Canada Asia Partnership committed itself to undertake systematic research into participatory processes. Some will argue that DID failed to maximize the potential of systematic research into developing.

As DID planned new initiatives and responded to new requests for its participation, it was only prudent to focus our limited resources and energy. DID claimed no monopoly rights on developing on the campus and operated in parallel with departments and faculties. This policy deflected any criticism that DID would inhibit the legitimate initiatives of others by imposing a narrow institutional "focus." The cluster of op-

portunities which came our way in 1986 indicated that DID had *ipso facto* concentrated geographically on remote rural areas, with a fondness for high mountains – whether in the Himalayas or Andes. We had also gravitated towards people-centred developing rather than more conventional forms of technical assistance. Given this predilection for community-based developing, we had favoured a participatory approach to developing. In effect, DID had adopted, almost by serendipity, a focus on "participatory community-based developing in rural and, in particular, mountainous regions."

Our focus on this priority was not an exclusive preoccupation. The engineering project in Nepal is based on technical assistance of a high degree of sophistication. It is a source of pride that it has been managed with consummate professional competence. The projects in Bhutan and Peru fall into a similar category and the Nepal HDP includes a significant element of technical assistance in the form of medical education. DID has had the opportunity to experience the costs and benefits of combining both forms of developing.

Participatory Action Research

Early in 1988 our interest in participatory developing led DID to host an afternoon seminar for faculty on participatory research (PR). Its success inspired confidence to mount a one-day national workshop later in the spring on the history, current status and potential of participatory research in contemporary society. This revealed widespread interest in participatory research and attracted almost 100 participants from all regions of Canada. As a direct outcome of this experience, DID held an ambitious three-day international conference on participatory research, a "Celebration of People's Knowledge," in the summer of 1989.

The 1989 conference has had a lasting impact on DID as well as the 350 participants who came from every continent. Teams from eleven regions shared their experience of participatory research – Sri Lanka, Nepal, Thailand, Mindanao, Mexico, Queensland, the English Midlands, Tennessee, Newfoundland, the Yukon and southern Alberta. The privilege of learning at first hand from the experience of people from these scattered parts demonstrated beyond question the potential of releasing the power and wisdom of local people in controlling their own developing. This intense experience reinforced our enthusiasm for the participatory form of developing.

The Canada Asia Partnership

The events which led to the designation of The University of Calgary as a "centre of excellence" in international development merit description.

A report of the Parliamentary Standing Committee on External Affairs and International Trade, "Canada's Official Development Assistance Policies and Programmes," provocatively titled "For Whose Benefit?" and widely known in Canada as the Winegard Report in recognition of its chairman, was tabled in the House of Commons in May, 1987. It received formal government approval four months later. This report provided a wide-ranging review of all aspects of Canadian Official Development Assistance (ODA), and its recommendations were embodied in CIDA's strategy document, "Sharing Our Future."

The Winegard Committee expressed a concern to strengthen public support for the provision of ODA and stressed the need to inform and mobilize public opinion. As a means to this end, it promoted "development research and training" and specifically recommended the encouragement of "centres of excellence in development studies at post secondary level." In April, 1988, the Minister for External Relations and International Development publicly announced CIDA's intention to move quickly to implement this latter recommendation.

CIDA subsequently entered into consultation with Canadian universities and colleges. Although reservations about the impact of this plan were expressed by several academics, implementation of these recommendations went ahead. Guidelines were circulated to the universities in early October together with an invitation to submit proposals for the creation of centres of excellence by the end of December, 1988.

We had become aware of these discussions in October, 1987, and the issue of "centres of excellence" appeared on the agenda of the DID council in November and remained a continuing topic for debate throughout 1988.

Starting early in January, a series of open workshops was conducted on the campus to facilitate the exchange of information and ideas. An initial proposal to plan a centre focused on "international health" met with little enthusiasm and was promptly discarded. A second position paper, entitled "Centre of Excellence (Partnership) for Education and Research in Rural Development," was prepared by members of the DID executive and distributed for discussion in April, 1988. A key feature of this plan was the idea of bridging two "partnerships": one which would link colleges and universities in western Canada, coordinated by DID,

and another linking institutions in Mindanao, Thailand and Nepal, coordinated by the ASEAN Training Centre for Education and Research in Primary Health Care – later renamed more succinctly the ASEAN Institute for Health Development (AIHD) – of Mahidol University, Bangkok. The purpose of this collaboration would be to "promote education and research in selected areas of community development in remote rural areas with a special concentration on high mountainous regions." The sectors to be selected would include "community education, management training, rural health, community organization and income generation." This plan was designed to build on DID's existing associations in South and South East Asia and its focus on participatory developing. This position paper was distributed three days before the minister's public announcement of CIDA's intention to elicit proposals for centres of excellence.

Although CIDA's formal guidelines for the content of proposals were not received until less than three months before the deadline for submissions, DID had spent a full year in preparing its plans. The draft position paper was revised extensively over the summer during lengthy conversations with all the potential partners in both western Canada and Asia. This dialogue resulted in a penultimate position paper for detailed discussion at a workshop to be held in Calgary in early October. This was attended by representatives from both Asian and Canadian partners. This version advanced beyond its precursors by indicating that both the Asian and Canadian "networks" would include both "academic and community resources," and by adding an Indian partner, Jahawaral Nehru University of New Delhi. The focus of this revised plan was more specifically targeted on "community education, community health/quality of life, local economic development, environmental protection, and critical reflection on community development." Based on reactions to this proposal expressed both during the October workshop and later during a series of exchanges of ideas in South East Asia in the latter weeks of the year, a definitive proposal was finally agreed on and submitted to CIDA in late December. It proposed the creation of a "Canada Asia Partnership (CAP) for Education and Research in Rural Community Based Development." As events transpired, neither Nepal nor India was represented in the final proposal.

Our proposal, along with over thirty others, was received by CIDA and all were processed through an exhaustive series of internal and external reviews. They culminated in an invitation to present our ideas directly to a National Advisory Committee. CAP was represented by the president of The University of Calgary, a colleague from Athabasca University and two members of the DID council. We learned later that

this committee had recommended that The University of Calgary should be designated as a centre of excellence by virtue of its CAP proposal. A formal announcement was made in Calgary in early October, 1989. The preparation and approval of a management plan and budget were slow processes. The final contribution agreement with CIDA and memoranda of understanding with Davao Medical School Foundation and Mahidol University were not signed until late July, 1990. CIDA contributed $6 million over a period of five years. This was subsequently extended to six years.

The practice of partnering was the core of CAP and its future would be determined by the effectiveness of this process. We envisaged the rapid evolution of a Canadian association of academic and community organizations which would unite their collective experience and expertise for the common purpose of advancing the practice of participatory developing. The creation and nourishing of national partnering would be one of CAP's prime responsibilities. Similar national associations would be formed in Thailand and the Philippines. Every effort would be made to forge links between these national organizations in order to foster partnering between Asia and Canada.

CAP undertook to study and analyze critically the participatory and partnering processes which underpinned its programme. It would attempt to influence public opinion and national policies by bringing its collective experience and reflection to the attention of policy makers, political leaders and the Canadian public. Seminars and symposia on partnering and participating would be a major vehicle for this purpose.

Given the tentative status of much of the theory underlying participatory developing and the paucity of objective evidence for its effectiveness, CAP undertook to document and study the process. It would develop outcome indicators which could be used by both communities and the CAP team to monitor the impact of interventions in terms of improvements in environmental, economic and health conditions.

One initial focus would be to offer educational opportunities to a variety of learners, including community development workers. This training would target six broad themes – participatory management, health development, business development, participatory action research, educational strategies for communities, and environmental restoration and protection. Each of the three national CAP partners would accept responsibility for two of these six themes.

Implementation of the CAP programme began officially in the summer of 1990 under the leadership of Dr. Ralph Miller.

DID'S First Quinquennium in Retrospect

DID and its director completed their first five-year term at the end of 1990. DID's internal review of the experience expressed general satisfaction with the productivity of this quinquennium. It had achieved, at least temporarily, financial self-reliance. With the exception of the university's provision of the salaries of the director and administrator, DID covered all its costs, including the estimated cost of space and the use of campus facilities, from the revenue it generated.

At that point, all its overseas programmes were progressing well. It could claim a growing body of collective experience and expertise in several forms of developing. DID had continued to be successful in establishing links overseas and had just completed negotiations for two new programmes in Latin America and India. It would soon take preliminary steps to explore additional opportunities in Vietnam and Tanzania. DID had been open to the campus and community at large, had established a broad base of support from most faculties and was continuing to innovate in the promotion of development education.

An external review committee was less enthusiastic and, while acknowledging significant strengths, described several weaknesses it had perceived. It suggested that DID was "driven" more by "project, funding or client" opportunism than by a sense of mission, and recommended that DID should exercise greater academic and ethical rigour in selecting future projects. It felt that DID had not drawn on all the available resources on the campus and had neglected or ignored faculty with significant expertise. It had not yet become fully integrated into the academic life of the campus. It had focused too narrowly on its overseas and national connections at the expense of its links with our own campus – as a consequence, while DID had gained an enviable international and national reputation, it did not enjoy equal credibility at home. It had not made a significant contribution to the educational life of the campus and had little "hard" research to its credit. This raised the question of whether DID was functioning as an "NGO" rather than as an academic organization. Finally, the committee uncovered suspicions that DID might not practice at home the participatory gospel it preached overseas.

DID had already recognized some of its limitations and was taking steps to correct deficiencies. However, some of the opinions expressed by the review team raise important issues and make assumptions that will be challenged in subsequent chapters.

My recollection of DID throughout most of its first quinquennium is of a stimulating and supportive environment. Visitors had commented favourably on their sense of the warmth and energy within the DID office. It had rarely been difficult to find willing volunteers to accept new responsibilities. Innovation and creativity had flourished and there had been a general air of confidence in our ability to generate new ideas and translate them into action. The collective effort that had been required to mount the participatory research conference in 1989 and the collective vision which had conceived the Canada Asia Partnership were testimony to the creativity and energy of this period. These reminiscences give me confidence in the potential energy which can be mobilized by effective "partnering at home."

I remained director of DID for a further eighteen months. This period proved to be turbulent and stressful. Perhaps predictably, some of our work overseas encountered difficulties. The problems which engulfed the Davao HDP have been described and discussed in detail. By early 1992, serious criticisms were raised about the performance of the Canada Asia Partnership. There was substance to each of these charges. Although the difficulties were complex and deep-rooted, they could have been resolved in an environment of solidarity and trust. However, cracks had appeared within DID towards the end of its first quinquennium and had widened over the following year. This deterioration in the working environment had an immediate and adverse impact on DID's effectiveness.

My recollections of DID's formative years are characterized by vivid highlights and occasional deep shadows. One fails to appreciate the overall composition if one ignores either. Since my purpose is to explore the process of partnering by reflecting on the experience of DID, one should examine both light and dark areas. I have no skill to paint DID in the forms of persons or actual events and can only hope to convey impressions of feelings and patterns of behaviour. But to depict DID in impressionist images incurs the risk of distorting truth, so I will bring my impressions into some semblance of order by fitting them into a framework for analysing the prerequisites for successful partnering (see Chapter 8).

1. A common vision. A key to DID's early vigour was its sense of mission. We were fortunate to find both time for endless debate and opportunities to translate our rhetoric into action. The ideas which emerged from this dialogue and from these enterprises created a consensus on the nature of developing which encouraged a unity of purpose. At this stage, the forces within DID faced in a single direction.

However, towards the end of DID's first quinquennium we lost our sense of a common destination and began to follow different routes.

The roads to "internationalism" and "developing" diverged. DID's mandate was to promote "international development." This can be interpreted to mean that DID should promote the processes of "developing among the nations," of which Canada is simply one member. From this perspective, the operative value in our mandate is "developing" as it applies to every society, including our own. An alternative perspective emphasizes the element of "internationalism." This puts a premium on coordinating all international activities – that is, those which are conducted by Calgary abroad. The latter was the original intention of the Centre for International Education and Business and remains the *raison d'être* of the International Centre. Some will argue that these differences are no more than shades of emphasis and that developing and internationalism are comfortable bedfellows. They may insist that they share common interests, face similar problems and should interact constructively.

I am persuaded that internationalism and developing pursue different goals and serve different masters. Their alliance may be expedient but their marriage would be no more than one of convenience. Universities "internationalize" for their own benefit – to enhance their reputation, to attract graduate students, to access international funds, to "globalize" their curriculum, or to expand research opportunities. Insufficient thought is given to the impact of these endeavours on the countries of the South. There is likely to be a serious conflict of interests between those of our home campus and institutions in the South.

The values internationalism reflects and the strategies it adopts may be legitimate and defensible from a local and national perspective. However, they do not sit comfortably with the principles of developing, partnering and participating as I have come to understand them. Developing, in this form, implies the scrupulous avoidance of any conflicts of interest and the pursuit of interdependence. It is incompatible with that form of internationalism which assumes a hierarchy of authority and power. Each perspective has its advocates. They can coexist on a campus at a discreet distance without conflict. In my judgement, they are not appropriate companions within a close community, such as an international centre. They are more likely to remain true to their values and principles if they operate independently. Although this view was shared by a minority, the divergence contributed to the fragmentation of DID's sense of a common purpose.

Following the participatory research conference in 1989, those who favoured the participatory, or people-centred, form of developing and those who preferred the technical assistance, or professional-centred, form of developing tended to move apart. This divergence was progressive, and led to polarization and, on occasion, confrontation.

These ideological shifts did not take place within a vacuum. They were necessarily intertwined with the personal interests and ambitions of many individuals – it is difficult to distinguish between the influences of ideologies and self-interest. They also occurred within a changing political climate both beyond and within the campus. By 1990, the world had become a place of insecurity and uncertainty. Conformity and expediency were more valued than flexibility, and innovation was regarded with suspicion. Radical ideas could easily be interpreted as a threat to the status quo. A wintry economic climate, the inevitable clash of personal ambitions and ideological differences conspired to weaken temporarily the cohesion and collective effectiveness of DID.

2. **Mutual understanding, respect and trust.** DID grew as a body of individuals who were attracted not only by common values but also by genuine friendship. Although we came from a diversity of disciplines and backgrounds, we enjoyed each other's company. It took time to understand each other's perspectives and interests, but we shared a high level of mutual respect and trust. These attitudes were the cement which created our internal cohesion.

Interpersonal tensions are common to any human organization. Conflicts of interests and divergence of purpose are readily converted into loss of understanding and a breakdown in respect and trust. To some extent, DID experienced this unhappy sequence of events. Trust and respect had taken time and effort to create but could be lost, at least temporarily, in an instant.

3. **Management styles.** An appropriate style of management facilitates the smooth operation of an organization. Given DID's claim to embrace the principles of participation, there were understandable expectations that DID should be a model of participatory management. Expressions of disappointment and dissatisfaction surfaced sporadically and with increasing frequency. Participatory management posed the challenge of balancing accountability and authority. A jaundiced eye could detect on occasion an imbalance tilted towards a weight of accountability that was not offset by proportionate authority. Given DID's intention to encourage and promote democratic participatory processes,

the need to achieve the correct balance between democracy and efficiency may continue to challenge future administrators.

4. **Time and Energy.** The effort which was required to bring DID to birth and guide it through its adolescent years was prodigious. It dominated the professional and social life of many individuals, and their families. It relied on willing voluntarism. The energy required to initiate programmes was considerable. However, it paled into insignificance beside that which was required to implement and maintain these initiatives. Towards the end of the quinquennium DID may have suffered from collective weariness.

These observations attest to the fact that "partnering at home" is not only as rewarding but also at least as demanding as partnering at a discreet distance. The constant proximity of colleagues and the inevitability of friction within the home base are more daunting than intermittent partnering at a comfortable distance.

Connections with Latin America and Asia

The Kathmandu and Davao connections have already been described at length and analyzed in critical detail. The following references to DID's connections with other institutions abroad are relatively superficial and cursory. These were coordinated by project managers who are best qualified to recount their own experiences. I have been close enough to their operation to observe their progress and appreciate broad trends.

The Desaper Programme

In 1990, DID entered into a cooperative relationship with the Latin American Centre for Perinatology in Montevideo, Uruguay, known as the Centro Latinoamericano de Perinatologica y Desarrollo Humano (CLAP). The structure of this arrangement deserves attention. This programme is the responsibility of the Pan-American Health Organization (PAHO), of the WHO, which receives the necessary funds from CIDA. The Centre in Montevideo, under the leadership of Dr. Ricardo Schwarcz, is the executing agency for the programme and is directly responsible to both PAHO and CIDA for its management. DID was subcontracted by PAHO to provide specific services to the Montevideo Centre on behalf of the programme. Canadians act only in support of the lead role of our Latin-American colleagues.

This is a form of institutional cooperation which was previously unknown to DID. Indeed, it is an arrangement which has many attractions. It avoids the trap of the "donor" institution exercising dominance,

even unwittingly, and creates opportunities for partnering divorced from unilateral authority. If I had been familiar with this mechanism earlier, it might have protected DID from arrangements which I came to regret.

The goal of the programme, known as Desaper (Proyecto de Desarrollo de la Salud Perinatal), is to reduce maternal and infant mortality and morbidity in two regions in each of four countries – Bolivia, Peru, Honduras and Nicaragua. It approaches this goal from two directions. It brings to these communities the best appropriate technical innovations in perinatal health care. At the same time, it attempts to empower these same communities to enquire systematically into their own situation in order to introduce their own changes. In broad terms, the centre in Montevideo provides leadership in perinatal technology while DID advises primarily on the community-centred aspects of the work.

This experience emphasizes that developing and healing are intimately related. Achieving synergy between two traditionally disconnected approaches to the health of people is challenging. It demands mutual respect and trust based on genuine understanding between those who take their stand within lay communities and those who are centred in professional health care delivery systems. This challenge can be surmounted by committed people, but it would be unwise to underestimate the effort required.

Other Links

DID worked with two other universities in the region – the University of Ancash in Huaraz in the Peruvian Andes and the Central American University in Managua, Nicaragua – to strengthen their faculties of environmental studies and social work, respectively. Experiences in not only Peru and Nicaragua but also the Philippines and, on occasion, Nepal and Bangkok, have demonstrated the systemic connection between poverty, injustice, political oppression and violence. "Peace and order" are the constant backdrop to any involvement in the promotion of popular participation in the life of low-income countries.

Two other experiences in the Himalayan region illustrate the many forms institutional cooperation can take.

In the late 1980s, I had the good fortune to visit Bhutan on two occasions. As a result of discussions with officials in the department of education, Calgary offered its support to Sherubtse College in the eastern region and the Royal Institute of Management in Thimphu. This linked an academic campus in Canada with an official government agency in Bhutan. It took the time and patience of both Bhutanis and Canadians to

reach the level of understanding which is the obligatory precursor of respect and trust. It took three years, several exchange visits between Thimphu and Calgary and some abortive exploratory efforts before Bhutanese and Canadians became familiar with each other and began to learn how to partner effectively.

A more recent connection with the Garhwal region of Uttar Pradesh in the Himalayan foothills has uncovered other links between developing and healing and another form of partnering. DID has worked with the Himalayan Institute, an Indian non-government organization, to promote the health of villagers. This programme is under the charismatic leadership of Swami Rama, a spiritual leader who grew up in these hills and has won the unqualified trust of its people. Our Indian colleagues are deeply rooted in the Hindu Vedanta and the practices of meditation and holistic medicine. They emphasize the complexity of healing and the reality of a spiritual dimension, at least for believers. Our Indian colleagues are constructing a regional hospital in the plains below the foothills. The kind of relationship that will evolve between their community health development activities and hospital-based health care may show if there need be a gap between a people-centred and a professional-centred approach to healing.

Over the last eighteen years, I enjoyed frequent contacts with Mahidol University in Bangkok. These included exchanges with Thai colleagues in the Centre for Tropical Medicine of the South East Asian Ministers of Education Organization (SEAMEO/TROPMED). In the late 1980s, we cooperated to establish links between four Canadian campuses and SEAMEO/TROPMED centres in Bangkok, Manila, Jakarta and Kuala Lumpur. Our focus was on finding appropriate linkage strategies and the place of people-centred health initiatives within the ASEAN region.

One outcome was the signing of a formal agreement between the SEAMEO/TROPMED centre within Mahidol University in Bangkok and the faculty of medicine in Calgary. The purpose of this connection was to foster cooperation in research and education in clinical medicine. It has diversified in unexpected directions – for example, into discovering common interests in cancer control and sports medicine and in the forging of research links between Bangkok and Kathmandu.

Contact with the ASEAN Institute for Health Development (AIHD) of Mahidol University was one of the factors that led to the proposal to create a "Canada Asia Partnership." The idea of Asians and Canadians collaborating to promote the practice of participatory health development arose from speculative discussions on Mahidol University's Salaya campus with Dr. Prapont Piyaratn and Dr. Krasae Chanawongse. Each

had played a significant role in changing the pattern of rural health care in Thailand to a participatory and intersectoral model. Dr. Krasae received the Magsaysay medal for his services to rural health in the region.

Dr. Prapont has played a significant role in the evolution of DID. His career started as a pathologist in Chulalongkorn University in Bangkok but moved into medical education in Thailand, human resource development with WHO and on into participatory health development. He contributed to the planning of the CAP proposal and then in its implementation in Thailand. His application of Buddhist ideas to the notion of developing have influenced many associated with DID.

II.
The Ideas of Developing and Partnering

7

The Idea of Developing

Worlds in Collision

The setting of the *Bhagavadgita*, the sacred Hindu text, is a battlefield where two opposing armies face each other in preparation for war. Arjuna stands between them in a mood of black dejection. He belongs to one camp but is well aware that his "enemies" include his relatives, friends and respected teachers. He turns in bewilderment to Lord Krishna to express his despair at the futility of conflict and prays for escape from unnecessary bloodshed. This introduces an account of the cycle of life and different ways of seeking release. It also offers a powerful image of the futility of conflict between potential allies.

My own reflections, which here follow, are derived almost exclusively from those experiences centred around three cities – Kathmandu, Davao and Calgary – described in the preceding section. They evoke many warm recollections which give pleasure and encourage optimism. However, a disturbing image of confrontation stands out from these memories. I have seen two forces drawn up to fight in the cause of "development." One is determined to "develop" others; the second aims to help others

to "develop" themselves. They might be expected to stand together as allies in a common cause but they are often divided and even opposed.

The Nepal HDP showed that it is remarkably difficult to persuade doctors and community workers to partner for the common goal of improving the health of rural people. Their instinctive approaches to health reveal a strong tendency to diverge rather than merge, and a yawning gap separates those who deliver health care and those who prefer to undertake their own healing. The DESAPER programme in Latin America tells a similar story. This programme was designed to improve the health of mothers and children by a coordinated approach through perinatal health care delivery and community-based health development. My interpretation of this experience confirms the difficulty of achieving synergy or even symbiosis between these two forms of developing and healing. The inability of Davao Medical School Foundation to combine the training of katiwalas and medical students illustrates the same duality. I have also described a divergence within DID between advocates of participatory developing and technical assistance.

This section explores the territory which separates these opposed forces. My purpose is to encourage reconciliation by examining the nature of the dividing ground. This task can be approached from two directions.

First, each camp has its own perception of its mission. In order to articulate its ethos to others, each speaks its own distinctive language. This metaphor is complicated by the fact that each uses the same words but attaches different meanings to them. Like trans-Atlantic allies, they are "divided by a common language." This chapter explores alternative languages of developing.

Second, the dividing ground is obstructed by contrary attitudes and behaviours. The fact that these forces fail to enter into an alliance is due not only to contradictory beliefs and perceptions but also to their inability or unwillingness to partner. The idea of partnering is the theme of the following chapter.

The Languages of Developing

This enquiry into the languages of developing is an attempt to explore the nature of two apparently distinct cultures. My concern is not primarily with words themselves but with the ideas which are concealed within them.

The negative reaction of many to the word "development" is itself an example of the unfortunate consequences of verbal ambiguity. An increasing number of colleagues in "developing" countries bitterly regret

the impact of development as they have experienced it over the last forty years in their own lives and within their own societies. They are determined to distance themselves from the paternalistic assumptions and behaviours which they associate with that form of development which has been practised in the name of "official development assistance." They also resent the pejorative label "underdeveloped" which was conferred on their countries by a post-war American administration which looked down on their predicament from a pinnacle of benevolent economic and moral superiority. From their experience, they would prefer to ban the word "development" from polite conversation.

At the same time, there are humanitarian principles and social actions to which we share a common commitment and which are often consigned to the same category of development. These include the ideas of the empowering of people and the practice of participatory developing. We desperately need to discover a richer vocabulary which will allow us to preserve these distinctions in our conversation. This is not simply an academic quibble over semantic niceties. It is a practical issue if we are to avoid the use of words which confuse by conveying diametrically opposed ideas.

The glib cooption of words – such as "participation" or "partnership" – without respect for their full significance is equally distasteful. The value of the ideas these words can convey is being debased by casual overuse and misuse. The practices of participatory developing and partnering are arduous and costly and should not be adopted lightly.

The linguistic problem goes much deeper than the mere choice of nouns and adjectives. It includes the use of appropriate syntax as well as vocabulary. Syntax refers to the way we put words together and, in effect, reflects the relationship between the ideas behind the words. The choice of conjunctions is particularly illuminating since they focus attention on the linkage between elements of thought. A conjunction is often simply omitted when the logical connection within a phrase or sentence is unresolved. DID has been guilty of obscurantism in coining the hybrid neologism "health development." A bland "and" begs the question and, to date, we have failed to make the connection explicit. A similar criticism can be raised against the expressions "business development" and "development education." Lack of syntactic conjunction may be symptomatic of lack of intellectual connectedness.

More fundamentally, verbs are to be preferred over nouns wherever the limits of linguistic conventions allow. Verbs can be dynamic and describe active processes. Nouns which are derived from these verbs

convey a sense of finality or closure and suggest completed products. The distinction between process and product is central to the following account of the nature of developing and partnering. This need to maintain a distinction between process and product discourages the use of nouns that obscure the idea of process. Gerunds are designed to fill the role of verb-nouns and are ideally suited to convey the idea of substantive activity. A fondness for gerunds reflects the desire to distinguish between the processes of developing or partnering and their products in the form of development or partnership.

"Developing" and "development" are scattered liberally throughout these pages. My preference is to abandon the use of "development" in favour of the gerund. In practice, it is virtually impossible to be consistent. "Development" is built into such expressions as "community development," "official development assistance," and "international development," and we have added "health development." Furthermore, when the use of the gerund would simply obscure my meaning I have reluctantly retained the noun. One would hope that it might become increasingly acceptable to talk in terms of verbs and gerunds.

Reflection on the use of verbs uncovers another layer of ambiguity. The same verb can represent a wide range of processes depending on whether it takes a transitive or intransitive form. The fact that this crucial distinction is lost in the derived noun is an added reason for discarding nouns in favour of verbs. Strong intransitive or reflexive verbs and their gerunds hold a particular attraction. They describe autonomous active processes without need for an object.

The professional choice of verbs in the clinical discipline of obstetrics gives food for thought. Birth is central to the practice of obstetrics or midwifery. The verb "deliver" is commonly used by English-speaking health professionals to refer to this process. However, it is unclear who delivers what to whom! Is the verb used in a transitive or reflexive form? There are some indications that professionals assume that the mother delivers herself of her own baby – as when they talk of an "assisted delivery." However, the pattern of conversation between clinicians – "I have delivered the patient" – makes it clear that they regard themselves as delivering either babies or mothers or both! The ambiguity in the language of obstetrics is more than semantic trivia. Words, and the attitudes which they reflect, build barriers between professionals and people. They also lead to the coining of such clumsy neologisms as "birthing" in an attempt to circumnavigate professional jargon.

Language is living and always in transition. Words can be best understood in their contemporary context, although their etymological derivation is often illuminating. The analysis which follows hesitates to define words with anatomical rigour. The act of precise definition conjures up an image of pinning words to an intellectual cork board and killing them in the process of dissection. My purpose is less ambitious. It is simply to describe the ideas which these words are intended to convey within a contemporary dialogue on developing.

An inadequate vocabulary prejudices clear thinking. The lack of appropriate words to convey the range of ideas hidden within the verb "to love" not only makes conversation embarrassingly inept but also distorts my own perception of what it means to love. Words are the material I use for constructing ideas in my mind and the way I see these images determines how I assemble them into systems and patterns as a basis for analysis and action. The lack of a language which can do justice to the wide spectrum of ideas which may be intended by the gerund "developing" can be detrimental to both my reflection and my conversation.

The purpose of this chapter is to review the key words which recur in talking about developing. The selection of words for consideration is based on the belief that they describe activities which are relevant to that form of developing which is centred within communities. Alternative views of developing may require a different lexicon.

The key expression is "developing" itself. I have chosen three processes which promote this form of developing – participating, facilitating and sustaining. Developing is a complex process and includes many elements. Given the spectrum of activities on which these reflections are based, I have selected three processes for attention – learning, enquiring and healing. The comments which follow are no more than preliminary observations which cry out for more detailed analysis. Exploration of these elements of language can throw light on the distinctive cultures of those who engage in the practice of developing.

Developing

The meaning of "developing" is central to these reflections and is the source of many related ideas.

There are advantages in using the verb "to develop" and its gerund "developing" in preference to the noun "development." The etymology of "develop" evokes subtle images which are concealed within the noun. An older form of "develop" is "disvelop," an antonym for which is "envelope."

This projects a picture of developing as a process of unfolding, unwrapping or revealing what has been concealed or latent. It is consonant with the idea of developing as one of people, individually or collectively, exploring and finding new needs and resources within themselves.

It is even more fundamental and illuminating to distinguish sharply between the uses of the verb in its intransitive and transitive forms. In its intransitive form the verb takes no object. "We are developing" describes a process for which we are directly responsible and which takes place within us. It is this intransitive or reflexive usage which resonates with the notion of disveloping. One would like to reserve "developing" for this form of community-managed or people-centred developing and lay claim to this as its primary and authentic meaning. The practice of substituting gerunds for nouns preserves the sense of developing as a dynamic and continuing process rather than a product which can be packaged and delivered.

The alternative transitive usage of the verb requires an object. "We" develop "them," perhaps by education or social services; or we develop for them a geographic region or an industrial estate; or we develop on their behalf national or regional policies. These latter processes bear no direct relationship to the former and the two forms may, in practice, be incompatible or even in conflict. The fact that we use one word so indiscriminately serves to gloss over a fundamental distinction. People-centred "developing" and rural "development" may reflect very different processes which are unlikely to be congruent and may clash.

It would be possible to avoid using the same verb in these two contexts. Given a predilection for the reflexive verb as the authentic form, one would elect to discourage use of the transitive verb and replace this form of develop by specific verbs which describe the precise activities intended – for example, to educate, manipulate, construct, manufacture, produce, provide, deliver, design, plan or exploit. This habit has potential advantages – it would make both communication and reflection less ambiguous and more transparent. It recalls an experience of encouraging a group of academics to discuss education using only "to learn" and proscribing "to teach." The benefits to clear thinking could be equally rewarding.

The outward expression of the inward process of developing is unpredictable and unlimited. It implies people searching within themselves to identify and prioritize their needs and recognize their latent capabilities and resources. The goal of this search is for some improvement in their quality of life in ways which are meaningful to them. They cannot be predicted, prescribed or neatly compartmentalized. If the outcomes

of developing are left open and unrestricted and directed towards people's own expectations for a better life, then one cannot confine the resultant activities into a few preselected sectors.

The needs and solutions which emerge through intransitive developing may be expressed in terms of economic growth, the construction of facilities, or better education and health services. They may also emerge in the form of a search for new social values and priorities. Societies in the affluent North are often uninterested in benefits which cannot be transmuted into currency. However, materialism does not drive all societies. An economic model of developing which measures progress exclusively in terms of growth of GNP fails to satisfy many. They may insist that other parameters of quality of life have equal weight – a sense of communal security and interdependence, a balanced order of social priorities and an awareness of spiritual values.

If this unrestricted and intransitive sense of developing is taken seriously, the rhetoric becomes more than mere platitudes or slogans. It has subversive implications for society. The distinction between developed and developing countries based on economic criteria can be challenged as superficial and incomplete. North American or European society may emerge as rich in income and possessions but starved of collective values and relationships. One hopes that all communities regard themselves as developing unevenly and, with even minimal insight, recognize ways in which they are poorer than communities with lower incomes. It is for this reason that I have rejected the notion of "First" and "Third" worlds and categories of "developing," "underdeveloped," and "developed" countries and prefer to use the neutral terms "South" and "North" in order to avoid any sense of hierarchy or isolation.

From this perspective, the limitations of our current vocabulary are apparent. Development is used to convey three distinct ideas. First, it is used to describe the transitive form of "developing" which can be characterized as professional-centred, managed, top down, imposed, bureaucratic and contrived. Second, it is used to refer to the intransitive form of "developing" which is people or community-centred, indigenous, bottom up, internal, democratic, participatory and evolutionary. Third, the same expression is used to designate the collective enterprise towards which both of these processes should be directed. In effect, this third form is the common end towards which transitive and intransitive developing are complementary means. Lack of an umbrella expression under which practitioners of both processes can shelter in comfort encourages a polarization that tends to entrench attitudes within rival camps.

If this perception has any validity, it is a strong argument in favour of refining the lexicon of developing to distinguish between each of these elements. In the absence of words which are generally recognized, I will use the somewhat clumsy adjectives intransitive, participatory, intrinsic, people-centred or community-centred as equivalent in defining one form of developing. I refer to the second category of developing as transitive, extrinsic or professional-centred. I have yet to find an expression which adequately describes the goal of both processes.

International or Transnational Development?

Etymologically, "international" should suggest the image of being "among" or "between" nations. It implicitly recognizes the autonomy of nation states between which interaction can occur. International sport describes competition between nations according to rules to which they all conform and "on a level playing field." Each national team brings its unique skills to the international arena.

By contrast, "transnational" carries the connotation of crossing or overriding national boundaries. The Northwest Plains First Nations do not observe the 49th parallel as a significant dividing line – Sioux and Blackfoot bands straddle Canadian provinces and American states. The Haida nation occupies land in both British Columbia and Alaska. They disregard Canadian and American citizenship and issue their own Haida passport. They are transnational people and regard national boundaries as irrelevant impediments to their progress and recognition of their artifacts of history.

In a similar way, transnational corporations regard continental and national boundaries as obstacles to their profitability and as legal artifacts to be negotiated. Their interests supersede those of national societies and, like the European colonizers of the sixteenth century, they scour the world for new markets, raw materials and cheap labour. Like the First Nations of Canada, but for different reasons, their interests transcend national borders. They treat the world as their global factory and marketplace.

"International development" should convey the notion of the interchange of experience and expertise between countries in order to promote developing among all people. "Transnational development" creates a picture of sending goods and services across borders from developers *qua* producers to the developing *qua* consumers. If one adds ideologies to the list of goods on sale, the picture of transnational development is complete.

"Transnational development" better captures the essence of the contemporary export of official development assistance from the North to the South.

Participating

"To participate" is "to partake, or take part" – by an almost aggressive act of appropriation. "Partake" has a flavour of Anglo-Saxon brusque directness which is lost in the softer Romantic "participate." "Taking part" reflects a deliberate decision to become actively engaged. "Partaking" also conveys ideas of consuming and assimilating nutrients for one's own benefit. "Partnering" and "participating" share a common root and both convey the idea of sharing parts of a common whole. They suggest such synonyms as "cooperating" or "collaborating," in the precise sense of working together. They would be incompatible with "directing," "controlling," "subjecting," "commanding," or "monopolizing."

Participating, in the context of developing, can have a very different significance depending on the mode of developing in which people are invited to partake. In an environment of transitive developing, it is likely that experts will plan and deliver services for the benefit of people and the latter may be encouraged to participate. In this sense, people are being invited simply to partake of, or consume, prepackaged pablum. Their participation can be measured in terms of compliance or conformity. In the context of developing, their participation is passive and comes at the end of the process.

When people engage in partnering in reflexive developing, they participate more actively. They help to determine which issues they wish to confront; they take part in the enquiry into the nature of the issue; they look within themselves for resources or look beyond themselves for help in acquiring new knowledge or skills or to obtain material resources; and they partner in the planning, implementing, monitoring and evaluating of their own programmes which they helped to create. This form of participating, based on a commitment to intransitive developing and partnering, welcomes and does not limit partaking. The participating is continuous instead of terminal. Rather than being content to partake of precooked meals, people take part in writing the menu, finding the basic foodstuffs and cooking the meal.

Nevertheless, the root "part," which is common to "participate," "partake," and "partner," suggests that the essential process is one of sharing rather than excluding other parts of the whole. From the perspective of the overarching goal of developing, these verbs are compatible with the idea of partnering between the complementary intransitive and transitive practices of developing. They do not fit comfortably with the posture of maintaining separate encampments for each ideology.

Facilitating

One can characterize participatory or intransitive developing as an intrinsic process, whereas transitive developing is essentially extrinsic. How can those who are on the outside of a community contribute constructively to the internal processes of its intransitive developing?

One approach is to act directly to change the environment in which people struggle for a better life – by striving on their behalf to create a more just society through political action and economic interventions, by providing aid in the form of money, food, shelter and essential infrastructure or by improving access to education and health services. These direct actions all fall within the category of transitive developing whereby "we" intervene to develop "them." In so doing, we function as developers who practice extrinsic developing.

The complementary practice of facilitating the process of intrinsic or participatory developing needs clarification. Given that this form of developing is fundamental, one can accept, at least in principle, the proposition that the perceived needs and aspirations of those who are engaged in their own developing are paramount. They should not be overridden by the best intentions of developers. Consequently, the role of outsiders who wish to promote intransitive developing is one of expediting the process. In so doing, we act as facilitators of an intrinsic process.

The practice of facilitating may become clearer if we can identify synonyms for "good facilitating." These include "to encourage," "support," "empower," "enlighten," "sustain," "liberate," or "catalyse." By contrast, verbs describing practices that inhibit rather than facilitate participatory developing include "to control," "direct," "manage," "deliver," "indoctrinate," or "make dependent." Other apparently neutral and bland ideas which should arouse suspicion are "to mobilize," "instruct," "train," or "counsel."

The intrusiveness or intensity of facilitating can vary widely between extremes of active interference, on the one hand, through to passive reactivity, on the other; from listening or observing, through to advising or counselling. The act of facilitating is never neutral or merely a social lubricant. Facilitators may strive to avoid leading or directing but their mere presence introduces their values and assumptions. In some chemical reactions, an enzyme influences the rate and direction of the reaction without being incorporated in the process. In a similar way, a facilitator influences both the speed and the direction of the process of developing.

Padam Lal Devkota was an exemplary facilitator in Surkhet. Perhaps by virtue of belonging to the district and his respect for his neighbours,

he scrupulously avoided shaping their plans and programmes and facilitated the form of developing which they chose for themselves. Nevertheless, his presence could only have influenced the directions they took and those they rejected. In Mindanao, the process of community facilitation was equally competent. However, within the framework of the Davao HDP, facilitating was confined to a predetermined agenda. The range of activities which the HDP could support was limited and the preconditions for participation were strict. I am aware, however, that other instances of "facilitating" have included religious and/or political indoctrination. Facilitating can easily approximate manipulating. Filipinos, in fact, have coined the expression "facipulation" to describe such veiled manipulating, wherein the facilitator is a developer masquerading in sheep's clothing.

The professional facilitator stands in the same relationship to intransitive developing as the professional developer to transitive developing. Pure forms of life are rare, and hybrids are more common. Although it is convenient to distinguish sharply between facilitator and developer as roles for outsiders who wish to promote developing, the two forms are rarely pure and tend to merge.

Sustaining

The countries of the South are littered with the debris of development projects which have not been maintained. Some were successful as temporary models but proved to be transient and could not be continued. Sustainability has recently attracted attention in terms of the costs of developing to the environment – that is, the local environment may not be able to withstand the impact of developing.

"To sustain" implies "to support," "maintain," or "nourish." "Sustainability" implies more than passive tolerance of a burden but rather a potential for symbiosis or mutual benefit from interaction. In the context of developing, there are several preconditions for the ongoing sustenance of activities.

The emotional content of the programme may be critical. Programmes in which people or institutions have participated actively in planning and implementing in response to their own perceived needs are more likely to survive and evolve, whereas those which are imposed or donated are likely to be short-lived. The emotional content people invest in programmes may be the major determinant of sustainability.

The moral content is equally critical. Programmes that disregard human rights, social equity and honest accountability will eventually reveal themselves as flawed and be allowed to die.

Economic viability is equally significant, whether programmes are managed by various levels of government or by communities. In the context of participatory developing, it may be necessary to build in a provision for business and investment strategies in order to create a pool of funds derived from community entrepreneurial initiatives as the basis for social investment.

Environmental sustainability has been thoroughly explored and popularized. It is universally recognized, at least rhetorically, that developing which causes irreversible damage to the physical and social environment is unworthy or incapable of being sustained.

Learning

It is instructive to examine the language of education for at least two reasons. At the simplest level, education looms increasingly large in programmes for "human resource development," a paraphrase of which might read – "the education of people (humans) as a resource for development." This interpretation points to the more significant second observation – that our perception of developing resonates with our understanding of educating.

In the spirit of the transitive form of developing, educators focus on teaching – that is, what "we" can do to instruct "them" for their benefit. This focuses attention on questions of curriculum design, pedagogic principles, levels of schooling (primary, secondary, post secondary) and distinctions between formal and non-formal education or between training and education. Teachers may perceive their role as simply to tell facts or transfer skills to uninformed and unskilled students. One could categorize this as a teaching or instructive model of educating.

By contrast, in the spirit of intransitive developing, educators shift their focus from teaching to learning. They become preoccupied with the goals of education in terms of the learning needs of students, learning styles and alternative ways of facilitating learning. One can designate this the facilitative mode of educating. It is self-evident that knowledge comes not only from formal schooling but also from living and from the collective experience of communities. This recognition strengthens respect for indigenous wisdom or knowledge.

In a fundamental sense, "developing" and "learning" are virtual synonyms and share a common goal – to transform society and allow people

to change for the better their own quality of life. Knowledge gained both from the community and from schooling is a resource which people can use to shape their lives. Parallels between the teaching-learning and transitive-intransitive developing dualities are instructive. As in intransitive developing, the only purpose of teaching is to facilitate learning by creating or taking advantage of situations in which people can gain new knowledge and skills. As in transitive developing, instruction can as easily inhibit as facilitate learning and instructors have a responsibility to be self-critical and ensure that their instruction does not impede learning. Teaching is a means; learning or knowing is the end.

Enquiring

The relationship between enquiring and developing deserves attention. "Research" is commonly used as a synonym for "systematic enquiry." Research and development (R&D) is commonplace in industry where it is unequivocally intended to imply research "for purposes of" development. The new knowledge which may be gained will be applied to enhance productivity. In R&D, "development" is simply a synonym for "productivity."

"Research" can be understood in a restricted sense based on the application of the principles of modern western science, at least as they are commonly interpreted – that is, processes of logical induction based on controlled experimentation or observation. This form of research requires professional researchers who seek out new knowledge for others to use. This version of researching is consonant with the instruction mode of educating and the transitive form of developing. This style of researching and educating is easily assimilated into programmes of official development assistance. Researching "about" developing puts the emphasis on the interests and priorities of investigators. They determine the questions to be addressed and the investigative methods to be used; they control the collection and analysis of data; they draw inferences from this analysis and may base recommendations on their findings. In the context of developing, it is likely that these recommendations will be returned to the communities that were the original objects of study. The participation of people in this form of researching is restricted to mere compliance. In this form of enquiry the investigators own the data.

This method of scientific research is not the only way to acquire new knowledge. There are alternative and equally valid forms of enquiry. People can partake in the process of investigating and, indeed, learning and knowing are integral parts of developing. It is in this intransitive

form of developing that "participatory research" is used to describe a process by which people take an active part in undertaking their own enquiring. They prioritize the questions they wish to address; they share in selecting and implementing the methods of enquiry; they reflect on the data which they have collected; they draw their own conclusions and base their action plans on their own findings. They own their programmes and the data on which they are based.

This thumbnail sketch reveals an assumption that participatory research must follow the linear sequence of the scientific method. It is more likely that indigenous learning takes entirely different routes, although the knowledge that it gains has equal validity.

These two approaches to researching are not mutually exclusive nor should they be ranked in value. It is entirely possible to find a middle way which combines the best of both approaches. However, experience suggests that some social researchers are possessive of their exclusive rights to research and find it difficult to share control.

For convenience, I will refer to these two methods as "researching" and "enquiring," respectively.

Healing

It is relatively simple to describe health rhetorically and theoretically in the most liberal and inclusive terms. WHO adopted the following definition, proposed by an international medical conference in New York in 1946: "Health is a state of physical, mental and social well being and not merely the absence of disease or infirmity." This definition conveys an expansive sense of wholeness or integrity of an individual or a society. It is in this general all-embracing sense that we refer to a healthy society, a healthy economy or a healthy environment. It is this perception of health which resonates with the idea of healing. In this sense, "health" can be regarded as a synonym for "a good quality of life."

When "health" and "healthy" are used in this broad sense, it is important to enquire if they are meant literally or metaphorically. If we use "health" only as a metaphor, it implies that there is an underlying meaning that is literal, factual and real. "Real" health would be an antonym for "ill-health" or "disease," and "health" would be a synonym for "the absence of disease." This restricted meaning is readily compatible with the conventional practices of curative and preventive health care. Even health promotion is oriented towards habits (exercise, avoidance of smoking or stress) that incur the risk of disease. If one distinguishes in this way between a literal and a metaphorical sense of health, the "real" or operational

meaning of "health" becomes "the absence of disease" and health professionals are those who are dedicated to disease control.

Conversely, if one accepts the extended description of "health" literally and not simply as a metaphor borrowed from the "health sciences," then "health" is indeed synonymous with "a good quality of life." Based on this understanding, "health professionals" include all those who contribute to an improved quality of life. The conventional structure of a faculty of health sciences (medicine, nursing, pharmacy, health economics, health administration, etc.) reveals a tacit acceptance of the restricted "real" sense of "health" as "disease control." However, the notion that an entire campus with its multiplicity of disciplines can be legitimately regarded as a "health faculty" is more than a fancy if one accepts the general idea of health as literally true.

Belief in this second view of health discourages the sequestration of "health sciences" on a campus and encourages the recognition of all disciplines as equal contributors to a healthy community. At a governmental level, it implies that the notion of a ministry of health is a misnomer since an entire government should have the health of the nation as its goal. It is logical, although not necessarily desirable, to create a department for hospitals or community health services. In this regard, I have found it stimulating to listen to conversations where Asian colleagues have speculated about the practicality of abolishing their ministry of health in order to facilitate an intersectoral approach to the well-being of their community.

The liberal idea of health is appealing and exhilarating but the gap between rhetoric and reality is wide. The temptation to preach health as quality of life yet practise disease control is overwhelming, and it may be difficult for health professionals to achieve an insight into this ambiguity. Indicators of adherence to the disease-control model include the preeminence of traditional health professionals, reliance on conventional mortality and morbidity indices, and an emphasis on health-care delivery systems. Evidence of a practical commitment to the quality of life concept include a preference for broad interdisciplinary health teams whose leadership is not restricted to conventional health professionals, the pursuit of qualitative health indicators and a reliance on an intersectoral approach to healing. The structure and philosophy of IPHC in Mindanao reflect this orientation.

Each sense of health is valid and they are not mutually exclusive. However, the vocabulary can be at best ambiguous. It is important to distinguish conceptually between health as "quality of life" and as "disease control" and to match our reflection with appropriate actions.

The words "heal" or "healing" do not crop up in the general conversation of doctors unless they are used in the narrow scientific sense of tissue repair. Most health professionals would disdain the title of "healer." "Healer" is suggestive of the paramedical, the unorthodox, the quack. Doctors are comfortable in treating, and perhaps curing, but rarely claim to heal – probably because they appreciate instinctively that healing is indeed an all-embracing process which is greater than therapy or cure. This reluctance to claim "healer" status reveals an implicit recognition of the distinction between controlling disease and enhancing the quality of life. "To heal" is "to restore integrity," "to repair deficits," "to make hale and whole." One can heal oneself or be healed by a healer. Health is the product of the process of healing.

The idea of "health development" is creeping into the language of health professionals who engage in developing overseas. The absence of a conjunction has already alerted us to the ambiguities in the relationship between healing and developing. There is an increasing awareness that healthy people are more effective agents for developing, equally applicable in whatever form one understands "healing" or "developing." This argument will be used to attract the attention of development agencies to the importance of funding health programmes. In this sense, "health development" implies "the promotion of healing as a prerequisite for efficient developing." Developing is the end towards which healing is a means.

An alternative interpretation of "health development" insists that healing is an outcome of developing, i.e., healing through developing. Healing, either in the narrow or broad sense, can be the product of developers or self-developing. In the context of participatory developing, pursuing an unrestricted agenda, there is immediate consonance with the broad understanding of "healing" as a synonym for "achieving a good quality of life."

Primary health care belongs rightly to the world of health care delivery systems focused on health as disease control. It is one component of a logical sequence of primary, secondary and tertiary levels of organization, planning and referral. The tertiary hospital is the centre where expertise, technology and authority are concentrated. Health care fans out through a system of second-level institutions towards the communities through a series of health posts or medical centres staffed by trained personnel. From this perspective, primary health care is the peripheral extension of an integrated health-care delivery system explicitly dedicated to disease control. It is implicitly based on the transitive form of "developing." Its goal is the eradication of disease and its strategy is developing in the form of treatment, education and construction of infrastructure. The language of this form of profession-centred health care

reflects the assumption that health is a commodity, or product, which can be provided and delivered to consumers.

By contrast, participatory health developing is a process which takes place beyond the health posts. It is instructive to conceptualize these "peripheral" communities as the true "centre" to which the health care system should react in response to the community's perceived needs. The tertiary "centre" is displaced to the periphery and attention switches to the people who draw on its services as required. Participatory developing demands that people partake by using their own knowledge to set their priorities and in planning their health activities. "Health" in this context means "an improved quality of life based on the people's own perceptions," and "health development" indicates that healing is the outcome of the process of people developing.

"Primary health care" and "participatory health developing" are not synonymous. They should neither be incompatible nor in conflict, and can be complementary. However, there is a serious risk of a lack of congruence and even competition based on different perceptions of where the centre lies and the attitudes and behaviours health-care professionals bring to their task.

Two Solitudes

This analysis of the languages of developing suggests that the concepts of "developing," "learning," "enquiring," and "healing" are deeply divided. The source of this division can be traced to alternative ways of understanding and styles of promoting developing. A professional-centred style is dominated by developers and can be characterized as transitive. A participatory style is associated with facilitators and has been designated intransitive. Exponents of these two approaches follow diverging paths and their choice of direction determines the form of education, research and health which they invoke. Developers choose the way of didactic teaching, scientific research and health-care delivery. These technologies are all extrinsic to the communities which are developing. By contrast, facilitators prefer to take the route of learning, enquiring and healing. These processes are all intrinsic within the developing communities.

In the world of developers, bureaucrats, experts and professionals take their stand within their establishment and command expertise and capital. They stand squarely within their centre from which they look out towards the mass of people for whom they are responsible. They are anxious to deliver their services and resources to those who are in need of them. The characteristics of this position are benevolent paternalism,

managed delivery of goods and services, and brimming confidence in professionalism.

There is a second world view which is more difficult to describe. Here the "centre" has dissolved and become dispersed so that it is widely distributed among the people. This world is literally and deliberately eccentric. People take their stand within their communities from which they intend to control and manage their own developing. They look out from their domestic centres towards a distant bureaucracy or professional oligarchy and insist that it is the role of administrators and experts to respond to their just needs.

These two encampments are pitched at a discreet distance from each other. Like Martin Luther, each declaims defiantly, "Here I take my stand." There is little evidence of tolerance or enthusiasm for compromise between those in opposition.

Hugh MacLennan, the Canadian novelist, used the image of "two solitudes" to describe the predicament of anglophones and francophones who coexist uncomfortably in Quebec. The roots of this situation can be traced to misunderstanding and distrust based on a historical abuse of power and wealth. It is tempting to borrow this image to characterize the relationship between developers, teachers, researchers and health deliverers, on the one hand, and facilitators, learners, enquirers and those who are healing, on the other. The poignancy of the image of two solitudes is striking. Each camp speaks a different language – albeit, in one case, using the same words. Each strives to remain a distinct society with its own mythology and creed. They live and work in close proximity yet remain separate and divided.

The solution to the reconciliation of Canada's two language and cultural solitudes is elusive, but one can anticipate where it lies. It will emerge only when francophone Québécois and anglophone Canadians come to acknowledge their common allegiance to a single nation. It is even more important that they should learn to understand and respect each other's distinctive culture and recognize the mutual benefits of partnering.

In a parallel sense, developers and facilitators must reach a consensus on the flag under which they serve. They must agree on that overarching end of "developing" towards which the transitive and intransitive forms of developing are merely means or enabling objectives. They cannot harbour private agendas which are in conflict. Partnering demands openness to understanding each other as a basis for mutual respect and trust in the expectation of eventually achieving a relationship of friendship. It will take protracted time and rich reserves of energy

to overcome unfamiliar styles and habits that irritate. Above all, consensus presupposes acknowledgement of the mutual benefits to be gained from reciprocal partnering.

A hidden trap is to assume, even unconsciously, that the two forms of developing, learning, researching and healing are alternatives – that is, that one can opt for one or the other. It is even more treacherous to rank them in some arbitrary order of precedence. On the contrary, one can recognize value in each form and incorporate them within a single synergistic system. The expression "alternative medicine" is unfortunate if it implies the need to choose "either or," One needs both. Different systems of healing or forms of developing are complementary rather than alternative. However, empirical observation suggests that they are uncomfortable bedfellows. The skills and attitudes valued by those who develop others are distinct from the competence sought by facilitators of autonomous developing. One of the obstacles still to be overcome by those who are committed to developing is to build bridges between these two solitudes.

Given this disquieting image of divided or opposing worlds, we can study the ground which separates them. The gap lies within the minds of people within each camp. Mistrust born of misunderstanding breeds concern over relative power and control. Instead of partnering between allied systems, we witness competitive jockeying for superior position. While it may be an exaggeration to depict the duality as a conflict, the defensive positions each camp occupies could become offensive if either feels threatened.

One can empathize with Arjuna as one stands hesitantly at the frontier between two opposing camps. The conceptual and operational gap is significant and perhaps widening. One fears an outbreak of hostilities between potential allies. The solution can come only from enthusiasm for the practice of reciprocal partnering.

8

The Idea of Partnering

Individuals as Partners

Before questioning how institutions can partner, it is instructive to reflect on relationships between individuals. Although there are limits to the value of argument by analogy it is useful to compare the idea of partnering by institutions with the many forms of interpersonal relationships.

The range of relationships that can link individuals is wide. It is helpful to visualize a "bonding" scale which, from left to right, spans the spectrum of relationships from mere acquaintance through companion and friend to lover or spouse. The left end of that scale is heavily populated by casual acquaintances whereas the right end is much less cluttered. The formation of strong "bonds" demands the expenditure of high energy. High-energy relationships are greatly prized but are costly and accordingly rare.

Many modern women and men consciously choose the expression "partner" to refer to a spouse or intimate friend. An English community advocacy group which recruits "partners" to assist the disabled, defines partners as "those who are prepared to give freely and wholeheartedly

long term support to another individual." In a similar spirit, the idea of "partnering" should be reserved for those rare and significant relationships which lie towards the right end of the "bonding" scale. We can reduce the risk of devaluing the currency of partnering by using the expression selectively rather than indiscriminately.

There are several preconditions which must be met before individuals can achieve this special form of partnering. These include the sharing of a common goal and the possession of compatible life styles. These relationships take time and patience to mature and they demand a restrictive focus of attention. Partners must retain their individual identity if their relationship is to benefit from their diversity and not degenerate into bland anonymity. These general principles can be seen in action in successful families and work places.

The relationship between spouses has been the subject of critical attention in western societies in recent years. Most contemporary spouses reject a gender-based hierarchy whereby the male assumes a dominant role. They strive for an equitable sharing of power, decision-making and responsibility. Successful partnering demands the abandonment of self-interest in favour of common interests. Intimacy implies the willingness to accept vulnerability and risk. While the idea of love as the basis of genuine partnering defies analysis, there should be little discomfort with the proposition that the minimal requirements for success in partnering are mutual respect, trust and commitment.

The parent-child relationship is particularly revealing. It requires the same essential ingredients of love, respect and trust. Yet, at the same time, there is an explicit hierarchy in terms of the exercise of authority and responsibility. The evolution of maternal and paternal relationships through adolescence often remains turbulent until the balance of power is resolved. Paternalism, even if benevolent, is not a sound basis for a stable adult relationship.

The way by which we function in the work place also accurately mirrors how we understand and practice partnering. Most people work within an environment of authority and dependence on colleagues. The ability to accept responsibility and to use it equitably and constructively, to recognize and work under higher authority without petulance or subversion, to relish interdependence and collegiality rather than search out solitariness – these are the hallmarks of successful partners.

The purpose of these reflections on domesticity is not to draft a manual for family counselling or to idealize the work place. My intention is simply to recognize those assumptions, attitudes and behaviours which are

conducive to good partnering between individuals. It appears that successful partners share a common purpose and compatible interests and behaviours. They are willing to risk subordinating their own self-interest in favour of a shared interest, while still retaining their individual identity. They aim for an equitable sharing of authority and responsibility. Their relationship takes time and effort not only to achieve but also to sustain. While one can enjoy many acquaintances and a wide circle of friends, one can have few intimate partners.

These same characteristics which are the prerequisites for effective partnering between individuals were equally essential for *DID* when it tried to partner. Institutions are composed of individuals, and institutional relationships are largely the product of a cluster of interpersonal friendships.

The analogy between interpersonal and institutional partnering suggests a simple but sobering corollary. Those who have the responsibility to recruit participants for overseas programmes based on institutional partnering may be able to predict their effectiveness by carefully examining how well they function within their immediate home and work environment. It is unlikely that those who are ineffectual partners at home can be effective overseas.

Institutions as Partners

The following observations are drawn from the experience of partnering on campuses. Universities represent only one example of many types of organization that enter into partnering arrangements for purposes of developing. The following ideas are particularly pertinent to academe. However, the broad principles may be equally applicable to any organization which intends to partner for purposes of developing.

The Forms of Institutional Cooperation

I distinguish between at least four broad categories or stages of institutional cooperation. They represent points which progress from left to right across an institutional version of our hypothetical "bonding" scale. The category of institutional partnering is reserved for those few relationships that lie at the right end of that scale.

Networking

The simplest form occurs when several institutions join together in a loose association to pursue a common interest. For academic institutions this common focus of attention is likely to be disciplinary or methodological.

The common bond may be an interest in a narrow academic pursuit or a new branch of science. They collaborate for only this specific purpose and have no need to cooperate more generally. This form of loose single purpose association is often known as a "network." The essence of this form of relationship is a single item agenda; the means of communication is typically electronic, interspersed with occasional conferences; there is little investment of energy or sharing of feelings; and little risk is incurred.

One visualizes many "nodes" scattered widely and linked by facsimile, modems, electronic mail, automated office systems and communication satellites. The image of networking is one of efficient but impersonal communication with minimal physical contact.

Linkageing

A more ambitious relationship is achieved when one institution requests another to undertake a specific task on its behalf. In the context of international development, as it is conventionally practised, one institution in the North is funded by a national or multinational development agency to provide a technical service to another institution in a country in the South. The latter continues to conduct its own affairs and effectively subcontracts a segment of its work to a foreign agency. This form of limited contractual arrangement is sometimes referred to as an institutional "linkage." The essence of linkageing is a legal obligation to deliver a specific service or achieve some measurable output. It need not require any intimacy or mutual feelings; it works within clearly defined limits; and it carries few risks.

To Scots, the idea of linkage conjures up an irreverent picture. In the Scots vernacular "links" refer to sausages. Links suggest a series of substantial bodies strung together by unsubstantial content. In human terms, the contact between linked individuals may be one of a discreet handshake, perhaps between gloved hands.

Partnering

A third and more expansive form of relationship evolves when an institution in the North expresses the willingness to join forces in a common mission to help a sister institution in the South to strengthen its institutional capabilities. They become bound together not only by a narrow obligation to deliver some defined service or product, but also they gain the confidence to share ideas about a common vision which embraces the overall mission of the "recipient" institution. The more privileged "donor" institution aligns itself with its "less fortunate" partner and

opens itself to respond, where appropriate, to changing needs as they may emerge. The notion of "partnering" should be preserved for this third form of relationship. It makes much heavier demands on each partner institution; it has vastly richer potential for good; it requires frequent and intimate contact and cannot escape the clash of strong opinions and personalities; and it is a risky enterprise.

The image of this form of relationship is one of a benevolent donor partner who is not content with a handshake but puts a protective arm around the shoulders of his neighbour.

Reciprocal Partnering

I now recognize a fourth form of relationship where partners embrace the goal of mutual benefit. At an early stage in the evolution of partnering the attitude of the "donor" is likely to be warmly benevolent and conceived in a mood of unwitting paternalism. The primary focus is likely to be restricted to the advancement of the "underprivileged" member. It may be only at a relatively late stage that the rich potential for mutual learning and benefit is appreciated. This understanding implies the abandonment of conventional donor-recipient polarities and adoption of an intention to work together towards the goal of mutual improvement, in turn requisite upon the perception that each partner has something of value both to give and to receive. What is needed then is both the confidence to give and the humility to take. It may be "more blessed to receive than to give." It is only when we recognize our shared and common human predicament that this higher form of partnering becomes even conceivable. The expression "reciprocal partnering" may begin to capture this notion of two-way partnering for mutual benefit. It is a form of conviviality in the literal sense whereby partners realize that they live together.

The only adequate image of reciprocal partnering is one of two individuals locked in a mutual embrace.

Reminiscences of Partnering

Using this frame of reference to reflect on the Kathmandu connection one can understand that in 1980 The University of Calgary entered into a contractual "linkage" with Tribhuvan University whereby Canadians undertook to provide technical assistance to the IOM in support of undergraduate medical education. In a sense, the origin of this relationship lay in a form of multinational networking. The original consultation that sparked future cooperation arose from a WHO programme for strengthening medical education in the Indian subcontinent. Over the

ensuing years this sense of a limited obligation evolved gradually and spontaneously into a form of open-ended partnering whereby Canadians became committed to try to respond, where appropriate, to the future needs of Tribhuvan University wherever they might emerge – whether it be in anaesthesiology, generalist training, obstetrics, medical research or engineering.

However, it is only recently that both Nepalese and Canadians began to glimpse the possibilities for mutual learning and conviviality. Our earlier vision was clouded by the veneer of material superiority of Canada and it has taken time to see below the surface of our societies to appreciate the common problems of humanity we share. It took a full decade to reach the stage where we could envisage the potential benefits of two-way partnering.

The Davao-Calgary relationship benefited from the extensive experience of IPHC and also from our own learning in Nepal. From the outset it was clear that our Filipino colleagues were more experienced in the practice of community organization and had achieved an understanding of the principles of participatory developing. There was little risk that Canadians would indulge any fantasy of superiority. We entered into this new relationship with eager anticipation of the prospects for mutual benefit by learning together.

The Virtues of Reciprocal Partnering

Each form of institutional cooperation has its own merits. Networking and linking will undoubtedly continue to be the most popular vehicles for university contributions to developing. They are relatively simple to implement and are least demanding. However, authentic partnering has special merits and the practice of reciprocal partnering for mutual benefit offers unique advantages. A relationship which is solidly founded on mutual respect, trust and a commitment to work together for mutual benefit is more likely to be able to withstand the strains of an uncertain future. It lays the foundation for the only form of international relationship that can begin the slow process of healing the painful wounds which separate global societies. Lesser forms of relationship based on hierarchy simply perpetuate a deep sense of injustice. The character of the dialogue with colleagues overseas changes perceptibly when we explain our belief in this form of reciprocal partnering.

Although the financial costs of reciprocal partnering are modest, the other costs are high. The preconditions for success are formidable and it is not for the faint-hearted. This form of partnering demands much more

than the adoption of a politically correct slogan. It requires a profound change in attitudes and behaviours, and the cost of these should not be underestimated. However, the benefits greatly outweigh the costs. The following pages focus exclusively on partnering and, in particular, that form of reciprocal partnering that aims for the goal of mutual benefit.

Preconditions for Successful Institutional Partnering

The Partnership Context

So, while the focus of this chapter is on the process of partnering, one must recognize the content of the partnership. It is equally true that partnering is both an end in itself and a means to an end. Institutions enter into partnering for a purpose, and to achieve this purpose each partner is required to contribute skills or other resources. Each must bring to the relationship those contributions to which it is committed. These may take the form of technical skills, or providing access to them. These provisions constitute the content of the partnership.

Reflection on the problems which beset the Davao HDP indicated that the inability of each partner to provide a key form of technical skill contributed to its demise. However, weakness of the process of partnering also prejudiced our ability to compensate for deficits in the content of the partnership.

The Partnering Process

The prerequisites for success in the process of partnering are similar to those which determine the fate of interpersonal relationships.

A Common Vision

A common vision or single intention is one key to successful institutional partnering. But the use of the expression "vision" can be misleading. One who places value on "vision" may be labelled as a visionary and put in the same category as medieval mystics. But the idea of vision is more appealing when used in a metaphorical rather than a metaphysical sense – that is, when it refers to the ability to "see" ahead and clearly understand one's direction and purpose. Such vision succeeds in seeing/knowing its mission and understanding and following its internal logic. The title of "visionary," with its implications of literal revelations, hardly captures the metaphorical connotations of intellectual perception and moral integrity.

One should distinguish between three discrete elements of this vision, or three categories of objectives. These comprise a shared end (the ultimate objective), agreed means to that end (enabling objectives), and compatible private agendas (secondary objectives).

The End. First, there is the ultimate goal towards which all our efforts are directed. We are unlikely to reach this point in our lifetime, but it sets the direction of our shared pilgrimage. This is our "end."

This end is the most powerful determinant of our actions. It is, therefore, unfortunate that it is often dismissed as ethereal and remote from present reality. It is dangerously easy to dismiss this goal cynically as no more than a platitude to which one has to pay lip service. In reality, the end towards which we direct ourselves reflects our value system and uncovers our intention or motivation. It may be difficult to recognize the end which drives our own actions. It is even more demanding to continue to refine and mould our understanding of this goal to a level worthy of our hopes and efforts.

In Nepal, several years passed before we were able to identify unambiguously the improvement of the quality of life of the rural people as our end. It is vital to renew and reinforce this vision continually and to share it with colleagues.

The more precisely we define our end the more narrowly we restrict the range of those with whom we can partner. It is unwise to try to travel together with those who are headed in a contrary direction. This apparent inflexibility does not reflect a tie to ideological correctness but rather a pragmatic recognition that it is simply unproductive for partners to work together when they disagree on their purpose. This is especially pertinent in the context of developing. As already observed, this expression is ill-defined and used indiscriminately to embrace a wide range of activities which are not only diverse but even divergent. It is unwise for too many programmes to sail under this same flag of convenience.

Intermediate Purposes. In order to move progressively in the direction of our end we establish a series of intermediate purposes. None of these is an end in itself but all are means to the ultimate end. These are our immediate purposes or enabling objectives. They are steps on the way towards our end.

Clarification of these intermediate objectives is rarely demanding. They commonly constitute the content of our programmes and are the substance of our collaboration. They may take the form of education, health care, social services or other forms of technical assistance.

Serious problems arise when means are allowed to become ends in themselves. It is also entirely possible to pursue intermediate objectives that lead away from the end we profess.

Secondary Objectives. Partners also pursue additional private objectives. These are not directed towards the goal of our collaboration but are incidental to the main purpose. They are by-products or fringe benefits. They may include personal career advancement, financial gain or the pursuit of honours. The precise content of these secondary objectives is not critical. However, it is essential that the private agendas of each partner should be compatible. It is unlikely that they will be congruent, and it is a recipe for disaster if they are in conflict. There is no place for competitiveness between partners in the pursuit of private gain.

Just as means can distract from the end so these private objectives can easily take precedence over the true end and redirect the programme towards private gain. In this way the purpose of the programme is subverted.

Inappropriate financial expectations are a common source of incompatibility of private agendas. There is cause for serious concern if each partner has selfish designs on the budget. Willingness to share financial control equitably minimizes this risk. Budgets are finite, and it is inescapable that the diversion of funds to the more affluent partner can only deprive the more needy. In this way, one partner can become parasitic on the weaker member. It is easy to fall prey to this temptation and fail to realize that the distribution of resources is inequitable. The fact that overseas colleagues may not complain openly is no ground for complacency. Their silence may simply reflect their awareness of the unwritten rules of the "development business" or their lack of confidence in us to raise such a sensitive issue. Frank discussion about the precise allocation of funds and acute sensitivity to the global maldistribution of wealth can reduce the risks of conflict. Unspoken resentment against perceived inequity can prejudice the prospects for the achievement of the mutual trust required for genuine partnering.

Inappropriate academic expectations can also cause conflict. The "donor" institution may assume unrestricted access for students or faculty to people or places overseas in a way that may prejudice the conduct of the programme. The presence of foreign students or other expatriates overseas can be a positive contribution to partnering if it is planned sensitively. However, it can also have a negative impact if it incurs costs which impinge on the budget, distracts local faculty away from their own teaching commitments or simply adds to the friction of partnering.

The way academic research is introduced into developing also deserves careful thought. Both partners should agree that research costs do not compromise the other needs of the programme. There should be a clear understanding about policies for the authorship of future publications so that each partner derives credit. If the project is based on a participatory research model, it is critical to ensure that external research does not interfere with the community's own enquiry.

More fundamental than any of these potential sources of friction is the intention, conscious or otherwise, to subordinate one partner to a position of dependency. The promotion of self-reliance and a reduction in dependency are guiding principles of developing. Acceptance of the principle of reciprocal partnering based on mutual respect implies automatic commitment to strengthening each partner and to subordinating self-interests to mutual benefit. Any intention to scheme towards future dominance subverts this principle. It is fundamentally wrong to use development assistance in order to try to impose opinions or in any way undermine the autonomy and integrity of the people whom we purport to serve.

These risks are insidious when motives are concealed, even to the perpetrator. Some may wish to prolong partnering simply in order to continue to proselytize on behalf of beliefs which are sincerely held. Development assistance undertaken as a vehicle for the propagation of religion or political ideology is susceptible to this risk. "Donors" who offer assistance as a carrot in order to win others over to their private cause are guilty of paternalism at best and undisguised imperialism at worst.

Governments use overseas development assistance explicitly as an adjunct to their foreign policies in order to gain political leverage. Some private companies exploit development assistance to establish business advantage and secure profit in a way which ruthlessly ignores the needs of their overseas partner. Non-governmental organizations may use development projects to promote their own ideologies or their own profit.

All forms of "development assistance" with these ulterior motives are reincarnations of the Trojan horse. Institutions overseas should still be wary of Greeks bearing gifts. Their apparent purpose may be a subterfuge for a real intention to win advantage over a partner and to perpetuate inequity.

A totally unacceptable form of partnering is parasitism whereby the stronger partner competes for resources to the detriment of the weaker. The lowest acceptable form of partnering is one of symbiosis or commensalism whereby partners can coexist without harming each other. The essence of reciprocal partnering for mutual benefit is the pursuit of

synergy rather than mere symbiosis. In this situation, each partner receives from their investment more than they contribute. The goal is not simply passively to avoid conflicts of interest but rather actively to seek out areas of common interest where each can benefit by learning together.

Partners may face common problems in their respective societies and they can work together on their solution. Alberta and Mindanao face the common challenge of learning how to help their indigenous people to improve their lot. Both societies also share the problems of urban poverty and helping street children. Furthermore, it is only a matter of time until the Canadian health care system collapses under the weight of escalating costs. We may then be ready to learn the lesson of participatory health development from our Asian and Latin-American colleagues. Shared problems offer opportunities for shared learning. Furthermore, the analysis of the costs and benefits of the Kathmandu connection demonstrates other considerable indirect benefits of partnering to each institution. Readiness to learn rather than to teach and to receive rather than to give transform a relationship. It moves us in the direction of shared power and responsibility and minimizes the threat of perpetuating dependency by deliberate or thoughtless paternalism.

Despite the opacity of these quasi-theological ideas of ends and means, they are critical steps to successful partnering. When we have set out to partner and have understood and agreed on each of these elements of our vision, then our relationship has been strong and our collaboration fruitful. Conversely, when our shared vision has been blurred and our private intentions concealed or unclear, then we have faltered.

Creating a Common Vision

Clarification of all our objectives was never easy. Perhaps in an ideal world potential partners would spend time together before embarking on a joint enterprise to explain their respective philosophies, confirm that they aim for a common end and ensure that their private expectations are compatible. In practice, this understanding has come slowly by degrees. Shared learning came only through shared experience.

The analogy between interpersonal and interinstitutional relationships is helpful. Future spouses rarely formally declare their personal goals and objectives to each other in order to calculate if they are compatible. More often they reach an intuitive understanding that there are reasonable prospects of conviviality. Confidence comes only with time and is confirmed by continuing to learn from each other.

This sequence of events has been true of the liaison which has evolved between Kathmandu and Calgary. Initially there was a sense that we had some common interests. In 1980, we gave no thought to debating our understanding of developing or its relationship to healing. None of us had the experience to undertake such an analysis. We simply recognized that we had a common interest in the immediate challenge of medical education in Nepal. At that stage our goal would have been described in terms of training doctors. The University of Calgary would have asserted that it was simply undertaking the responsibility to provide technical assistance to the IOM to set up the MBBS programme. For five years, our perception of education as an end in itself remained unchallenged. We did not question whether or not there was a larger enterprise of which our academic work was simply one component.

It was the experience of encountering at first hand the realities of health and disease in Surkhet which made it clear that the health of village people was our true end and that our training activities were only one means to that end. At this stage, what had been an end had to be downgraded to that of an enabling objective with the end redefined as health or quality of life. Only at this point did we question the nature of healing and developing and their interrelationship.

In retrospect, it would have been prudent to have paused at this stage to clarify and define our new understanding. This exercise would have been equally important for both Nepalese and Canadians. In reality, each of us lived through our own private experiences and learned independently. There was insufficient collective learning either within the Canadian team or between Canadians and Nepalese. Consequently, we may have lost temporarily that essential shared vision and the sense of direction such a vision confers.

Some of our frustrations can be attributed not only to this clouding of the vision of our goal but also to confusing means with the end. The generalist programme is the most obvious example of this fundamental error. However, the experience prepared DID for its later collaboration with IPHC. In that case, the question of a common vision was never in doubt. From the onset the explicit end was the improvement of the quality of life of the rural villagers in southeast Mindanao.

Throughout its formative years, DID was obsessed with its clarity of vision and sense of mission. Successive workshops and annual retreats focused on sharing ideas about the meaning of developing, partnering, participating and health development. At times the debate seemed to be circular and unending. There was also a risk of becoming too blinkered

to alternative ideas and seeking the security of an oversimplified understanding which might have degenerated into a form of fundamentalism. However, there is little doubt that this unusual effort to achieve and maintain a collective vision was the basis of DID's early strength. Loss of this consensus later contributed to a temporary loss of cohesion and solidarity.

Respect, Trust and Commitment

Attitudes of respect, trust and commitment are difficult to capture in words and are even more elusive in practice. Yet they are keys to genuine partnering. Without them a relationship is cold, fragile and ill-equipped to withstand the inevitable stresses of partnering in an uncertain world. Legal contractual obligations cannot compensate for a lack of mutual respect.

It is easy to pay lip service to the importance of these attitudes. It is tempting to assume that verbal acknowledgement is all that is required and that these attitudes and behaviours will follow automatically. While these elements are vital keys to even the rudiments of partnering, they do not happen naturally and cannot be taken for granted. They require careful thought and conscious preparation, and encouragement of these attitudes is one of the responsibilities of leadership.

Understanding and respect

Respect implies that we recognize something of value in another. Partnering requires mutual respect whereby each partner acknowledges something of worth in the other. Respect is usually attributed in a restricted rather than a general sense. We may respect personal charm, professional competence, business acumen or a record of achievement without approving every aspect of an individual or institution.

True respect must be based on true understanding. Respect founded on false or incomplete knowledge is weak and likely to disintegrate as time unveils unsuspected truths. Consequently, to be willing to respect another requires the readiness to make a deliberate effort to understand the other and to be open to recognize qualities of worth. Unfortunately, understanding is always incomplete – we "see through a glass darkly." It takes time to understand, and the process of understanding is inevitably gradual and provisional.

The meaning of respect is not always clear. One can respect the right of another to hold a belief or follow a practice without respecting either the belief or practice. The simpler form of respect is to acknowledge and

value the rights of another human person. A more demanding form of respect is to value the person.

For initial respect to grow and mature, it must be confirmed by subsequent experience. Consequently, the maintenance of respect requires that initial impressions should be continuously reinforced by our growing understanding of each other. In this sense, respect is contingent on ongoing mutual revelation.

When there has been a failure to achieve mutual respect there has been no partnering. Such failures have not been isolated events. One might have assumed that the circumstances of developing would have cast a warm glow of benevolence and good intentions. However, it should be appreciated that the very nature of developing is poorly defined and that the skills and qualities which it demands are often unclear. It requires people from a diversity of backgrounds, disciplines and cultures to understand each other, communicate and work together. There is no professional qualification which automatically attracts respect; differences in the understanding of the nature of developing are wide and deeply held; and cultural differences can create misunderstanding. It should not be surprising that respect between community development practitioners is not invariable and cannot be taken for granted. It is unhelpful to attribute blame where this situation has occurred or even to distinguish between lack of respect based on real or only perceived inadequacies. Breakdowns in understanding simply serve to stress the importance of consciously fostering attitudes of respect rather than taking them for granted. This requires care and good fortune in the recruitment of participants in order to try to ensure that there is a basis for mutual respect.

Trust

Respect is the foundation on which trust can be constructed. However, trust does not follow automatically on respect. One can disinterestedly admire the competence of an organization without giving it one's confidence. Trust has to be earned by reputation or experience and validated by consistent performance. Trust takes time to win but can be lost in an instant.

Whereas respect is a passive attitude, trust requires an active, outgoing response. It implies the confidence to accept dependence on another. It is an act of faith that makes us vulnerable to disappointment. At the same time, trust creates the only basis of strength through confidence in others. Trust is the cement that binds a team together, and loss of trust results in the dissolution of these bonds.

It is difficult to devise a recipe for the achievement and sustenance of trust. It requires consistent commitment to the three elements of a shared vision and mutual respect based on genuine understanding.

Commitment

In this context, commitment refers to the giving of something that we value to our partner as a consequence of our trust. This may be time, money, resources or moral support. Whereas respect is a passive attitude and trust represents a form of potential energy, commitment is an unequivocally active process. Commitment of ourselves is a demonstration of trust. Trust expressed only in words or principle and not in action is shallow. It recalls the biblical aphorism that "faith without works is dead."

On reflection, I believe the progression of understanding, respect, trust and commitment has been the crucial "rate-limiting" factor in determining our partnering's effectiveness. The "respect factor" requires the greatest care – both to coax it to life and to ensure its survival. Where mutual respect has been achieved, trust and commitment have usually followed. Conversely, where respect has been lacking, there could be no partnering.

I am conscious that the idea of a linear progression from understanding through respect and trust to commitment is an abstraction and does not always reflect reality. On occasion, I have made an initial jump of faith and trust which was later justified by events; I have made instinctive judgements as a basis for respect which were later validated by true understanding. While recognizing understanding as a sound foundation for constructing a partnering relationship, I have to admit that the sequence was rarely as logical. This observation has practical implications. It emphasizes the need for time to gain understanding and the reality that our intuitive judgements are fallible and often provisional.

Institutions as Friends

Mutual respect, trust and commitment create a powerful triple bond. "Friendship" may be a synonym for a respectful, trusting and committed relationship. It may not be too fanciful to begin to think of "institutional friends" as more expressive than "institutional partners."

The significance of friendship may have been devalued in recent years. In the sixteenth century, Henry VIII , while still married to Catherine of Aragon, wrote to Anne Boleyn asking her to become his mistress and "friend." The notion of friend was clearly more meaningful than in current usage. In the following century, George Fox established the Religious

Society of Friends, implying the closest bonds of mutual support in the idea of "friend."

As bonds of friendship strengthen and become more intuitive and unquestioned, they approximate closely to the notion of love. This is treacherous and uncomfortable territory. "Love" has so many divergent meanings and associations that the word may have been discredited and lost its value as a means of communication in modern society. This would be unfortunate since love is a powerful and valuable human emotion. Discomfort with the language need not detract from the values it conveys. Provided one discounts sentimental charity, or pity, and recognizes *caritas*, or caring, as the deepest form of human bond, then it becomes possible to use the word with comfort and conviction.

It is not unrealistic to propose that just as individuals can achieve a loving or caring relationship so may institutions. Even if this goal is not attainable, it is still a desirable end to pursue.

It is difficult to analyze the relationships between Asians, Latin Americans and Canadians, as well as those within the Calgary campus community in these terms. Yet there should be no hesitation or embarrassment, as such relationships go to the heart of the experience of partnering. For many of those who travelled between Asia, Latin America and Calgary and shared a common vision, the relationship certainly exceeded the level of contractual obligation and became a friendship. The willingness of some to sacrifice for friends, whether Asian, Latin-American or Canadian, revealed the characteristics of love.

Compatible Styles

The use of the expression "style" needs clarification. It includes those habits which are determined by the culture in which we develop. The importance of understanding cultural differences is well recognized, at least in theory, even if it is often forgotten or ignored in practice. It is impossible to overestimate the need for would-be partners to try to understand and respect each other's culturally determined attitudes and practices. However, even the most exquisite cultural sensibility is no compensation for a general insensitivity towards people at large. Conversely, a pervasive innate kindness and generosity in the way we deal with all people can compensate for cultural ignorance or ineptitude.

In addition to these cultural attributes, partners have their own idiosyncratic "style" of working. Within conventional organizational structures, management style is influenced by both the personal characteristics of the leaders and the form of the organization. Organizations may have

a distinctive national identity, particularly in terms of the strength of hierarchy and gender balance.

In our experience, differences in management style between countries were not a significant obstacle to partnering. The problem of style was more intense within each organization rather than between organizations, reinforcing the observation that it is easier to partner overseas than at home. The difficulty of partnering is inversely proportional to the distance which separates partners.

Styles of management are important within any organization. The issue is heightened in any organization that focuses on the practices of partnering and participating. In such a circumstance it is appropriate that each organization should examine its own structure in order to determine if it is practising what it preaches.

Time, Energy and Focus

The form of partnering that I advocate takes time to germinate and grow. The analogy with personal relationships is again compelling. Most valued friendships are not instantaneous but evolve gradually.

Mutual understanding is required for mutual respect and it takes time to come to "know" one's partner. During the initial sharing of ideas which led to the formation of a new commitment to partner, we did not attempt to "investigate" our future partners systematically. The level of appreciation which this kind of calculated scrutiny can reveal is superficial. It is only with the passage of time that we begin to recognize the true character of our colleagues and our partner institutions. It takes time to know what is worth learning and to gain the confidence to ask. Sharing experience and the spontaneous actions we observe, not the words we hear, reveal true character. It is only in the last few years that I began to understand and appreciate the quality of the people and institutions with which I partnered for many years.

It takes time to understand the situation in which we work together. It is tempting to bring to a foreign situation our own preconceptions. Experience over time shows us the shallowness of our appreciation of the complexity of the situation and enables us to begin to understand. It follows that one should be suspicious of interpretations or solutions that are the product of short visits. The time factor is inescapable.

While it takes considerable effort to create this kind of relationship, it takes even greater effort to sustain. Several Calgary colleagues have had the opportunity to plan new programmes. All would agree that the en-

ergy required to bring an idea to fruition is considerable; but the efforts required to nourish a relationship are infinitely greater. They require resources of strength which were never anticipated.

One individual or organization will rarely be able to sustain more than a few of these relationships. We can participate in many networks and enter into several linkages but can maintain very few partners. It is tempting to suspect that there is a form of institutional promiscuity when organizations flirt with multiple partners to their mutual dissatisfaction.

III.

The Practice of Health Development and Institutional Partnering

9

The Practice of Health Development

Overview

Reflection on the Kathmandu connection has stirred disquieting questions about the effectiveness of conventional health-care delivery systems in the countries of the South. What do doctors, and other health professionals, contribute to the well-being of their nations? What role does education play in producing professionals who will make a positive contribution to the health of their people? Could people participate more effectively in their own health care? Could professionals and people learn to partner more effectively? These concerns have been heightened by subsequent experiences in Mindanao and other countries of Asia and Latin America. The same questions apply with equal force to the more affluent societies of Europe and North America.

There are two complementary approaches to the promotion of health development. One is profession-centred. It rests on the assumption that professionals can "deliver" health care to society and that they should direct the process. Doctors have traditionally assumed leadership among the health professions. Since medical education influences the professional attitudes and behaviours of doctors, it follows that the form of

professional training plays a major role in determining the pattern of health-care delivery.

The second approach to health care is people- or community-centred. It assumes that people have the right, responsibility and capability to contribute to their own healing. They can participate at all levels – in determining their priorities, enquiring into their own situation, planning their own solutions and using for this purpose resources which they assemble. Furthermore, it is unhelpful to distinguish a category of authentic "health" actions which can be teased apart from other elements of developing. The twin ideas that people can participate actively in all aspects of their own healing and that the processes of healing and developing are indissoluble have suggested the expression "participatory health development."

Each of these two "centred" approaches incurs its own problems. However, arguably the greatest challenge is to bring these two centres into a synergistic relationship. I will, therefore, discuss three facets of the practice of health development in sequence in this chapter – the training of health professionals, as it influences the delivery of health care; the facilitation of participatory health development; and the integration of professional- and people-centred approaches to healing.

Some issues stand out in sharper profile in the countries of the South. Realities are more starkly outlined. Problems are greater; options are fewer; the consequences of failure follow inexorably; and outcomes are expressed unambiguously in terms of life and death. The same issues may exist in the North but remain concealed. The expenditure of vast sums of money can purchase extensive clinical services and high technology which may compensate for misdirected efforts. Issues which are crystal clear in Asia, Latin America and Africa have been diffused by extravagant expenditures in the North. However, problems that once seemed confined to southern continents have come to haunt the North.

After reviewing the practice of health development in the continents of the South, I will comment briefly on the applicability of the same principles to the North.

Practising Health Development in the South

Training Health Professionals

From the perspective of the liberal WHO definition of health (that is, health as a state of physical, mental and social well being and not merely the absence of disease or infirmity), health professionals include all those

who contribute to the physical and mental as well as the social, economic and political well-being of society. They include educators, agriculturists, engineers, economists and politicians as well as those who specifically manage disease. A common feature of all these professionals is that they study others in order to plan and deliver products and services for their benefit.

Although the physician is only one member of this professional species, the following paragraphs focus exclusively on the training of doctors. They could as well have targeted the training of nurses or any other health professional, and specific reference to medical education could be generalized to other forms of professional training. This restriction is inevitable since my experience in Nepal throughout the 1980s was limited to medical education.

The following propositions are the product of reflecting on experiences in Nepal and have subsequently been reinforced by observations in other countries. They do not result from an examination of the inner workings of medical education – competing pedagogic models, alternative curricula, evaluation methods, or the cascade of undergraduate, postgraduate and continuing phases of education. Instead, I take up a position outside the enterprise of medical education and regard the entire exercise as a single project to be managed effectively and directed towards an overarching purpose. From this perspective, the MBBS programme and the several postgraduate programmes of the IOM can be regarded as a single educational undertaking to be set against the health needs of the people of Nepal.

The following seven propositions reflect concerns about the overall orientation of medical education as it influences health care.

1. Medical education is primarily a means to a social end.

The end, or goal, of all health development is the improvement of the quality of life of the people it serves. The delivery of health services to people is only one means to this end. The production of health professionals, including doctors, should simply be a means to facilitate the delivery of health services. Medical education can exert a positive impact on the health of people, but it loses its value if it is disconnected from this societal end and becomes an end in itself.

Academics are tempted to regard medical education as a world within itself, with its own internal values, traditions and purposes. This perception incurs the risk of disconnecting education from the society it should serve. It neglects the wider vision and focuses introspectively on its immediate pedagogic purposes. The production of doctors becomes

the goal of medical education and ceases to be merely an intermediate step towards a social end.

When means are allowed to become ends, they subvert their original purpose. The ambitions of the profession and its members distract attention and resources away from public towards private ends. When this occurs, the effect is not merely to fail to reach the intended end but to put it even further out of reach. Misdirected professional education is not merely irrelevant but is a disservice to the people it purports to serve.

Two general observations suggest that these fears are more than idle speculation. First, when the interests of the career aspirations of individuals clash with the priorities of society, the former take precedence – without demur from the profession. Second, when academics are challenged to measure the effectiveness of medical education, their natural inclination is to compare various pedagogic methods using the efficiency of the production of doctors as the end point. The yardstick of success is the professional competence or performance of doctors. There has been less enthusiasm for attempting to evaluate the entire enterprise of medical education in terms of its impact on the health of the people.

Our experience in Nepal gives weight to this sweeping generalization. The attempt to train generalists became disengaged from its original intention – to contribute to the quality of life of rural people – and imploded into an introspective concern for the status of generalists. The decision to modify admission criteria in order to admit college students to the MBBS programme also betrays a preoccupation with the advancement of individuals rather than the priorities of health care.

Recent observations in the Philippines reinforce this concern. Over the last twenty years, the number of medical schools has increased from seven to twenty-seven and the annual output of doctors from 800 to 3,000. Despite this virtual fourfold expansion of medical education, precisely the same proportion, 60 percent, of Filipinos die without having seen a doctor and 28 percent (120 out of 429) municipalities in Mindanao have not had the services of a doctor within the last ten years. It is hard to escape the conclusion that medical education in the Philippines has become disconnected from the needs of the Filipino people. This criticism is not restricted to medical education. Nursing education in the Philippines has been part of a growth industry for the export of nurses to the rest of the world, especially North America and the Middle East.

Professional training that loses its social vision perpetuates a system which siphons scarce personnel and finite resources away from the people in order to satisfy its own professional appetite. Health budgets

are prioritized to provide medical technology in capital cities; teaching hospitals consume a disproportionate share of scarce funds; and doctors, in order to protect their lifestyle, are reluctant to serve in rural districts. The outcome is the diversion of resources away from the areas of greatest need.

It is irresponsible to dismiss these observations as the inescapable consequence of an inviolable law of human nature. It is also naive to expect market forces to protect the consumer of health services against professional self-interest. Unwillingness to highlight the social unresponsiveness of the medical profession in both South and North simply legitimizes an inequitable distribution of scarce resources and condemns the people to continue to be denied access to health care.

2. Medical curricula should be planned "from right to left."

This proposition is a corollary of the previous statement. One pictures a page carrying the legend:

Curriculum content ⇒ clinical competency ⇒ health improvement.
(learning objectives) (purpose) (goal)

In the English language, these words read from left to right. Content comes first and the goal follows last.

The planning of medical curricula commonly follows this same sequence. The content of the curriculum has its own internal logic based on the assumptions and traditions of academic disciplines. Curricular content is often determined in an orderly progression from left to right – that is, from the preclinical disciplines in order of increasing complexity through to the clinical specialities. Rather than being the source of curricular content, the goal of medical education becomes its byproduct. The curricula of established medical schools have been weathered by the impact of progress in scientific knowledge and shifts in public opinion, but their essential structure stubbornly resists change. When medical curricula are reviewed and revised, changes are commonly limited to conformity with current pedagogic fashions or to cosmetic shifts in emphasis. Vested interests and reluctance to dismantle existing structures are formidable blocks to radical innovation in the training of doctors.

The national priority in most countries in the South is to provide health care to villagers and the urban poor. Yet, medical education remains cloistered within hospitals and its values are patently those of western specialist medicine. Curricula have been allowed to conform to the

assumptions of clinical disciplines and have ignored the plight of the mass of people.

Nepal offered an unusual opportunity. There was no existing tradition within the country to be dismantled and no body of faculty to feel threatened. Consequently, it was possible to plan a curriculum from right to left. Content was determined by its relevance to national needs and not by the preconceptions of academic teachers.

In retrospect, one shortcoming was that we conceived the MBBS curriculum only in terms of those clinical disciplines which would be required to manage disease. We might have taken a broader view of health as an element of quality of life. This would have encouraged a concern to situate the health profession within a much wider community and have emphasized the need for integration of services. We may have been blinkered by the disease management model of health, and unwittingly have contributed to the continuing segregation of doctors as a distinct species detached from other parts of the health team.

3. International recognition of qualifications is a low priority.

Planning curricula from right to left puts the emphasis squarely on the right side of the equation – that is, on the health needs of the nation it is designed to serve. It makes a curriculum the servant of the national society rather than a contrived model borrowed from other countries. It puts national health priorities before conformity to an international standard.

The gap between the role of doctors in many countries of the South and those in the North is wider than has been recognized. If one considers the spectrum of illness and disease, the conditions in which doctors work and the resources available for health care, then the challenges facing medical educators in the South and North are seen to be vastly different. A curriculum based on unique national conditions bears little resemblance to one based on a standard European or North American model. To plan a bland intermediate model which can accommodate both is doomed to disaster – at least, in terms of its value to national societies.

The price to be paid for placing national needs before international criteria for recognition may be reluctance of other countries to recognize medical credentials. This can create difficulties for doctors who wish to travel abroad for further training or to find employment beyond their national boundaries. In this circumstance, there is a conflict between the career aspirations of individuals and the needs of society. Given the proposition that medical education is not an end in itself and is only the servant of health care, then the needs of society take precedence.

Despite the political climate in North America and Europe, the time may be ripe for abandoning the free market in medical education. With a surplus of doctors in almost every country, health administrators in the North are less dependent on junior foreign doctors to maintain unattractive sectors of their national health services. They may have less inclination to attract a cadre of temporary young doctors from overseas for whom they feel no long-term responsibility. At the same time, there is a commendable heightening of national pride throughout the South and a concern to break overseas dependence. These twin trends may create an environment in which professional training can be solidly grounded in societal needs rather than designed with a sidelong glance to the international market.

4. Indigenous programmes are preferable to foreign imports.

The consequences of borrowing pedagogy from the North are all too familiar, especially in the old colonies of Europe and the United States. Medical education in India, Indonesia, the Philippines and Indochina is unmistakably British, Dutch, American and French. The values, organization and priorities of the old imperial cultures have survived independence almost unscathed. Graduates from medical schools in Delhi and Manila fit comfortably into medical practice in London and New York – perhaps more comfortably than into their own rural areas.

Old imperial capitals are reluctant to relinquish their grip on the education of erstwhile colonies – a reluctance sometimes cloaked in the guise of a concern not to abandon old colleagues. At the same time, those professionals who were trained abroad in the "old country" often retain a nostalgic fondness for their alma mater. The outcome is a survival of educational dependency in the countries of the South, even after colonial ties have long been severed. If professional training in the South is to achieve a semblance of relevance to the needs of people, educational leaders in the South must find the confidence to reject the comfort of importing familiar foreign pedagogy and devise their own solutions to their national needs.

The influence of foreign advisors is often pernicious. Short-term consultants and peripatetic experts find it difficult to leave their customary attitudes and behaviours at home and situate themselves in a different culture. In some circumstances, the offer of advice and assistance is well motivated and is born of a sincere intention to share knowledge and "transfer technology." However, it is hard to suppress the impression that some overseas institutional "aid" is founded on less worthy motives – the romance of foreign travel, the attraction of building up a circle of

dependent clients in foreign parts, the expectation that educational links may lead to trading links, or the short-term attraction of profiting from selling education services overseas.

5. Overseas training is hazardous.

Where possible, basic medical education should be provided within each country. Where this is impracticable, it can certainly be found within the region. The practice of training doctors from the South in the medical schools of the North has little to commend it – at least, in terms of its benefit to the country of origin of trainees. The risks of postgraduate training overseas are well known but conveniently forgotten.

The litany of past misfortunes is familiar. Medical education in the North ignores the common illnesses which ravage the South. It encourages dependence on expensive technology and discredits simple methods and remedies which are appropriate to the South. Overseas training provides an internationally marketable qualification which encourages graduates not to return home. This incurs a net loss of doctors from the South to the North. Perhaps more sinisterly, those who do return with higher degrees cluster around capital cities where there are opportunities to practice western medicine. They are likely to become the future national leaders of their profession and their fondness for the technology which they learned overseas can distort health priorities.

Our experience of training anaesthesiologists and obstetricians in Nepal demonstrates that it is entirely possible to promote national training programmes, even in apparently unfavourable circumstances. Our negative experience with generalist training in Canada reinforces my prejudice. There is still a place for obtaining appropriate training overseas but it should be planned with greater sensitivity and respect for national needs.

6. Educational programmes should match national manpower needs.

As a corollary to accepting subservience to social needs, the plans of medical educators should be consonant with the expectations of those who will employ their graduates. It is counter-productive to train graduates who cannot be employed. Our experience in training generalists in Nepal illustrates this predicament.

Conversely, it is irresponsible for medical schools to fail to respond to national needs. When a health service requires doctors to work in rural areas, it is reprehensible to entice young graduates into specialities that will guarantee their congregating in large cities.

7. Only radical innovation in medical education deserves attention.

Those who observe the processes of developing in the continents of the South are almost unanimous in regarding the presence of doctors as an expensive luxury. Physicians are often considered to distract attention from the health needs of the people at large and carry the responsibility for distorting the use of the limited resources available for health care. There is little enthusiasm for providing support for medical education among those who undertake to promote health. The practice of medicine must change dramatically and radically if doctors are to be seen as relevant to the healing of people.

Unfortunately, medical educators appear to be blind to this widespread perception. Although there are remarkable innovative experiments in the training of health professionals in the South, they are fragile buds, easily blighted. Memories of the original idealism of the pioneers in both Davao and Kathmandu linger in the memory. A recent initiative from the department of health in Manila to enable residents of rural barangays to progress from health volunteer through bachelor training to become a physician is one example of radical innovation which deserves attention and respect.

The health of people in the South is in a state of crisis, and health professionals have not been focused on the situation. The education system which produces those professionals cannot escape a share of the responsibility for this neglect. The sources of social malaise run deeply and such problems demand radical solutions from medical educators. Recapitulation of old themes or minor revisions do not deserve respect.

Facilitating Participatory Health Development

The idea of popular participation is in high fashion. It is politically correct to pepper political statements with ample references to building public consensus. Political leaders engage increasingly in town-hall meetings and regional consultations. To proclaim the value of participatory democracy is simply to flow with the tide of conventional wisdom – a circumstance which stirs a sense of unease.

The skill of political leaders in manipulating the democratic process to serve their own ends and the apparent reluctance of people at large to participate actively in their own affairs are equally disconcerting. They raise doubts about the feasibility of genuine popular participation in a cooperative approach to health care. However, I have been witness to

people-centred processes in countries of the South which sustain optimism in the potential power of people and suggest some principles of participatory action.

1. The voices of all the people must be heard.

The idea of "community" lies at the heart of the democratic process. Uncritical assumption that the European or North American system of popular enfranchisement ensures effective community representation carries little conviction. Electoral practices do not guarantee a true reflection of the voice of the people. While conventional democratic processes will continue until some better model emerges, there is a pressing need to establish a more indigenous grassroots power base.

Perhaps the greatest challenge facing those health administrators and managers who sincerely wish to facilitate popular participation and to share power is to listen to and understand the communities they serve. It is insufficient to rely solely on the input of elected or appointed representatives. They are likely to reflect biases based on race, gender, age, wealth and social status and cannot be trusted to reflect the voice of the people at large. The starting point for engagement in authentic participating is recognition of the need to listen to the voices of all the people and acceptance of the price to be paid in terms of time and energy.

Memories of Surkhet have left an indelible imprint of a process of empowering villagers to participate actively in their own developing and healing. Although elected officials were acknowledged and respected, the process of engagement penetrated much more deeply into the homes of small village communities. Attention was paid to ensure that the voice of the disempowered was not muffled – women, low castes and the poorest were all heard and respected. A community organization gradually emerged from this process of listening which almost literally took its origin from the grassroots. There was a price to be paid for this strategy in terms of committing time and energy and relinquishing unilateral authority. The process of community organization in Mindanao reflected a similar concern to try to empower communities to engage in their own developing. Some will question the effectiveness of either of these essays at popular empowerment, but I take their basic assumptions to be self-evident.

2. Communities should participate from the onset.

In Surkhet, villagers engaged in the planning process from its inception. They determined their own priorities and conducted their own enquiry into their situation. They laid their own plans, assembled their own resources and implemented their own programmes. In reality, their

participation was continuous and dominant. At the same time, the Nepal HDP offered its own input in terms of support and resources. The fact that communities participated from the beginning of activities helped to create a sense of ownership and commitment. Although the Davao HDP was organized differently, it placed equal weight on the initiative of local people.

When communities are brought into a programme only after plans have been set by others, their participation is unlikely to amount to more than compliance. Passive conformity with the plans of others is no substitute for authentic active participation.

3. **Communities should share control and authority.**

Bottom-up participation is incompatible with top-down control. It is necessary to construct a form of participatory management which does not hesitate to share power. This was achieved to some extent within the rural communities in Surkhet and Mindanao. It was less characteristic of the parent institutions in either Kathmandu or Davao; nor did we achieve it in Calgary. Those of us who occupied managerial positions may have been handicapped by our professional stereotypes and had neither the breadth of vision nor skill to find a management style which mirrored our ideas of developing. Some of the difficulties we encountered stemmed from this weakness.

4. **"Facipulation" is to be avoided.**

The role of those who are external to the communities they purport to serve demands constant scrutiny. Given the bias of human nature, the bounds of honesty are strained to avoid manipulating communities in the name of facilitation. It may be sufficient to ensure that the private agendas of facilitators are not in conflict with those of communities. The skill of diplomacy has little value if it represents a facility to convince others to do what is not in their own interest.

Integrating Professional-centred and People-centred Health Care

The proposal to integrate health professionals and laity implies that there already exists a state of disintegration among the healing forces within society. I have depicted an image of two distinct centred approaches to the healing of communities. I see these as existing in isolation or even as opposing forces drawn up in confrontation. This division within health care reflects a deep schism throughout society between proponents of tran-

sitive and intransitive developing. If these two systems of healing are to unite forces, it will be necessary to bridge the gap that separates them.

One can study the gap – the ground which divides the professionals from the laity. It is characterized by mutual misunderstanding, disrespect and mistrust. The roots of this divisiveness can be traced to two factors: professionalization, or acculturation of apprentice health professionals to a "foreign" technical culture; and the conflicts of interest which emerge between providers and consumers in the health-care market.

Given that each centred approach is potentially complementary and has intrinsic value, the challenge is to bring them into a cooperative relationship. The expression "integration" conjures up thoughts of achieving integrity or wholeness – or images of reconciliation, collaboration and conviviality. Integration does not imply unification, assimilation, cooption or conquest. Professionals and laity can retain their individual identity and bring their special contributions to a common purpose.

The goal is to build partnering between professionals and the public. The relationship should exceed remote networking between anonymous representatives of each constituency. It should eclipse a calculated contractual obligation to deliver circumscribed services, and can transcend unidirectional partnering grounded in benevolent paternalism. The goal is to reach the level of reciprocal partnering where professionals and laity recognize the mutual benefits of working in harmony.

I wish to recover the idea of partnering for a commitment to a relationship which aims to create a common vision, avoids conflicts of private interests, fosters trust built on mutual understanding and respect, finds an appropriate system of sharing power, and is prepared to invest the necessary time and energy to achieve this purpose.

If the connectedness between professionals and people is to reach the level of reciprocal partnering, both partners will be required to subscribe to the following propositions:

1. The benefits of partnering outweigh the costs.

For most people in the South, the exercise of weighing the benefits and costs of partnering with health professionals would have a hollow ring. Most of them have no alternative but to provide for their own healing without external assistance. Their governments do not have the resources to "deliver" or "provide" health care. For the majority of people living in Asia and Africa, and parts of Latin America, professional health care is remote and barely touches their lives. They came into the world with no more assistance than that of a relative or lay birth attendant. They

rely for their healing on local wisdom and consult traditional healers. External health services may come no closer than a health post – and this may be little more than a nominal presence which offers little practical help. Hospitals may lie many hours away and are likely to be understaffed and ill-equipped. Villagers may find themselves distanced from health professionals by a wide cultural gap – at least as wide as that which divides multicultural societies in the North. They have not had the option to enter into a partnering relationship with the professional health-care system. If the opportunity does arise in the future, then their long experience of isolation, and even alienation, will have to be overcome before a trusting relationship can begin to be built.

On the other hand, reciprocal partnering, as I have described it, makes little sense to most health professionals. The language and ideas are unfamiliar and unappealing. The prospect of relinquishing responsibility and authority for activities for which they have been specially trained goes against the grain of their professional culture. They look around in vain for successful role models of partnering. Without some reasonable prospect of substantial benefits to be gained from discarding comfortable habits, the ideas of reciprocal partnering between professionals and people for the promotion of healing will remain a fantasy. It is necessary to demonstrate some substantial benefits which might accrue from leaving the security of familiar ground and venturing into strange and forbidding territory.

In terms of short-term benefits, benevolent paternalism has many attractions. It avoids the time required for consultation, the irritation of contradiction and the inconvenience of building consensus. Yet, paternalism, however enlightened and well-intentioned, is unlikely to be sustainable in the long term. By contrast, reciprocal partnering with communities offers the following long-term advantages to professionals:

i. Professionals can gain the satisfaction of knowing that they are responding to the moral imperative to act for the common good – in this case, the well-being of their people.

ii. Partnering with the people offers an escape route from the *cul de sac* into which health services have strayed. If the perception that doctors have become trapped in their professional "centre" and disconnected from the health needs of society is justified, then there may be no alternative for health professionals but to find an alternative role.

iii. Governments throughout the South do not have the resources required to deliver health care to their population through health professionals. It is little more than absurd when Nepal is obliged to provide

health care to a sick population at an annual cost of seventy cents per person. Although conditions in the Philippines are less harsh, the department of health spends only four dollars per person each year and cannot deliver health care to all its people. In these circumstances, governments are obliged to turn away from professional systems and foster people-centred healing. Professionals would be wise to leave the security of their "centre" and join forces with the people.

iv. Health professionals have acquired a tarnished reputation among the public. Whatever the source of this loss of credibility, the professions can no longer rely on the support of public opinion. Enlightened self-interest should encourage professionals to reconstruct their relationship with the laity.

Until both professionals and the laity appreciate the potential benefits to be gained from partnering together, no progress will be made. Furthermore, the construction of a new charter between a professional elite and the mass of the people will not come cheaply to either partner.

2. A common vision of health is a prerequisite for partnering.

If professionals and the laity are to partner effectively and work for a common purpose, they should share a single vision. It takes time and effort to achieve this level of mutual understanding.

Health professionals will learn that people at large may not share their priorities or basic assumptions about the nature of the healing which they value. Practitioners of western medicine are trained to think mechanistically of the body as a machine or complex computer, and they interpret their role as mechanics or technicians who keep the machine working to its full capacity. They often work within a reductive frame of reference which regards the person as the sum of its constituent parts. They are most comfortable with processes which can be measured in quantitative terms and are suspicious of qualitative or subjective values. Ideas or practices which fall outside the boundaries of their philosophy disturb them. They are interested only in those diseases which fit within their categories.

By contrast, many people, especially in the countries of the South, have a very different understanding of their body and of the nature of illness. These ideas are rooted in folk culture and traditional belief systems. They recognize a different spectrum of illness, believe in a different system of aetiology and adopt practices which are meaningless to exponents of western medicine. Our experience in Surkhet demonstrated that village people placed conventional health care as a relatively low priority and judged that irrigation, transportation and education would

contribute more to their ideal of well-being. The starting point of partnering in Surkhet was respect for the people's understanding of "health" and readiness to work with them without insisting on overriding their priorities with our own preferences or superior knowledge.

Before reciprocal partnering can become an option, it will be necessary for proponents of both systems of healing to be open to understand each other, probe the limits of respect and build trust on a basis of working together. Only then can they begin to share a common vision of the form of healing which will become their common goal.

3. Conflicts of private interest are a deterrent to partnering.

Each partner has a legitimate private agenda as well as a commitment to the common good. Individuals pursue career interests, and institutions hope to enhance their status and resources. These special interests need not jeopardize the common good, provided that care is taken to minimize the risk of conflicts of interest.

4. Mutual understanding, respect and trust must be fostered.

Lack of trust between professionals and people is the ground which divides them. Popular distrust is bred from years of the professional exercise of unilateral authority, withholding of information and thoughtless pursuit of self-interest. At the same time, professionals have been discouraged by their perception of the apathy and ignorance of the masses.

Professionals need to discover respect for the innate wisdom and skill of people whom they may perceive as unschooled and, by definition, ignorant. Respect cannot come without an openness to understand others who are culturally different from ourselves. Differences based on professional acculturation are just as powerful as those based on ethnicity, race, language and religion. Enthusiasm for cultural diversity and willingness to build mutual trust based on understanding and respect may be the most critical prerequisites for reshaping the relationship between professionals and laity.

5. Power must be shared equitably.

Once attitudes of respect and trust based on mutual understanding have been generated, trust can be translated into a commitment to share power and control. Sharing does not imply dereliction of responsibility by either partner.

Willingness to share responsibility is a test of trust. In many societies accountability is carried by one individual or executive group – those "at the top," where the "buck stops." In an atmosphere of insecurity and assumption of pervasive corruption, it is difficult for those in au-

thority to share power since they cannot delegate a commensurate level of accountability. It is necessary to create an environment of confidence where both power and responsibility can be shared equitably.

6. The performance of work is required of both partners.

Unfortunately, there are no short cuts to reaching the level of reciprocal partnering. The potential energy of mutual trust has to be converted into actual work. The effort required to engage in reciprocal partnering can be measured in terms of the expenditure of energy over time. Given that human resources are finite, it follows that the allocation of personnel and money to promote partnering mirrors our actual priority of purposes.

Having weighed the potential benefits and costs of partnering and become open to understand the future partner, the remainder is a function of sheer effort. Work is required to learn how to communicate – how to listen and to talk; to learn a common language; to understand each other's perceptions and expectations; to share decision-making – to make compromises and reach a consensus; to build respect and trust – to allow time for failures and learning from sharing in finding solutions; and to share both authority and responsibility, based on experience.

Practising Health Development in the North

It may be thought that these observations on health development in the South show signs of naivety – in my cavalier rejection of current health-care systems and advocacy of radical change; in my expectation of rigorous standards of social responsibility and personal disinterestedness among health professionals; in my disrespect for the tenets of medical education and plea for a new pedagogy; in my disregard for academic traditions and scorn for conformity with international standards; in my enthusiasm for active public participation in all aspects of health care; and in my assumption that professionals should take time to listen to the laity and share power with them. Some may have concluded that this call to colleagues in the South to blaze a new trail in health development is unrealistic.

It is also difficult to defend against the charge of practising double standards. While preaching a gospel of radical change overseas, I have lived and worked in educational and health-care systems in Scotland and Canada which guard their academic traditions jealously. I belong to a profession which has shown little enthusiasm for partnering with other health professions – far less with the laity. I live in a society where individual rights are sacrosanct and the idea of collective responsibility is

out of fashion. The very idea of "posting" doctors to areas of high need would be dismissed as a "socialist" conspiracy. The admonition not to gloat over the speck in another's eye and neglect the beam in one's own strikes uncomfortably close to home.

I am acutely conscious of the risks of both naivety and hypocrisy in adopting a stance which challenges conventional wisdom and may cause offence. The source of my discomfiture lies in the experience of having confronted realities in the South. I am grateful for having had the opportunity to have worked, even briefly, in societies where the distractions of wealth and technology are absent and one can observe conventional health and educational systems in a clearer light. Familiar habits appear strangely out of place. Health care, as I have known it in the North, holds little promise for the mass of people in the South. On the contrary, it has the potential to worsen a situation which is already desperate. The only adequate explanation for the stubborn survival in the South of health-care practices borrowed from the North is that health professionals put their own interests before those of their people – and they are encouraged in this stance by colleagues in the North.

The ideas of health development, popular participation and reciprocal partnering make more sense. In circumstances where health is determined by access to potable water, an adequate diet, irrigation, access to land, literacy, security, and basic human rights, healing and developing are inextricably intertwined. Physical, mental, and perhaps spiritual healing are heavily influenced by the natural and social environments. When governments cannot "deliver" health care and people have no choice but to undertake their own healing, their participation is mandatory. In such circumstances, health professionals are obliged to enter into partnership with the people they serve.

These observations are the roots of my plea for radical solutions for healing in the South. I equate naivety with realism and struggle with double standards, not by tolerating expediency and a tired "realism" in my own society but by insisting that both South and North should search for a new ethic. The magnitude of the problem demands a proportionate response. Social reform is not the child of complacency. It is born of urgency to redress desperate need. Such is the situation in the South.

To add a separate section in this chapter on the practice of health development in the North might suggest that the North is so different from the South that it needs special consideration. It may indicate that the North faces different problems and has access to a different set of solutions. However, if my understanding of the predicament of people

in the South is valid, do the same observations apply to the countries of the North? Or, are there, indeed, First and Third worlds which are qualitatively distinct? Are there different laws which govern those two societies, or do they operate under the same rules? North Americans and Europeans may accept my characterization of participatory health development and reciprocal partnering when they refer to a distant South but reject them when they are applied to their own "developed" societies.

People of the North enjoy higher incomes and access to richer national resources. Expenditures on health, education and social services are significantly higher. They can purchase advanced technology which enhances agricultural and industrial production and drives further economic growth. Technology facilitates the dissemination of information. It transforms the delivery of health care and helps to reduce mortality and morbidity. Expensive technological manipulation of the natural environment provides comfortable housing, convenient transportation, reliable communications, safe sanitation and ample water and energy supplies. Similar spending can purchase security forces to control crime and corruption.

However, this same economic growth has other consequences. The distribution of wealth is uneven and inequity creates social unrest. The way by which technology has been introduced has created unemployment and underemployment. Practitioners of technological health care may have lost their sense of caring. The exponential expansion of information has not been matched by an increase in wisdom in using the facts which are already at our disposal. The "managed" natural environment in the North may be on the brink of ecological disaster. The North has been unable to buy social security or protection from crime and corruption.

Some of those who reflect on conditions in the North and compare them with the South see a glass half filled. They focus on higher incomes, greater spending on social services, advanced technology, and cleaner, safer cities. Others see a glass half empty. They are disturbed by the inequitable distribution of wealth, a steady decline in social spending and a technologically advanced society which cannot use its powers for the common good.

I regard the South and North as qualitatively similar and united in facing the same existential human predicament. We all search for values and meaning; we cannot escape from the cycle of interdependence; we all want to live in dignity and expect basic human rights, including the opportunity to work and support our families.

In effect, the South and North are part of one struggling world with more in common than in diversity. The South is not a distant planet to be visited and experienced by travellers from the North as a remote curiosity. An appropriate response to the South should include at least three elements.

First, we can see beyond the poverty and scarcity of material resources and recognize a richness in society which balances these negative images. In Nepal, one can distinguish three categories of visitors. Some look downwards to see the dirt and squalor around their feet; others look upwards towards the mountains to enjoy the romance of the Himalayan panorama; others look ahead into the eyes of the Nepalese people and appreciate the dignity and strength of a distinct society. It is this last perspective which permits the growth of understanding and respect.

Second, we need to reflect on our share of the responsibility for the hardship and poverty we encounter. It takes little insight to appreciate the interdependence of world society and to reflect on the negative impact of the North on the South – both historically and in our own times.

Third, we can look into the South as a mirror and see our own society reflected in a new light. The North may be facing similar problems, perhaps ameliorated by vast expenditures and the accumulation of massive debt. We can learn from the experience of our colleagues in the South who have learned to adapt to a harsh environment. The opportunity to see ourselves reflected in the South may help us to understand ourselves better. We may be able to predict the outcome of our actions or inaction. We may learn that ideas which have evolved from conditions of constraint and harsh necessity can have meaning for our own society. Innovations which we applaud in the South may come to our own aid.

If this image of the South as a mirror on the North has merit, then one may address to the North those same questions which I applied to the South. What do doctors, and other health professionals, in the North contribute to the well-being of their nations? What role does education play in producing professionals who will make a positive contribution to the health of their people? Could people participate more effectively in their own health care? Could professionals and people learn to partner more effectively?

One may question whether the propositions I advanced in earlier pages apply to the North. In brief, it is timely to enquire if medical education in the North functions as a means to a social end or is simply an end in itself; if our medical curricula have been planned "from right to left" with respect for national health-care priorities; if our educational

programmes match national manpower needs; and if we have introduced sufficiently radical innovations into medical education.

As we reflect on medical education in the South, we should consider the extent to which the North has fuelled the demand for international recognition of foreign qualifications; promoted the export of western curricula to the South; and encouraged inappropriate overseas training.

It is instructive to consider whether health professionals in the North could find value in the idea of participatory health development; whether those health planners who talk about responding to community needs have fully appreciated that the voices of all the people must be heard and that communities should participate from the onset; whether professionals have been willing to share control and authority with communities; and whether they are sensitive to the risks of "facipulation."

We might ponder the relevance to the North of the image of two alternative "centred" approaches to healing. If we recognize the same gap between these two centres, it becomes mandatory to begin to bridge the gap and consider the merits of reciprocal partnering. For any such analysis, it is necessary to weigh the potential benefits of partnering against the costs. Professionals and the laity have to discover a common vision; how to avoid conflicts of private interest; how to foster mutual understanding, respect and trust; and how to share power equitably. They must to be willing to undertake the necessary work.

10

Universities as Institutional Partners

All the events chronicled in earlier chapters were initiated from a home base on a Canadian campus. Many of our overseas partner institutions are also universities. These connections brought us into close contact with many colleagues on other campuses who share our interests in developing. This predominantly academic environment has inevitably coloured my understanding of the nature and potential of institutional cooperation. It has strengthened the conviction that universities and colleges can play a unique role in the promotion of developing.

In the following pages, I catalogue the potential strengths and weaknesses of campuses as agents for institutional cooperation; reflect on the special challenges of the partnering mode of cooperation; and comment on the demands that both reciprocal partnering and participatory developing make on a campus.

The observations that follow focus exclusively on universities as potential partners and ignore networking and linkageing. They are also heavily slanted towards the participatory mode of developing. In the interests of brevity, I use the term "university" to refer to both universities and colleges.

General Attributes of Universities as Potential Partners

Whatever their preferred category of relationship, universities and colleges have some intrinsic features which determine their potential effectiveness as cooperants or partners. They have significant strengths:

1. Universities have immediate access to a wide range of expertise in many disciplines among their faculty, administrators, librarians, secretaries, technical staff and the undergraduate and graduate student bodies. The cumulative expertise of a campus is formidable in terms of both quantity and diversity. The population of The University of Calgary campus exceeds 25,000, most of which is well-qualified and constitutes an invaluable resource of knowledge, skills and experience. In effect, the campus is equivalent to a small town in terms of its human resources.

Senior faculty, particularly those approaching retirement or emeritus professorships, represent a special resource. They are not driven by the need to conform to campus conventions in order to gain "merit"; they may enjoy relative financial security; and grey hairs often attract respect overseas.

Academics enjoy unusual freedom and flexibility in their use of time. They have access to sabbaticals, special leaves and generous vacations. Faculty find it easier than most to adapt their time commitments to their interests. Campuses also attract a core of enthusiasts and idealists who are passionately committed to their personal ideology and relish the opportunity to express their principles in social action.

This broad base of available, flexible and trained personnel is a university's single greatest asset.

2. Academics are committed to education and research. Many easily see career advantage in overseas experience in terms of enriching their teaching and research.

3. Universities normally have an efficient and stable administrative organization and reliable systems of financial control. They enjoy the many services of campus – libraries, student services, residential accommodation, communication systems and extensive support services.

4. Most universities accept some role in service to their community and are becoming increasingly aware of their place in the wider global society. They are familiar with the idea and practice of community outreach.

5. Public universities are non-profit organizations and should be able to commit themselves to developing on a genuine cost-recovery basis with-

out the expectation of profit. One can question the integrity of academic institutions that compete with the private sector for financial gain from overseas development contracts.

6. Most universities have many overseas contacts through their faculty and students. They enjoy a high degree of credibility overseas, and they are generally perceived as politically non-aligned and are well tolerated by most foreign governments.

7. Universities have considerable experience in fund-raising. They are socially acceptable recipients for gifts from individual donors and foundations. Many funding agencies have special arrangements for making money available to academic institutions. A campus is a convenient strategic base from which to launch an initiative that will have to attract special funding.

These positive attributes create a capacity for universities to function as effective agents on behalf of developing. It would be unwise to underestimate the potential energy of a college campus as a vehicle for some forms of developing.

However, campuses have other characteristics which tend to prevent them from reaching their full potential.

1. Some academic expertise is narrowly theoretical and faculty experts may have little practical experience. This criticism is levelled most commonly at professional faculties. Campus competence at a post-secondary level of education is also of limited value if the priorities for developing are primary and non-formal education and vocational training. This is not an issue in university-university collaboration but may impose severe limitations if a campus partners with an NGO or even directly with communities.

2. Some academics tend to affect an air of intellectual superiority and have a limited capacity for assisting the less educated to learn. Some have a blinkered perception of research and may indulge a highly protective view of themselves as the "researchers." These attitudes may be tolerated within the transitive form of developing through technical assistance, but it creates an inhospitable environment for the growth of participatory developing.

3. Although universities may express an unequivocal commitment to developing in principle, few have found a satisfactory method of recognizing and rewarding faculty who contribute to these programmes. This is a serious obstacle for younger faculty who are required to pursue promotion and merit on the basis of conventional academic criteria.

In the absence of positive recognition, the least acceptable standard should be that faculty are not penalized for work overseas.

4. The repetitive cycle of changes in administrative leadership and the vulnerability of universities to changes in government funding create an unstable environment for long-term programmes.

5. In today's wintry economic climate, universities and colleges in the North may be tempted to look towards cooperation with universities in the South primarily as a potential source of monetary gain through direct costs or overhead. It takes little imagination or diplomatic skill to cloak self-interest in the guise of benevolent internationalism. It should be cruelly clear that the pain of declining budgets which the North is now experiencing is trivial in comparison with the chronic penury which our colleagues in the South have suffered for decades. Our new familiarity with frugality should serve to strengthen our commitment to share finite resources more equitably. It would be a travesty of justice if centres of higher learning in the more advantaged North were to choose this time to tighten their purse strings and focus narrowly on protecting self-interests.

6. Perhaps the greatest obstacle confronting universities that intend to function as effective institutional partners is their lack of a corporate identity. Academics cherish a right to "academic freedom" and may resist the discipline of membership of a team. If carried to excess, this is a recipe for anarchy. There is no effective mechanism for translating an enlightened mission statement into a cohesive programme of action in the same way that a private company can set policies and insist that its employees either accept their place in the team or find alternative employment. Campuses can be comfortable havens for prima donnas.

It is sometimes difficult to generate and sustain a sense of corporate mission which rises above the level of expediency or banality. There are few large goals which nourish a common vision or purpose. It could be argued that the type of endeavour, which joint ventures such as the Nepal programme represent, can provide one such focal point for campus-wide collaboration. This programme certainly served this purpose for a significant group of faculty in both Kathmandu and Calgary.

7. Most university ventures in developing are based on volunteerism. Many participants in these programmes contribute their time and energy out of a sense of social obligation or good will. Others may be motivated by the lure of travel or to escape from the dull routine of campus duties. There is rarely any obligation on them to maintain their support. They may not be paid for their service to these programmes but their salary is usually continued without interruption. Consequently,

continuing faculty support depends heavily on maintaining their enthusiasm to give their time and energies freely. It is easy for faculty members to withdraw their support at any time without prejudice to their own career. This makes campus-based programmes for developing vulnerable to shifts in popular support. One of the tests of leadership is the ability to attract initial support for these initiatives and then succeed in maintaining the level of enthusiasm.

Some of these negative characteristics are structural and resistant to change. This analysis suggests that the major obstacles to effective partnering across a campus are attitudinal and similar in nature to those which influence relationships within families.

On balance, there are compelling reasons to believe that a campus has a great deal to offer for the promotion of some aspects of developing. However, there is a grave danger that campuses may flaunt their academic muscle uncritically in order to display their right, almost by divine prerogative, to qualify as purveyors of development assistance. This brief survey of the innate weaknesses of institutions strongly suggests that the effectiveness of universities for purposes of developing is strictly limited by their ability to correct these inherent defects. They require campuses ambitious to make a significant contribution to developing to work to eliminate inappropriate attitudes and behaviours on the part of individual faculty and the corporate body.

Universities and the Challenge of Reciprocal Partnering

Progression from unidirectional to reciprocal partnering requires a quantum leap in terms of understanding and attitudes. This form of relationship advances beyond benevolent paternalism and the assumption of a donor role. It implies becoming aware of the possibilities of working together in a common learning environment for collective advantage. It requires a high level of mutual respect based on a new understanding whereby the erstwhile "donor" organization recognizes something of value to itself in the "recipient" partner. This requires a recognition of our own deficits and our partner's strengths and an openness to become a recipient. It marks a shift from the status of imposed dependency to one of interdependence.

Benefits

The precise nature of the benefits we hope to gain have to be explained in concrete terms. When this idea of "partnering for mutual benefit"

was first discussed with colleagues in the South, they expressed polite but guarded interest. A common reaction was to question precisely what benefits we had in mind for The University of Calgary. My early inability to provide an unambiguous and satisfactory response made it clear that the idea of mutuality of benefit was still a remote ideal which was too lacking in substance to be taken seriously. The dream of reciprocity might be no more than a mirage. Before the goal of mutual benefit deserved serious attention, it became necessary to explain exactly what benefits we hoped to receive from our partners.

At the simplest level, our expectations of our partners can be expressed in tangible terms, such as those which are enumerated in the cost-benefit analysis of the Kathmandu connection. By these criteria, it can be demonstrated beyond reasonable doubt that both partners gained substantial benefits in quantifiable and even monetary terms. The Kathmandu connection led directly to a sequence of opportunities for The University of Calgary which have significantly enriched our campus. The privilege to be able to work with colleagues in Latin America, Bhutan and Mindanao all stemmed directly from relationships forged in Nepal. Our cooperation with Davao played a key role in the designation of The University of Calgary as a "centre of excellence." This Canadian "centre" derived much of its strength and credibility from its interdependence with colleagues in both Davao and Bangkok.

These experiences illustrate direct forms of reciprocal advantage to each partner institution. These are benefits which Calgary has derived from our Asian partnerships. Perhaps this form of direct material benefit to each institution is sufficient justification for joining the pursuit of this elusive goal. However, these benefits fall within the category of secondary objectives and should never be in competition nor distract attention from the "end" of the relationship.

Costs

Sharing of benefits comes at a price – the sharing of power and control. The form of open relationship required to facilitate a free two-way flow of learning is incompatible with a one-way exercise of control. Benefits and power both need to be shared.

The sharing of power is never equal. Certainly within the circumstances in which "aid" funds are provided to "donor" institutions for joint ventures with foreign partners, the assignment of accountability is not shared equally. In DID's experience, accountability for the use of funds and for the outcome of programmes was entirely the responsibil-

ity of the "donor" institution. This poses an intolerable strain on an institution that wishes to work towards an equitable if not an equal relationship. While an enlightened "donor" may wish to share or delegate control and authority it does not have the right to share accountability. It can divest itself of authority, but not responsibility. Within current structures, the goal of reciprocal partnering remains a distant ideal. It is, however, still a worthy end to pursue.

As partners better understand and trust each other, it becomes possible to share control with increasing confidence and comfort. The pursuit of equity, if not equality, is an essential element of reciprocal partnering. Respect for this goal is not only a problem for each partner but also for agencies that contribute resources to the enterprise.

Extending the Range of Reciprocal Partnering

This account of partnering has been restricted to the relationship that can exist between two institutions – a Canadian campus and a sister organization overseas. However, campuses can act as agents or intermediaries for the developing of their local communities. This allows the horizon of the scope of reciprocal partnering to expand widely.

Reciprocal partnering is feasible not only between two partner institutions but also between each institution and its own local community. This offers the prospect for creating an extensive and powerful series of linked partnering bonds which can bring together in friendship not only two institutions but also their respective communities. In this way, reciprocal partnering has the potential not only to unite institutions across the oceans in a common purpose but also to facilitate mutual understanding and trust between people across national boundaries. Institutional cooperation can be one vehicle for people at large to experience the reality of sharing. In this way, reciprocal partnering between institutions can be much more than an end in itself but also a means to a much more significant end.

In this spirit, DID embraced with enthusiasm the role of partner with both Tribhuvan University in Kathmandu and IPHC in Davao to facilitate the processes of community-centred developing in Surkhet and South East Mindanao. These ideas were the essence of both the Nepal and Davao HDP.

It is not difficult to visualize ways by which collaboration with sister institutions overseas can extend to offer practical benefits to their local communities. This expectation was explicitly built into our work in Nepal

and Mindanao as "quantifiable outputs." Much of this joint effort was directed towards improvements in the quality of life of communities. These benefits were intended to be measurable in terms of economic development, community organization or health status. The purpose of institutional partnering was to intervene within communities overseas for their benefit.

However, thoughtful reflection on the possibilities of campus-community interaction in Calgary and the notion of reciprocity of benefit raised the possibility that our learning overseas could be transmitted to our own community. In other words, the partner institutions in each country should act as vehicles for the sharing of experiences between people living within their respective communities. Institutions could function as more than passive conduits. They could energize the transfer of learning by interposing mechanisms of active transport which could facilitate the exchange of experience and knowledge.

The ideas which underlie this notion are, in many ways, foreign to conventional academic assumptions. Universities regard themselves as centres of higher learning – that is, a place where learning occurs and from where knowledge is disseminated to a less-learned community. This implies a gradient of knowledge from academe to community. It focuses attention on a campus's obligation to distribute its knowledge outwards to people at large. This is essentially a profession-centred perception of the role of a university. It tacitly accepts the transitive form of developing in terms of a campus's responsibility to its own community – that is, it offers its technical assistance in order to develop its community.

However, the role of teacher is also that of learner. It is expedient for academics to respect the wisdom of people. It is a mistake to equate schooling or formal education with the ownership of knowledge. There may not be a gradient of wisdom that parallels knowledge. We can value the form of knowledge that derives from life experience. This allows academics to welcome opportunities to celebrate with our communities in a common learning enterprise.

To welcome the notion of reciprocal learning implies that we recognize our own ignorance and appreciate the opportunity to learn from another, perhaps "disadvantaged," institution overseas or from our own local community. Even the willingness to think hypothetically in these terms is a sign of an open mind. To act on them with sincerity and enthusiasm requires a significant attitudinal change.

It took several years to comprehend this possibility in Kathmandu and Davao and even longer within our own community. This reinforces

the unfortunate reality that it has been easier to partner at a discreet distance than at home.

The translation of these abstract ideas into reality is challenging. It must be confessed that DID's experience of mutual learning is still fragmentary and stronger in concept than in practice. For its expression in terms of real living, it requires that a campus should engage in a reciprocal partnering relationship not only with a sister institution overseas but also with its own local or national community. Such a two-way relationship between a campus and its community is rare. Campus-community relationships are usually only a pale shadow of genuine partnering, at least in its reciprocal form. A campus looks towards its community for financial and political support; it tries to sense the community's perceived needs in order to make its programmes relevant and therefore marketable; and it aims to respond to these expectations by both formal courses and community outreach. However, the orientation of outreach is strictly unidirectional – outwards from the campus.

It would be unusual for a campus to admit its own inadequacies of learning and openly declare its interdependence for a better understanding of "less fortunate" colleagues overseas and, even more so, among its local community. It would be an even more unfamiliar role for a campus to act as a channel for the transfer of learning between peoples. It is not surprising that this form of reciprocal partnering between institutions and communities remains unexplored territory.

Extened Reciprocal Partnering in Practice

Despite the remoteness of the ideal, DID took some tentative steps to bring it closer. In general terms, it becomes necessary to ensure that all the links in the chain of partnering are in place and fully functional. Having established the structure it becomes possible to nudge it into action.

There are at least three links in the chain – the partnering relationship between the two institutions and those between each institution and its respective community. In the case of Davao, the partnering process between DID and IPHC was well-established and functional. Over the last fifteen years, IPHC has built a close relationship of trust with many communities throughout five provinces in southeast Mindanao. The weakest link in the chain was that between The University of Calgary campus and the people of southern Alberta.

With the ultimate goal of eventually creating a bridge between the people of Mindanao and Alberta, we tried to build into the Davao HDP an element of Canadian community participation. In order to bring such

a relationship to life it was essential to define a purpose around which it could grow. This was less difficult to conceive in terms of a flow of resources from Alberta towards Mindanao. We were able to achieve this to a limited extent in several ways. The Alberta Agency for International Development contributed to several community projects throughout southeast Mindanao, particularly for the provision of potable water to rural communities. A Calgary-based NGO, Childreach, supported attempts to train children in an urban slum area in Davao City. In proposing this latter initiative, I encouraged the Calgary group to recommend that Davaowenos should share their experience with Calgarians who face similar problems. This reverse flow of experience has yet to materialize.

We anticipated other ways by which Albertan communities might share in our partnering with communities in Mindanao. Our work included a focus on the stimulation of microbusiness. The Davao HDP had the capacity to provide credit for business initiatives to only a limited extent. Beyond that limit, local entrepreneurs in Mindanao had to find capital or business partners. It would have been entirely feasible to encourage linkageing between entrepreneurs in Mindanao and Alberta in order to create joint ventures. This strategy had the potential to foster meaningful cooperation between our two societies. The untimely termination of the Davao HDP at an early stage in its evolution brought these ideas to an abrupt halt.

The experience of the First Nations in Canada has many parallels with the predicament of the tribal people of the Philippines. They both continue to suffer oppression and exploitation and the dubious benefits of paternalistic "development." Tribal societies in each country share a common determination to reject external authority, to try to maintain their culture and to exercise control over their future. Since we worked within the context of participatory developing, there were grounds for mutual learning between the indigenous peoples of Mindanao and Alberta.

With this in mind, a community nurse, a member of the Siksika Nation, joined the Davao HDP team and visited the Philippines. She was able to meet with tribal groups in both northern Luzon and southern Mindanao. It became immediately apparent that her experience was greatly valued by colleagues in Davao and in the tribal areas. We were encouraged by the potential value of using the opportunities within the Davao HDP to foster partnering between these communities. This is clearly a slow process. It would be inappropriate to stage-manage an "arranged marriage," and it is preferable simply to provide opportunities for people to come together when and how they choose.

We later incorporated Alberta communities in other projects in south Asia and Latin America. The latter project is managed on behalf of DID by Lorne Jaques, a community development leader from a Calgary community centre. We took this initiative in the expectation that it would lead to a broader base of community participation. This process is slowly emerging insofar as community groups in Alberta are beginning to share in DID's work in South and Central America. Community representatives also began to play a substantial role in several of DID's project teams. Because of strong community links between Alberta and Central America, there is already an openness for Canadians to learn from the experience of participatory developing in the oppressed communities of that region.

The goal of widening the scope of reciprocal partnering beyond our academic institutions to include our communities in a direct sharing and caring between peoples still lies in an uncertain future. However, indications suggest that institutional partnering has the potential to fulfil an important role in catalyzing friendship between not only faculty but also our societies. This notion that universities might welcome a role as an intermediary between communities is still untested.

DID took substantial steps to invite community participation in its affairs. Members of provincial non-government organizations shared in DID retreats, in organizing joint activities and played a substantial role in DID's overseas work. This may be perceived by some faculty as weakening campus control or diluting academic content. It remains to be seen if such a degree of intimacy between campus and community is feasible.

Universities and the Challenge of Participatory Developing

Participatory developing reflects the intransitive or reflexive form of developing. It understands developing as an internal process for which individuals or their communities assume responsibility.

Universities are, by their very nature, attitudinally and organizationally more comfortable with a role in the transitive, technical assistance mode of developing. However, they also have the potential capacity to contribute to the processes of participatory developing. Universities engage in adult education. They are familiar, at least in theory, with the principles of self-directed learning, problem-based learning and participatory research. Within The University of Calgary campus there are many areas where these principles are enthusiastically pursued. They are well known to educators in the faculty of education and are the principles of

outreach within the faculty of continuing education. The MD programme in the faculty of medicine is based on the principle of problem-based learning. However, these ideas are better understood in principle than in action and they are not widely respected throughout our or any other campus.

Those who are committed to these principles of self-directed learning, problem-based learning and participatory research find no difficulty in working in the intransitive mode of developing. On the contrary, the experience of engaging in participatory developing in communities enriches our ability to follow the same principles within our own campus community of learners.

It follows that it is entirely appropriate for some academics to engage in the facilitative form of developing while still retaining their capacity to provide technical assistance where appropriate. They should be familiar with the principles; they have the opportunity to reflect critically on the process and evaluate its applicability; they have the potential to develop outcome indicators to monitor the process.

It is sometimes suggested that this style of working is more appropriate for a community-based non-government organization than an academic campus. The team which reviewed DID's first quinquennium advanced, in critical tones, the suggestion that DID was operating as an NGO rather than as an academic organization. This opinion is likely to have stemmed from the assumption that the only legitimate business of a university is to teach and undertake research. Academics should provide their service to their community through either of these channels.

However, universities can engage in a much wider spectrum of ways of promoting learning and enquiry. From this perspective, it is entirely appropriate for a campus to engage in participatory research without prejudice to its more conventional habits. Universities have a unique opportunity to practice both forms of developing and enquiring and explore how they can become complementary. Any campus that can help to foster mutual respect based on clear understanding between those who value scientific knowledge and those who value the innate knowledge of people will make an invaluable contribution to human endeavour.

Participatory research has a respected track record within the areas of community development and adult education both at home and abroad. However, the principles of people-controlled enquiry and action are foreign to many areas of academic life. Academics who have the opportunity to experience the practice of participatory research overseas have unlimited opportunities to apply similar strategies to their own area of expertise.

As an obstetrician, I have little difficulty in conceiving how this could be applied with profit to the problems of childbearing in the countries of the North. We still encounter a bedrock of maternal and perinatal mortality and morbidity. Obstetricians tend to study these issues exclusively in terms of biological and epidemiological concepts in an attempt to arrive at a better understanding of their basic causes. In at least some instances, this line of enquiry leads only to clarification of the mechanisms rather than the causes of poor reproductive outcome. While this may not be regarded as a matter of the highest priority in countries where mortality and morbidity rates have fallen to low levels, they are still a matter of the highest concern in the low income countries of the South. In these situations it could be instructive to apply in parallel a conventional medical analysis of mortality and morbidity and a simultaneous people's enquiry to determine their understanding of the causes. Academics could seize the opportunity to explore in such ways the complementary value of popular and scientific enquiry.

The Practice of Institutional Partnering

So far, this chapter has provided general observations on the potential of universities and colleges as agents of international development. It has stopped short of formulating principles of action and has offered no specific recommendations to campuses.

Many universities and colleges have extensive experience in international development, most commonly in the form of networks and linkage agreements. Some participate in partnerships with campuses and other organizations overseas. Most have built up a wide circle of international connections for purposes of teaching and research. In the presence of such massive experience, one hesitates to comment critically on the international role which academics sometimes assume. However, universities in the North are obliged to consider the purposes and beneficiaries of their international ventures if they are to maximize their effectiveness and avoid unwittingly inflicting damage on the people of the South.

Its choice of role has elements unique to each campus. For sound internal reasons, some campuses focus their attention on particular geographic regions or specific areas of expertise. Others wish to build on existing international connections. Each campus chooses its preferred way of organizing and coordinating its international activities, and this level of decision-making is entirely within the domain of each campus. However, general principles could be formulated to govern the form

and content of institutional relationships with the South, especially those which purport to have some "development" purpose.

I have come to regard two propositions, one positive and the other negative, as self-evident and constituting an appropriate moral foundation for authentic partnering between the South and North. Some will dispute their truth and others may dismiss them as empty platitudes to be acknowledged in passing but ignored in practice. Yet, considered commitment to these principles would transform South-North relationships. They may serve as a topic for debate among the academic community.

1. **Societies in the South should be respected as ends in themselves.**

This proposition rests on three assumptions. First, it is an extension of the moral precept that I should treat others as ends in themselves and never use them as means to my own end – a sound basis for equitable interaction between individuals. This first proposition contends that institutions should follow the same precept when they enter into partnering agreements. Second, it assumes that the needs of society take precedence over the demands of individuals. Third, it asserts that, in South-North relationships, equity demands that the interests of the South have priority over those of the North. As elsewhere in this volume, "South" is used as a code for the low income countries of Asia, Africa and Latin America.

This proposition has already been advanced in the previous chapter in commenting on the role of medical education in health development. In terms of the responsibility of universities and colleges to provide tertiary education, the educational demands of individuals are subordinate to the need of society for appropriately trained personnel. It emphasizes that their obligation to serve the needs of society takes precedence over their desire to cater to the ambitions of individuals.

This proposition is expressed in language which reflects my perception of that common vision which is essential for authentic partnering (see Chapter 8). According to that frame of reference, this proposition states that the well-being of societies in the South is the primary goal of South-North partnering for purposes of "development."

Rigorous application of this criterion would make heavy demands on academic institutions. It would require that campuses should weigh carefully the consequences of their actions on the people of the South before they venture overseas. It is insufficient to be satisfied that a few individuals will benefit because the professional expectations of individuals often conflict with the needs of their society. It is only when actions undertaken on behalf of individuals match the interests of their society that they are morally defensible.

It may be difficult to predict the impact on society of actions that we might undertake. There are ample opportunities for unconscious self-deception or deliberate obfuscation in justifying actions which are likely to be to our benefit. Yet, some gross misadventures might be avoided if universities routinely question the social consequences of their forays abroad.

2. Societies in the South should never be used as means to the ends of others.

This proposition is a corollary of the first statement. Expressed in other language, it states that secondary objectives must never subvert the primary objective, or goal. More pointedly, it insists that, in South-North partnering, the private agenda of the partner in the North must never compromise the interests of societies in the South.

This proposition does not contradict the principle of mutuality of benefit which is the basis of reciprocal partnering. It simply requires that the benefits to the North should be compatible with those of the South. In favourable circumstances, the interests of both may be complementary.

The operational significance of these statements may be expressed in the form of negative injunctions, all of which prohibit using or exploiting the South for self-aggrandizement. They include the following cautionary admonitions to universities in the North.

Do not exploit the South for financial gain.

Academic administrations in the North are experiencing unfamiliar fiscal restraint. Some are tempted to look abroad for opportunities to market their expertise in order to generate additional income. When financial gain becomes the primary goal of an enterprise, other purposes become secondary. Profit is the end, and benefit to others is subordinated to this priority. Academic, and perhaps moral, principles may be sacrificed for revenue.

When administrations decide to engage in educational activities overseas primarily for financial gain, the needs of the local society take second place. Foreign students may be welcomed to Canadian universities or colleges primarily as a source of additional revenue. Development projects may be undertaken for our own economic benefit. They are unlikely to give sufficient weight to the needs of the recipients of our "assistance." Simple arithmetic may be enough to demonstrate the maldistribution of project funds. On occasion, our campus has unwittingly fallen into this trap.

Do not strengthen campuses in the North at the expense of the South.

It would be unfortunate if the reputation of a campus for "internationalism" was measured by the number and diversity of foreign stu-

dents it attracts. Some may go to extraordinary lengths to entice students from every continent. From the blinkered perspective of a campus in the North, it may be highly desirable to recruit overseas students. They might be claimed to enrich the cultural life of the campus and promote global understanding. Judged solely by conventional academic criteria, most overseas student scholarship programmes will be rated positively, almost by definition. However, when seen from the perspective of the priorities of the countries of origin, these same programmes may have unfortunate consequences.

Even well-intended educational programmes can stunt the growth of post-secondary education in the countries of origin of overseas students; they may entice some of the best students to study abroad and tempt them not to return; they may provide technical training which cannot be used at home; and they may focus attention on problems which are of low priority for countries in the South.

Do not manipulate institutions in the South to perpetuate dependency.

Campuses in the North may be tempted to maintain a permanent clientele of dependent institutions around the world. Dependency is characterized by paternalism, an inequitable distribution of power and resources and the unconscious adoption of the attitudes and assumptions of colonists. This is qualitatively different from promoting reciprocal partnering and interdependence between South and North. To avoid perpetuating dependency it is necessary to keep relationships with the South under regular scrutiny.

When institutional cooperation takes the form of unidirectional partnering, when the flow of expertise and resources is from "donor" to "recipient," the time comes when it is prudent to discontinue this form of "assistance." As in families, it is necessary for our partners to assume full responsibility for their programmes and assert their independence, albeit reluctantly. It is a matter of judgement to determine when it is time to sever ties and discontinue the provision of assistance in the interests of breaking dependency and encouraging autonomy. There is a distinction between the intention to preserve continuity of genuine friendship for mutual benefit and the desire to perpetuate dependency for selfish motives.

Others may add to this catalogue of admonitions for consideration by universities in the North.

The consequences of acting on the aforementioned two principles could be perceived as negative and a threat to the promotion of international cooperation. They would impede the free flow of expertise from

North to South. They would curb the growth of academic entrepreneurism in the "international development" marketplace. They would inhibit the proliferation of casual institutional relationships. More fundamentally, they would create a climate of concern for the impact of our incursions overseas on the social ecology of the South – in the same way that environmentalism has heightened concern to protect the natural environment. The meaning of conflict between "developer" and community would take on a new significance. It would increase consciousness of the instinctive predatory habits of major or "super" powers.

Campuses might be persuaded to call for social impact analysis before they approve academic programmes which will affect the South, whether these would be conducted at home or abroad. Principles of action, such as those I have suggested – or others which gain wider acceptance – could be used to monitor and regulate the traffic in "development assistance." They would discourage the random movement of "experts" and ideologies for trivial or unworthy reasons.

However, adoption of such guidelines could also have substantial positive effects. They would protect universities from predictable failures, improve the outcome of partnership agreements, and heighten awareness of the importance of campus-community interaction in a way which could benefit both overseas and local cooperation. The net effect would be to situate the practice of institutional partnering in an environment of greater respect for society.

Universities should be encouraged to explore a variety of forms of institutional partnering. At the simplest level, they could experiment with arrangements which aim for greater equity and mutual learning. In some circumstances, it would be natural to extend the process of partnering between institutions to include communities overseas. Canadian faculty could engage their local communities as co-partners with their campus. Many academics have the energy and skill to implement their own version of extended reciprocal partnering. Universities could benefit from supporting a few well chosen initiatives in partnering strategies.

Politicians and power brokers deafen our ears with the rhetoric of participatory democracy, bottom-up management and community-based development. In most cases, the gap between polemic and practice is immeasurable.

Campuses are not immune from this charge. Academic administrators are reluctant to share power with communities in preparing educational programmes. While they appreciate the benefits to the institution of satisfying social needs, they do not engage their communities actively

in planning, implementing and monitoring programmes which are putatively designed for their benefit. Academic isolationism prevents the release of energy which would flow if communities were encouraged to participate actively in academic planning. Communities could do much more than raise funds and lobby politicians on behalf of campuses. They could share in setting the academic vision and bringing it to fruition.

Universities which recognize the potential energy of participating communities would benefit from engaging in community-based development overseas. Universities in the North could take part in one of many such imaginative and successful programmes in the South. By so doing, they would discover the value of learning from partner institutions in the South rather than being content to instruct and advise them. They would also learn participatory strategies which they could apply in their own communities.

If universities are to find opportunities to explore partnering and participatory processes, they will require the support of funding agencies – perhaps those which control official development assistance.

11

Official Development Assistance and Institutional Partnering

The preceding chapters have described relationships which can evolve between institutions at home and abroad. They have advocated a practice of institutional partnering – a process which can be extended to connect academic institutions with their local communities. Within this framework we anticipate a two-way flow of learning between all participants. These partners join forces to create a circle of friendship where benefits and power are shared equitably.

It would be naive to assume that this is a closed circle or that these institutional and community associations exist in a financial vacuum. This would ignore the supportive role of those agencies which control the allocation of funds for international development. We have to add to the partnering equation the variable of funding agencies. They enter the community of partners not simply as remote bankers or silent benefactors but as active and, on occasion, dominant participants.

Several kinds of organization provide funds for international development. They vary widely in the level of control they exert. Individual donors, charitable foundations and some non-governmental organizations identify programmes which they wish to support financially without as-

suming direct responsibility for their management. DID acted as agents or intermediaries on behalf of such donors to direct their funds towards those communities overseas with which we were actively partnering. Accounting for the use of these funds required no more than regular reports. These were essentially relationships based on trust. DID's relationship with the Alberta Agency for International Development was more formal but there was little official intrusion into the conduct of the work.

The conditions under which funds are provided by larger national or multinational development agencies are necessarily more intrusive and restrictive. DID relied heavily on the Canadian International Development Agency (CIDA) for support of its work overseas. The observations which follow are based exclusively on the experience of interactions between DID and CIDA. Other development agencies differ in some respects, but many elements of funding policies are widely applicable.

CIDA is an official agency of the federal government of Canada. The annual budget allocated to CIDA constitutes the major part of Canada's Official Development Assistance (ODA). The expenditure of this money is subject to official policy guidelines. The government of Canada determines the proportion of its gross national product which will be assigned for ODA, approves the broad policies under which CIDA operates and, through its auditor general, requires CIDA to be accountable for its expenditures and the outcome of its programmes. To a significant extent, the use of ODA is designed to support Canada's foreign policies.

Canadian organizations have been free to present proposals for development projects to CIDA. The latter may agree to contribute to the costs, and this would constitute a "contribution agreement" between CIDA and the Canadian organization. The essence of such an agreement is that the Canadian proponent that submitted the proposal undertook to make its own contribution, usually in kind rather than in cash. The overseas partner also agreed to contribute resources to the joint enterprise. In this financial sense, CIDA becomes a partner in the project, usually meeting most of the financial requirements. Such contribution agreements were the basis of all DID's associations with CIDA, and the contribution agreements into which CIDA entered were with the Canadian proponent. Any arrangements between the Canadian and overseas organization were entirely the responsibility of the former.

CIDA played a much more active role than that of a remote banker. In earlier years CIDA planned and managed many of its own programmes. Later, it largely withdrew from direct project management and opted to act through other organizations which operate on its behalf.

CIDA designated these executing agents as "partners" and its relationship to them as a "partnership." CIDA retained the right to refine and modify projects before giving its final approval and committing itself to financial support. It required that projects should fall within its own internal priorities and meet its preconditions. Budgets were constructed along standard lines; reporting schedules were detailed; monitoring procedures were put in place; outcome indicators were agreed; and the entire project was fitted into a tight timeframe.

In this context, "partnership" denoted a contractual agreement between CIDA and its Canadian "executing agency" to undertake a clearly defined service. CIDA was explicit as to what it agreed to contribute, under what conditions it would continue to fulfil this commitment, and what progress it required. This form of "partnership" is distinct from that which I have advocated and described as "partnering."

It is salutary to observe again how badly we are served by our vocabulary. It is unfortunate to use a single and valuable expression to embrace too many different ideas. The distinctions between networking, linkageing and partnering are significant and are much more than verbal niceties. They reflect different values, represent different levels of relationship and express a commitment to different forms of developing. Just as the indiscriminate use of "development" creates confusion and even offence, so the casual use of "partnership" demeans the value of relationships.

CIDA's use of "partnership" is consonant with that form of transitive developing or technical assistance which is concerned with the delivery of a product. The latter may take the form of infrastructure to be constructed, health care to be delivered, a training programme to be presented, or some other form of service to be provided. The key verbs in the preceding sentence are all unequivocally transitive with implied subjects and objects. Whatever the precise nature of these objects, they constitute the output or goal in the form of a finite product.

By contrast, adoption of the practice of partnering places at least equal weight on the process by which the product is produced. From this perspective, the partnering process is a significant output in itself.

The fundamental difference between the process of "partnering," as understood in these chapters, and CIDA's expectation of "partnerships" is that the latter makes no distinction between different forms of cooperation – in particular, it does not distinguish between linkageing and partnering. In truth, it may see little purpose in encouraging different degrees of association and applies similar policies to all. The essence is a

contractual agreement to deliver a finite product or service with business-like efficiency.

The question to be addressed here is how development bureaucracies might respond to the challenges of institutional partnering, reciprocity of benefit and participatory developing. A logical approach would be to weigh the potential benefits against the costs of these practices. If the balance favours the advantages of partnering and participating, then it would be timely to consider the implications for development agencies that are prepared to follow the logic of their analysis.

The Benefits of Institutional Partnering to Nations

The following analysis focuses narrowly on the process of partnering rather than any product it may deliver. This does not imply any lack of respect for the quality of product. It can be assumed that the value of the product or service which constitutes the content of a "project" has been agreed and that its achievement is assured. Given this guarantee, are there additional intrinsic merits in the process by which successful production is achieved? Accepting the necessity to be efficient in the use of resources and the timely delivery of a product, does it matter if this happy conclusion is reached by a process of linkageing or partnering?

Some insist that the quality of the product is the only criterion of success; others believe that the process is itself a product and constitutes a superior yardstick. In essence, for the first, the product is the end towards which the process is simply the means – and the end justifies the means. For the latter, the process is the end towards which collaboration in production is simply an enabling objective.

One may set out to achieve an efficient outcome by the rigorous application of tight management control over all aspects of a joint venture. From this perspective, a Canadian "partner" might deduce, from its unambiguous contractual accountability to CIDA for expenditures and outcomes, that it is required to exercise unilateral control and undisputed authority. The essence of such a process is efficiency measured in terms of quantifiable inputs and outputs.

Another may put a premium on practices which emphasize the subtle relationship between Canadians and their partners. This understanding ascribes at least equal value to their relationship as to the product of their collaboration. From this perspective, each partner pays at least equal attention to the process of partnering as to the product. It remains to justify this preoccupation with relationships.

The goal of ODA has at least two dimensions. It is concerned with providing goods and services to those countries in need of them. This aspect of ODA has the scope to embrace both the transitive and intransitive forms of developing – that is, both technical assistance and the facilitation of participatory developing. Another equally significant dimension of the goal of ODA is the promotion of better understanding between the "donor" and "recipient" countries. These two aspects of the goal of ODA reflect the twin elements of product and process. Again, while respecting the importance of the product, we value even more the process of partnering.

This underlines the necessity to nourish better understanding, respect, trust and commitment between nations. We interpret the pursuit of mutual trust to be much more than an exercise in slick public relations or skilled diplomacy. The mutual trust which we value is rather the fruit of a shared experience of learning and working together in a synergistic relationship. We prize mutual trust as the end product of an equitable process.

For efficient linkageing, an adequate process may be characterized as business-like efficiency. It can operate within narrow limits of respect and trust and is not dependent on achieving compatible attitudes and common values. It is strictly task-oriented. It is consonant with an unquestioned donor – recipient relationship and sits comfortably within dependencies and hierarchies. These attitudes suggest satisfaction with the status quo, at least in terms of the exercise of dominance. While these assumptions and the practices which derive from them may be acceptable to governments which play by rules of expediency and veiled self-interest, they fail to impress the mass of people who suspect or reject that form of assistance or "aid."

This process of "development assistance" is falling into well-earned disrepute because it can do nothing to reorder the relationship between the people of the nations. To fail to understand and respect the higher form of partnering condemns us to perpetuate an unworthy form of relationship.

By contrast, institutional partnering makes a legal contract almost redundant. Even in its most primitive form, partnering implies a willingness to respond to the needs of our partner as they might emerge. It readily vaults over the boundaries of contractual obligation. It looks for opportunities to share control and power in the cause of greater equity, is rooted in attitudes of mutual respect and trust and shares an enthusiasm for learning together. The relationship becomes one of collegiality or conviviality rather than hierarchy.

In contrasting these two forms of association I am not encouraging anarchy or lawlessness. It is entirely practical to fulfil the letter of contract law but deliberately go beyond it. The analogy with the clash between Mosaic Law and the later injunction to love our neighbour is obvious. In the same spirit, partnering does not offend the obligations of contractual linkageing but simply supersedes it.

Some may dismiss these ideas as no more than idealistic dreams and assume that they have no place in the real world. This is precisely the place to counter that charge, by referring to those experiences which constitute our tale of three cities. While our achievement in reaching our project purposes, at least within the parameters within which we worked, was only partially successful, the experience of partnering was persuasive. Even the temporary lapses in the partnering process in Davao cannot detract from the positive impacts of that association. One can only speculate that the heroic effort we undertook collectively to overcome a major crisis would have strengthened our relationship. It is the experience of sharing setbacks and overcoming them together that forges an authentic relationship. This first-hand knowledge sustains the conviction that the practice of partnering is both feasible and rewarding.

These are the benefits of the partnering process to individuals and institutions. Can they be translated to national from institutional levels? Politicians and bureaucrats may feel that they cannot risk the implications of following the logic of their convictions and principles. While it may be impracticable for the managers of ODA to talk publicly in these expansive terms, I would urge an openness to the feasibility of these ideas. There is no prospect of a "new world order" if the process of relationships is sacrificed in the interests of productivity. Of course, what I am suggesting does not come without costs.

The Costs of Institutional Partnering to ODA

Given that an international development agency recognizes some value in encouraging the practice of partnering, as defined here, several logistic implications follow inexorably.

1. Financial Costs

The monetary costs of partnering are modest and less than those of conventional project management. In most linkageing arrangements, CIDA contracted with a Canadian executing agency to manage a project. The bulk of administrative costs were incurred by the Canadian partner and these were paid at Canadian dollar rates. However, if the Canadian agency were to adopt a partnering mode and be genuinely concerned to

share control and authority, one can anticipate a progressive devolution of administrative responsibilities to the overseas partner.

Any decision to locate expatriates overseas requires compelling arguments in its favour to counter their obvious disadvantages. They are prohibitively expensive – perhaps five or six times more costly than local staff. They can rarely match the local knowledge and experience of nationals. Their success rate is depressingly low – perhaps one in three can be rated as successful. In many circumstances, qualified individuals are readily available within the country or region. Although some forms of technical expertise may be lacking, it is extremely unlikely that competent and reliable managerial personnel are not available within the country. Entrusting the control of our joint enterprises to national managers demonstrates the sincerity of the rhetoric of our commitment to partnering. The converse is equally true – insistence on importing expatriates in managerial positions suggests a lack of trust or confidence in our partners.

First-hand experience has confirmed that the practice of partnering can significantly reduce administrative costs. Only inexperience encouraged DID to recruit four Canadians to locate in Nepal. Despite the protestations of some observers, the presence of a Canadian manager in Davao would have been ill-conceived and counter-productive. The mechanism whereby a national organization subcontracts a component of a project to a Canadian partner, of which we have experience in Latin America, deserves wider application. Genuine partnering, far from incurring additional costs, should optimize the use of money and ensure a more equitable sharing of resources between partners.

2. Time

Authentic partnering is time-consuming. There are no shortcuts to reaching an adequate level of respect and trust based on genuine understanding. Sharing of managerial control may result in a slower rate of progress than could be achieved by the exercise of unilateral authority. Measured solely in terms of productivity, benevolent despotism is more efficient than democratic management. However, those who recognize the wider benefits of partnering look beyond the immediate value of production and enter into a long-term commitment for long-term benefits. It follows that partnering requires a generous allocation of time and consistency of purpose throughout that period.

It is unfortunate that governments have neither the capacity nor the inclination to make long-term commitments. Their intrinsic impermanence discourages any enthusiasm for the effort required to generate a

new vision and to follow it patiently through to its ultimate goal. The attention span of governments tends to be strictly limited to the length of their term of office, and official policies tend to be packaged in segments of four or five years. It may be more than a coincidence that CIDA normally approves projects in blocks of three to five years. While this time limit is often prudent, longer-term commitments could be made judiciously.

3. Continuity of Purpose

CIDA is an arm of the department of external affairs and is subject to the vagaries of the political persuasion of successive governments and secretaries of state. Ministers may be replaced even more frequently than governments and changes at the top can have profound repercussions on the lower echelons of bureaucrats. Government policies can fluctuate widely and unpredictably according to political and economic circumstances and the personality and priorities of ministers. CIDA is no exception to this generalization. Over a period of only five years, the policy direction of CIDA has changed dramatically. The philosophy which pervaded the Winegard Report and CIDA's subsequent strategy document are no longer recognizable. The ethos of CIDA in the mid-1980s appears to be repugnant to policy makers in the nineties. One is tempted to suspect that the only constant principles are the pursuit of political advantage and short-term economic gain.

The effects of lurches in official development policies are compounded by inconsistency in their implementation. At the operational level, confusion is ensured by the random movement of CIDA staff. As in the upper reaches of the diplomatic service, CIDA officers are transferred from country to country with bewildering regularity and unseemly haste. This procession of staff encourages discontinuity of style and interpretation of guidelines; it discourages a sense of responsibility for the long-term impact of actions taken by transient officers; it hinders the acquisition of more than a superficial understanding of complex local situations; and it does little to foster lasting friendships and commitments.

Changes in agency policies at headquarters and inconsistency in their application at field level undermine any sense of confidence in continuity of purpose. The entire orientation and ethos of a CIDA office in a foreign mission can be reversed dramatically overnight simply by the transfer of key staff. CIDA's short-lived policy of decentralization in the late 1980s exaggerated this tendency to discontinuity. While decentralization had strategic merits, the delegation of control to local officers intensified the propensity for idiosyncratic swings in bureaucratic practices.

Radical shifts in official policies and random swings in their interpretation at local level threaten any commitment to a long-term goal. Discontinuity of purpose and inconsistency of application have unfortunate impacts on organizations which undertake long-term programmes. There is no guarantee that funding agencies will not switch their policies and attitudes during the course of the programme. I suspect that development agencies have not fully appreciated the costs of their inconsistency. The damage to Canadian executing agencies is significant but not lethal, and the harm to individual participants is painful but temporary and recoverable. However, the impact on organizations and communities overseas is incalculable and may be irrevocable. The lessons drawn by other nations from their experience of inconsistency may be damaging to international relationships. Mutual respect and trust, the prerequisites for friendship between nations and world societies, are destroyed.

If development agencies, such as CIDA, wish to improve the process by which organizations relate and if they wish to test the feasibility of fostering genuine partnering, it is imperative that they learn to remain steady in their stated convictions. To achieve partnering that rises above the level of contractual obligation, it is necessary that they be willing to ride out temporary rough patches.

4. Accountability

Concerns about accountability for the disbursement of public funds and the outcome of publicly funded activities dominates the minds of public servants. The spectres of the auditor general and investigative journalists haunt senior administrators. Accountability also presents a challenge for those Canadian organizations wishing to practice genuine partnering. Those organizations find themselves in a quandary. Under CIDA's standard contractual regulations, the Canadian executing agency carries total responsibility for expenditures and outcomes whereas, in the interests of equitable sharing of power, it may relinquish unilateral authority. To accept responsibility without retaining commensurate authority is a test of the strength of mutual trust.

Given the desirability of sharing both responsibility and authority in the interests of equity, it is timely to recognize this predicament and seek some answers to the problem of assigning accountability. One solution would be for CIDA to enter into a direct contractual relationship with a foreign organization and require it to select a Canadian institution to become a partner without relinquishing the lead role. This arrangement has worked well for DID in its agreement with PAHO; it could have been an appropriate administrative mechanism for the Davao

HDP; and we could well have evolved towards this arrangement in Nepal. It translates into action the rhetoric of a commitment to achieve greater equity in the exercise of power and the control of resources. Another possibility would be to build into the design of a project the progressive transfer of responsibility and accountability – perhaps making this transfer contingent on the reaching of intermediate objectives.

A key to the solution of this problem is the explicit recognition of the intention to share power and responsibility from the outset and agreement among the partners and the funding agency to follow this strategy.

To weigh the potential benefits of partnering against its costs is a matter of fine judgement. If a development agency finds that the balance is favourable, even for limited purposes, it has to face the practical implications of following the partnering route.

There will be an increased cost in terms of a more generous allocation of time and, perhaps, greater flexibility in arriving at intermediate stages. However, the monetary implications of additional time can be more than offset by reduced administrative costs. Officials should be conscious of the nature of the operation and approach it with appropriate sensitivity and flexibility. Agencies which assume top-down managerial control and the exercise of unilateral authority are ill-equipped for the purpose. Furthermore, if agencies enter into a long-term programme, they should recognize the necessity to remain constant in their purpose.

Postscript

Those reflections on the ideas of developing and partnering and on the practices of health development and institutional partnering would be of little consequence if they were pertinent only to specific situations in the past. However, although they are derived from particular experiences in Kathmandu, Davao and Calgary, they can be applied widely – not least in my own contemporary society.

I will refer briefly to two situations where they are proving useful. First, the ideas of health development, community participation and reciprocal partnering throw light on the situation of the First Nations in Canada. Second, they can be applied to the current practice of medical education to allow it to adapt to the needs of a culturally diverse society.

The First Nations in Canada

Health Development. The health of native bands is undermined by harsh social, economic and political conditions. Any attempt to improve the health of native people is doomed to failure if it does not address, within one comprehensive and integrated programme, all aspects of their life.

The poor status of health on reserves is associated with high levels of unemployment, widespread poverty and dependence on social welfare, inadequate and overcrowded housing, lack of water, sanitation and power supplies, fire hazards, school drop out, and loss of self-respect and cultural identity. Such deprivation results in reduced life expectancy, high rates of infant mortality, suicide, abuse of women and children, dependence on alcohol and other chemicals, fatalities due to violence, fire and accidents, and such diseases of poverty as tuberculosis, acute respiratory infections and diarrhoeal diseases. To try to isolate from this chaos a few specific diseases which can be managed by conventional clinical medicine is an exercise in futility and an abrogation of social responsibility.

Perhaps more fundamentally, native people who retain their traditional beliefs insist on the holistic nature of healing and reject the professional tendency to compartmentalize illness into systems and categories. Just as many indigenous people prefer to follow a spiritual way of life rather than conform to the creed of a formal religion, so they insist that healing cannot be conceived as belonging to a special discipline but as pervading every aspect of life. The concept of health development is consonant with the native view of healing.

Community Participation. The First Nations are equally insistent on the value of genuine community engagement. Since the time of their first contact with European colonizers, they have suffered under every form of paternalism – sometimes softened by good intention but often imposed with callous cruelty. They are still subject to forces which drive them inexorably towards assimilation into white society. However, over the last twenty-five years, the First Nations have stoutly refused to be assimilated or integrated and demand access to their aboriginal rights and to self-determination, however these may be defined. They deny the assumptions of transitive development. They dispute the need to be developed by others, to have health care delivered to them, or to be provided with social services. They demand the right to set their own priorities, plan their own programmes and manage their own affairs. They are committed to a form of authentic participating which goes far beyond mere acquiescence or conformity. So the idea of participatory health development reflects the ethos of contemporary native society.

Reciprocal Partnering. Native people are exquisitely sensitive to signs of false partnering. They have learned from bitter experience the need to ensure that all the preconditions are in place before entering into a partnership with non-native health-care organizations. They will confirm that any potential partner shares a common vision of wellness and

illness – although it may be expressed in different terms. They will be wary of private agendas that might threaten their autonomy, and they will look for evidence of respect and trust based on realistic understanding. Management practices must be compatible with their traditional style. They will expect an appreciation of the considerable time and effort required to achieve genuine friendship, particularly if it is to acquire an institutional dimension.

Native people respond warmly to the idea of reciprocal partnering for mutual benefit – provided that our actions match our words. They know that they have much to offer to Canadian society but appreciate that they can also gain from the association. The conditions are ripe for reciprocal partnering between native people and health professionals as co-learners. However, there is no shortcut to this end.

On reflection, I could have learned the ideas of developing and partnering and the practices of participatory health development and institutional cooperation from native bands close to home. There is no remote Third World on distant continents which operates under a special dispensation. There is only one world where the same universal principles apply with equal force.

Training Doctors to Serve a Culturally Diverse Society

After I returned to the faculty of medicine, I was given the opportunity to advise on the modification of the Calgary MD curriculum in order to prepare future doctors to practice more effectively in a culturally diverse society. Whereas school systems and police forces across Canada have struggled for three decades to meet the needs of an ethnoculturally diverse population, medical educators have been slow to take up the challenge.

Approximately 65 percent of Albertans are European in origin – half of them of British or French stock, while those of German and Ukrainian descent are the next most numerous. Approximately eight percent are of Asian origin, the most common ethnicities being Chinese, South Asian, Filipino and Indochinese. Immigrants from Latin America and the Caribbean make up a small but significant minority. Aboriginal people – native Indians, Metis and Inuit – comprise less than three percent of the people of Alberta. The five reserves of Treaty Seven in southern Alberta are home for 19,000 status Indians. In these percentages, the population of Calgary mirrors that of the province.

This ethnocultural complexity is further compounded by socio-economic variables – gender, age, disability, poverty and level of education. Each social group has its own "subculture." How can traditional North American medical education be adapted to match the health expectations and needs of such diversity? One can use the propositions drawn from our experience in Asia to serve as guiding principles (see Chapters 9 and 10).

Planning a curriculum "from right to left" puts priority on the end to be served. The goal of this curricular change may be expressed as follows: "to create a society where ethnicity, race, language and religion do not prejudice the quality of life/health of people." From this social goal, educational planners can then establish the particular competences required of future health professionals in order to serve a culturally diverse society.

Canadians live under an official policy of multiculturalism whereby we attribute equal respect to every element of the Canadian ethnocultural mosaic. In principle, we reject all forms of monoculturalism, whether pursued through policies of assimilation (anglo-conformity) into the dominant white culture or integration into a national melting pot. When applied to health care, multiculturalism imposes an obligation to respect alternative views of wellness and illness rather than to assume the dominance of the prevailing western scientific paradigm. It requires medical educators to demand from medical students respect, even enthusiasm, for cultural diversity and an acute awareness of the influence of ethnicity on every aspect of illness. A monocultural approach to health care is inappropriate for a society which endorses multiculturalism.

Potential learners include both faculty and students. At DID, we recruited a core of interested faculty to address this aim. All expressed enthusiasm for the challenge of incorporating cultural elements into their practice and teaching but also admitted their unpreparedness for the task. It followed that our primary concern was faculty development as a means towards improved student learning.

Preliminary discussions with the bands of the First Nations were particularly helpful. Native leaders expressed no interest in any intention we may have harboured of "studying" them as objects of our curiosity. Nor did they encourage us to devise innovative health services for their benefit. In general, they were disinclined to be recipients of any form of transitive development assistance, whether it should take the form of education, research or health care. Their position simply served to reinforce our enthusiasm for partnering with the native community.

We requested our native friends to teach us about their way of life and their understanding of wellness and illness. We hoped to learn directly from the native people rather than indirectly through the intermediacy of non-native experts. This reflects our intention to avoid the risk of appropriating the voice of the people. At their suggestion, faculty joined members of the Blood band in the sweat lodge in order to begin to experience their culture.

This process of learning together is still in its infancy, yet it is already setting the tone of our evolving relationship. It has the potential to encourage understanding and lay a foundation of mutual respect and trust on which we can construct reciprocal partnering. It lends added meaning to the idea of the "patient as partner." It is also a way to begin to narrow the gap which separates professionals from the laity.

If this partnering style is applicable to the First Nations, it should be equally appropriate for non-native communities. Consequently, we embarked on a similar journey with immigrant communities in Calgary. Since reproductive medicine is one of our priorities, we entered into a series of dialogues with women who have immigrated to Calgary from many countries. These meetings took place off the campus within their communities. The role of faculty was simply to listen to unstructured conversation. Those women were remarkably generous in their willingness to share personal, and sometimes painful, experiences. These dialogues served several purposes. They opened our minds to the rich diversity of cultures in our city. They demonstrated the importance of family and community to the well-being of individuals, the unfortunate consequences of conflicts between western medicine and folk wisdom, and alternative ways of understanding the etiology of illness. The experience confirmed the potential benefits of partnering with these communities.

If learning directly from communities in this way is good for faculty, then, we reasoned, it should be equally valuable for students. They are entitled to the same privilege of interacting with communities rather than being taught exclusively by experts who are knowledgeable about "others." Thus, members of native and immigrant communities are presently teaching our students about their beliefs and practices in the context of such issues as preventive health, dietary advice and reproductive health. We have experimented with the practice of inviting elders to introduce students to native reserves before they go out to rural areas, and members of ethnocultural communities have joined faculty as co-faculty in small group teaching.

We took these tentative steps without full consultation with our communities. However, we are unequivocally headed towards active community participation and community-campus partnering. An advisory forum has been established, which consists of equal representation from communities – both First Nations and immigrants – and faculty. Its mandate is to advise the office of medical education on the theme of "Culture, Health and Illness." This may be the single most important step that we have taken to date. It translates into action our rhetorical commitment to authentic participation and a form of partnering which does not shrink from relinquishing unilateral authority, and which bridges the gap between professionals and the laity.

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Partnering and Health Development

THE KATHMANDU CONNECTION

Based on extensive first-hand personal and institutional experience, the book describes and analyses the experience gained from partnerships between The University of Calgary and institutions in Nepal, the Philippines, and other countries in Asia and Latin America which targeted medical education and participatory health development. Dr. Kerr explores the ambiguous language in which discourse on development is conducted, examines the diversity of forms that institutional cooperation can take, and advocates a practice of partnering for mutual benefit.

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