Integrating Poverty and Gender into Health Programmes

A Sourcebook for Health Professionals

Module on Curricular Integration

World Health Organization
Western Pacific Region

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CONTENTS

BOXES

TABLES

ACKNOWLEDGEMENTS

This module is one of a complete set entitled *Integrating Poverty and Gender into Health Programmes: A Sourcebook for Health Professionals*. It was prepared by a team comprising Alan Barnard and Carol Windsor (consultants and principal writers), Anjana Bhushan (Technical Officer, Poverty, Gender and Human Rights) and Kathleen Fritsch (Regional Adviser in Nursing), World Health Organization Regional Office for the Western Pacific. Breeda Hickey edited the module. Design and layout were done by Zando Escultura.

ABBREVIATIONS

AHEC	Area Health Education Center
ANMC	Australian Nursing and Midwifery Council
BS	Bachelor of Science
DFID	Department for International Development
MS	Master of Science
ND	Nursing Doctorate
OECD	Organization for Economic Cooperation and Development
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
WB	World Bank
WHO	World Health Organization
WPR	Western Pacific Region

PREFACE

Over the past two to three decades, our understanding of poverty has broadened from a narrow focus on income and consumption to a multidimensional notion of education, health, social and political participation, personal security and freedom and environmental quality.[1] Thus, it encompasses not just low income, but lack of access to services, resources and skills; vulnerability; insecurity; and voicelessness and powerlessness. Multidimensional poverty is a determinant of health risks, health seeking behaviour, health care access and health outcomes.

As analysis of health outcomes becomes more refined, it is increasingly apparent that the impressive gains in health experienced over recent decades are unevenly distributed. Aggregate indicators, whether at the global, regional or national level, often tend to mask striking variations in health outcomes between men and women, rich and poor, both across and within countries.

It is estimated that about 70% of the world's poor are women.[2] Similarly, in the Western Pacific Region, poverty often wears a woman's face. Indicators of human poverty, including health indicators, often reflect severe gender-based disparities. In this way, gender inequality is a significant determinant of health outcomes in the Region, with women and girls often at a severe societal disadvantage.

Although poverty and gender significantly influence health and socioeconomic development, health professionals are not always adequately prepared to address such issues in their work. This publication aims to improve the awareness, knowledge and skills of health professionals in the Region on poverty and gender concerns.

The set of modules that comprise this Sourcebook are intended for use in pre-service and in-service training of health professionals. It is expected that this publication will also be of use to health policy-makers and programme managers, either as a reference document or in conjunction with in-service training.

All modules in the series are linked, but each one can be used on a stand-alone basis if required. There are two foundational modules that set out the conceptual framework for the analysis of poverty and gender issues in health. Each of the other modules is intended for use in conjunction with these two foundational modules. This module on curricular integration is designed to support health professional educational institutions in the process of integration of poverty and gender concerns into existing curricula.

All modules in the Sourcebook are designed for use through participatory learning methods that involve the learner, taking advantage of his or her experience and knowledge. Each module contains facilitator's notes and suggested exercises to assist in this process.

It is hoped that the Sourcebook will prove useful in bringing greater attention to poverty and gender concerns in the design, implementation and monitoring and evaluation of health policies, programmes and interventions.

Introduction

Introduction

The aim of this module is to strengthen the capacity of teachers, administrators, and those developing training materials to introduce changes into curricula that will ensure health professional curricula or courses include the concepts of gender, poverty and health. This module is designed to assist leaders to develop the necessary skills and tools to manage curriculum development and change. Accordingly, the module sets out a systematic framework that incorporates the knowledge, strategies and techniques needed to develop and implement a curricular change process which will bring about the integration of poverty, gender and health concepts. It is divided into five sections:

- **Section 1** defines WHAT a curriculum is and provides an explanation of different types of curriculum models.
- **Section 2** discusses WHY it is important to integrate poverty and gender concepts into health curricula.
- **Section 3** discusses HOW poverty and gender concepts can be integrated into health education curricula. It presents examples of approaches to curriculum integration and appropriate teaching. The discussion focuses on ways of integrating gender and poverty across curricula and includes various training aids, overviews their strengths and outlines possible ways to include them in training sessions. An overview of approaches to monitoring and evaluating curricular integration of poverty, gender and health concepts and assessing the impact of curricular changes is also included.
- **Section 4** provides notes for training facilitators.
- **Section 5** is a collection of additional resources and references, to support health professional educational institutions in the process of integrating poverty, gender and health into existing curricula.

It is expected that readers and participants have established leadership skills for the promotion of collaborative work necessary for the production of an enduring revised curriculum. There is also a need to foster accountability in evaluating the effects of changes to curricula. The discussion is general in its overall scope while highlighting key issues, strategies and measures to bring about curriculum change and the introduction of gender and poverty in health care curricula.

1. What is curriculum development and change?

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What is a curriculum?

A curriculum is the totality of all that occurs in the education process as a result of objectives, intentions, assessment, values, activities, interaction, evaluation and change. It is anything and everything that teaches or communicates knowledge, planned or otherwise. It reflects the individual, social and cultural dynamic(s) of the organization, society and the aspirations of a profession. A curriculum should evolve and be open to debate, modification, negotiation and change. Factors that combine together to influence curricula include:

- traditions and cultural norms
- social forces and lobby groups
- politics
- business and industry
- competency associated with discipline knowledge and skills
- textbooks
- assessment
- new knowledge
- teachers.

A curriculum is not simply a collection of separate subjects but rather a programme of study of which the whole is greater than the sum of the parts. The emphasis therefore lies on meeting the goals of both individual subjects or units and the whole curriculum. For example, in 1995, the University of Dundee, Faculty of Medicine, identified 11 outcomes for their undergraduate medical curriculum. These were: professionalism and role of the doctor within the health service; knowledge as a basis for medical practice; clinical skills; communication skills; clinical reasoning and judgment; attitudes, ethics and legal responsibilities; health promotion and prevention; practical procedures; patient management and investigation; information handling and retrieval skills; personal development and transferable skills.[3]

Whether the goals of your curriculum look like these or are different, the presentation of content and development of each student needs to be considered in relation to the broad learning opportunities and experiences needed to foster a breadth of understanding about health. In particular, key curriculum issues affecting developing countries include:

- changes to professional roles and employment opportunities as a result of globalization and technological development;
- continued marginalization of groups and classes of peoples within and between countries (for example, women and children; ethnic minorities; rural or isolated populations; urban poor, etc.);
- increasing inequalities in relation to income, health, education and social services;
- rapid changes to the ways education is delivered and the media used to provide resources, information and contact with others;
- changes to the knowledge and skills demanded of people and groups in light of rapid epidemiological, demographic and technological changes; and
- opportunities to address values and ethical conflicts and dilemmas.

What comprises a curriculum?

A curriculum has a number of different components, parts or levels (see Box 1 for a summary).[4,5,6] The different parts of a curriculum need to be considered when undertaking curriculum development and evaluating the integration of knowledge and skills into a course.

1. The *overt, explicit or written curriculum* is simply that which is written as part of formal instruction. It may include curriculum documents, textbooks and references, film and other media and additional teaching materials chosen to support instruction. It is restricted to written understanding and directions formally designated and reviewed by administrators, course coordinators and teaching staff.
2. The *hidden or covert curriculum* is implied by the structure and nature of the school or department and expressed in the routine running of the course. It includes the learning and experiences that derive from the organization of the course, as well as from the values, behaviours and attitudes

of teachers and administrators. Learning from the hidden curriculum, such as the learning of attitudes and values, can be very powerful. This constitutes a strong rationale for addressing gender and poverty in the overt or explicit curriculum, so as to overcome any biases or preconceptions about gender and poverty. In some circumstances, the overt curriculum may bear little resemblance to the education actually taking place.

3. The *null curriculum* refers to the knowledge and skills that are not taught. What is not taught (such as gender or poverty) can often give students a message about what is not important in their educational experience. It can also communicate what knowledge and skills are not considered essential. The null curriculum influences students by what is excluded from their education.
4. The *curriculum-in-use* is the formal curriculum (written or overt) that comprises resources (such as textbooks or curriculum guides) and clinical experiences. Many of the formal elements are not taught but are acquired in developing knowledge and skills. These elements need to directly support the premises and directions that underpin a curriculum. The curriculum-in-use is the actual curriculum that is delivered and presented by staff members.

Box 1: What comprises a curriculum?

- The **overt or explicit curriculum** refers to all written curriculum documentation.
- The **hidden or covert** curriculum reflects the values, behaviours and attitudes of staff and the institution as they impact upon a curriculum.
- The **null curriculum** refers to what is not taught within a curriculum and the way this shapes knowledge and values.
- The **curriculum-in-use or formal curriculum** is that which is actually delivered.

The **retained curriculum** refers to the skills and knowledge that students apply in practice and in their daily lives and thus extend beyond the educational institution.

The *retained curriculum* refers to the actual knowledge and skills that students take away from their learning experience(s).

Curriculum models

To develop a poverty- and gender-inclusive curriculum, curriculum change leaders need to be aware of various curriculum models and their strengths and limitations. Curricula are not necessarily of one particular type or another, but often represent a combination of models or designs. Curricular design considerations are important in integrating new concepts, to ensure that these concepts are linked with existing content and to avoid duplication or overcrowding. Five curriculum models are described in Resource 1 (Section 5):

- product- or subject-centred curriculum
- student-centred curriculum
- competency-based or core curriculum
- problem-based or problem-centred curriculum
- integrated curriculum.

Some curricular models are more objectives-based, logical and sequential, while others are more interactive or integrated. Various curriculum models are described in this section, to enable institutions to identify the most appropriate one for their circumstances.

What is a poverty- and gender-responsive curriculum?

A poverty- and gender-responsive health curriculum incorporates poverty and gender concerns as they relate to health and sensitizes students about gender- and poverty-associated disparities in health; the needs of poor and vulnerable population groups; poverty- and gender-related barriers to care; and ways to overcome these barriers. It emphasizes the diverse health needs of all community members, particularly the most vulnerable. It helps learners understand the poverty- and gender-related circumstances of individuals, groups and regions. The overall objective is to prepare health professionals to acknowledge and respond to issues of poverty and gender in addressing health problems.

Educational trends influencing curricular integration of poverty and gender

In recent decades, attention has increasingly focused on integrating development, poverty and gender issues into health professional educational curricula. This implies a move away from a 'narrow sectoral focus on health issues' towards a multi-dimensional and interdisciplinary approach.[7]

An acknowledgement of the relationship between education and development is driving new approaches to education more broadly. The Task Force on Higher Education in Developing Countries, convened in 2000 by the World Bank and the United Nations Educational, Scientific and Cultural Organization (UNESCO), emphasizes knowledge as a major driver of development. Tertiary education is considered a critical factor in the development of human and social capital and thereby in social and economic change.[8] According to the World Bank, tertiary education is linked to opportunity, empowerment and the development of social capital and thus to building healthy societies.[9] More specifically, the aims of a WHO/UNESCO collaborative project, Universities in Solidarity for the Disadvantaged, include 'optimizing universities' potential to improve the health of the disadvantaged' through knowing the disadvantaged and their health conditions.[10]

Health curricula also place increasing emphasis on training people to work in their own national contexts. According to the United Kingdom's General Medical Council, whatever the context of health education, major emphasis must be given to understanding "the wide range of cultural, environmental and ethical issues that will increasingly impinge on the problems of health."[11] A study of essential public health functions in three countries of the Western Pacific Region stressed the need for developing the public health workforce, one of a number of essentials required to improve health and quality of life and reduce health inequalities.[12]

The integration of poverty and gender concepts is likely to be more demanding than traditional approaches. However, exposure to poverty and gender analysis can enable health professionals to appreciate diversity, challenge prejudice, analyze change and understand what shapes the health of an individual, group or a society. It can thereby change practice.

2. Why is it important to integrate poverty and gender into health curricula?

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Poverty, gender and health–the links

Development efforts are increasingly focusing on health as central to poverty reduction. Health status is widely recognized as a strong indicator of socioeconomic development. Health conditions and access to health services are known to differ significantly between the richest and poorest population groups. Poverty also interacts with other forms of social exclusion–such as class, race, ethnicity or gender–to result in unequal health risks, access to services and outcomes. In this way, inequalities in health reflect inequalities at the individual, household and community levels.[13,14]

Recently, gender issues in health are also receiving increasing prominence.[15] Gender refers to those characteristics of women and men that are socially constructed, in contrast to those that are biologically determined. Gender relations play a critical role in the distribution of work, income and education and in determining unequal health risks, health-seeking behaviour and health outcomes. Since women typically lack control over the production and distribution of resources, relative to men, they generally have lower access to health and other services. The impact of gender inequality is reflected in marked differences in health status between men and women. Gender-based inequalities also help perpetuate the poverty of women and, in turn, families, communities and generations.[16,17]

The rationale for integrating poverty and gender into health curricula

The strong links between gender, poverty and health provide a clear rationale for the integration of these issues into health professional education, so as to improve health outcomes.

The primary rationale for this shift in approach is the need for **more efficient use** of resources in optimizing health status and overall development. In 1995, a Pew Health Commission Report noted that practitioners of the future "will have to possess a broad understanding of all the determinants of health, such as the environment, socioeconomic conditions, behavioural health care, and human genetics to be able to effectively fulfil their roles as professionals."[18] The Report emphasizes integrating knowledge and services across discipline areas.

In addition, a focus on poverty and gender in health is justified on grounds of **equity** or social justice. Societies have always observed inequalities in health risks and outcomes. Many, although not all, of these inequalities are avoidable or unfair and result from structural inequalities or barriers faced by some groups relative to others. Addressing the needs of the most vulnerable and underserved populations helps make the goal of "health for all" more attainable.

There is also a strong **human rights** rationale for addressing poverty and gender concerns in health. The WHO Constitution (1946) reflects "the right to the highest attainable standard of health." This was reiterated in the 1978 Declaration of Alma Ata and in the World Health Declaration adopted by the World Health Assembly in 1998. The right to health implies the need for effective public policies that ensure access for all populations–including men and women, rich and poor, rural and urban communities–to affordable, accessible, acceptable health services of adequate quality.

Educational philosophies underlying the integration of poverty and gender

In the field of education, it is considered crucial that teaching and learning programmes are socially relevant and linked to life situations and the world of work.[19] The relationship between education and social change is most notably theorized in the influential work of Paulo Freire.[20] Genuine learning, in Freire's terms, involves helping students engage directly with the concrete or material conditions of their lives and become aware of how those conditions limit their ability to learn. Effective education encourages students to reflect on the context in which they live and thereby develop the critical capacity to bring about social change.

Critical thinking requires educational approaches vastly different from those in which students absorb information passively. It is achieved

through a learning environment that challenges the traditional hierarchical teaching model in which the teacher has absolute authority. Freire's alternative approach assumes a partnership between student and teacher, in which all bring knowledge to the learning situation. Dialogue and discussion are key to promoting active learning. Freire also stresses the importance of participatory learning and links with communities.

Community participation, dialogue and mobilization need to be essential features of health professional education initiatives, particularly given the many, complex determinants of health. This also calls for expanding traditional discipline-based health professional competencies to include understanding of health determinants, public health and the health of communities. The Pew Commission on Health Professions has urged health professional schools to focus on education that serves community needs and the health of communities.[21] Development of the public health workforce, including the training and continuing education of health professionals, is one of 10 key elements for strengthening the essential health functions, which are vital to an ethically based and socially responsible approach to promoting the health of populations.[22] Understanding and addressing the poverty and gender aspects of health, including identifying ways to overcome barriers limiting access to care by vulnerable population groups, are thus key aspects of public health functions.

3. How to integrate poverty and gender into health professional education curricula

3. How to integrate poverty and gender into health professional education curricula

Principles underlying poverty- and gender-responsive health curricula

There is no one 'best' way to design or develop an integrated curriculum. The selected approaches will depend on the type of course offered and the resources available. Shorter courses, such as in-service training, may be designed around the concepts of poverty and gender. Established and longer courses may involve integration of the concepts in selected subject areas or full integration across the programme.

Nevertheless, some fundamental principles underlie the process of curriculum development or revision to incorporate poverty and gender. One principle is that the curriculum should connect the areas of concern through academic, practical and vocational or community-based learning. This promotes students' understanding and better enables them to develop the attitudes and skills to address poverty and gender issues in health. To a great extent, a curriculum that integrates poverty and gender, and applies related learning opportunities, embodies what research shows about meaningful and engaged learning.

Curricula must therefore support appropriate learning and assessment methods, be designed to improve students' academic and practical skills and link concepts and issues related to poverty and gender. The objective is to enable health professionals to make a difference to the health of a community and to design policies, plans and services that address the needs of the most vulnerable.

Approaches to the curricular integration of poverty and gender

There are a number of possible approaches to the integration of the concepts of poverty and gender in a health curriculum. This section briefly describes some approaches; the types and levels of integration achieved; and the respective benefits and limitations of each approach. More than one approach may be used to achieve the curricular change goal.

Option A: Developing or modifying a subject or unit or developing a short in-service programme on poverty, gender and health

Type of approach: Creating or modifying individual subjects or units or implementing in-service education workshops.

Level of integration: This approach involves the modification of individual health study units to include poverty and gender content. Individual subjects recognize broader curriculum objectives and principles and incorporate these within the teaching content.

Benefits: Key concepts may be connected or targeted within a specific discipline or area. This approach is particularly relevant to smaller programmes or for orienting health professionals to the poverty and gender aspects of health through continuing education. The benefits for longer or established courses include ease of adoption and limited additional expense. In-service education workshops to orient health professionals to poverty and gender concepts and related skills can also be carried out without incurring excess costs.

Limitations: The approach does not eliminate the segregation of discrete subject areas. The responsibility for gender and poverty content lies with the subject and individual staff members may not have the required expertise. A stand-alone unit on poverty and gender within a larger programme may have limited impact. There is also a risk that gender and poverty will be 'tacked on' to existing units or dealt with superficially. In-service education, though quite appropriate for health professionals, does not always result in sustained change in the education of professionals entering the workforce, unless combined with pre-service curricular change.

Option B: Sequencing poverty and gender into existing units or subjects

Type of approach: Sequenced.

Level of integration: This approach is designed to consider the point at which basic competencies

and skills related to poverty and gender are introduced within a health professional educational programme. The core knowledge and skills are addressed through appropriately sequenced units within the overall curriculum. The approach requires cooperation between all educators.

Benefits: This approach is flexible and low cost and has the potential to coordinate across existing teachers and courses rather than needing the development of new courses. The objective is to create a coherent sequence of units where, for example, basic knowledge and skills related to gender and poverty learning are developed early, rather than modifying existing individual courses that are independent of each other.

Limitations: A potential limitation is that the introduction of essential skills in other subjects or units may be delayed. The segregation of subjects or disciplines remains, with the risk that competencies related to poverty, gender and health are addressed as discrete, rather than applied in conjunction with other core professional competencies.

Option C: Problem-based learning on poverty, gender and health

Type of approach: Problem-based learning.

Level of integration: This approach requires modifying the whole curriculum to integrate poverty and gender content in a context that helps students learn how to learn. Learning takes place through a problem-based curriculum that incorporates poverty and gender perspectives into health cases or problems and related problem-solving activities.

Benefits: This approach provides a shared focus on poverty and gender across the curriculum and promotes participatory, active and group learning. It requires continuity and consistency in planning, instruction and assessment across an entire programme of studies as well as preparation of teachers to become facilitators of learning.

Limitations: This approach requires fundamental changes in the overall curriculum. Teachers must learn new skills to become student-focused rather than teacher-centred. There may be resistance to moving away from the traditional didactic approaches. Resources for case development and problem analysis and solving must be available and accessible.

Option D: Integrated, multidisciplinary approach

Type of approach: Integrated or multidisciplinary.

Level of integration: In this approach, educators collaborate and team-teach in all areas of the educational programme.

Benefits: This approach links and coordinates all subject areas, instead of treating them as discrete areas of knowledge. A multidisciplinary approach creates the diverse educational skills and materials needed to teach poverty and gender concepts.

Limitations: A limitation is the greater resources typically needed to develop such a programme. The approach may also result in less concentrated teaching in essential subject areas. Too much integration risks the curriculum becoming a "hodgepodge," unless poverty and gender are integrated without neglecting other core content areas.

Option E: Community-based academic partnerships

Type of approach: Collaborative partnerships, shared responsibility.

Level of integration: In this approach, academics, often representing different disciplines, collaborate with health agencies to structure learning, with the participation of vulnerable communities, so that students acquire the essential competencies. Community collaboration and mobilization of community resources are designed to include application of poverty- and gender-related knowledge and skills.

Benefits: This approach focuses on community-identified priorities and promotes student understanding of health determinants–including

poverty and gender–and community collaboration and empowerment. Cross-discipline work facilitates shared learning and a broad-based approach to community public health.

Limitations: This approach requires careful preparatory planning, as well as mechanisms to ensure collaboration and sustainability. Respect for and valuing of community voices and partnership are essential ingredients for success. Efforts must be made to guarantee the participation of vulnerable communities, which are often underrepresented and underserved, making the establishment of sustainable partnerships more difficult.

Case studies examining the outcomes of integrating poverty and gender into health curricula

This module stresses that there is no "best" approach to developing a curriculum that emphasizes the relationship between health, gender and poverty. Currently, there is a lack of evaluation of poverty, gender and health curricular change processes and outcomes and of research addressing the design and implementation of integrated curricula.[23,24] Curriculum change is also influenced by contextual factors, including resources available and disciplines involved. A further critical factor is the challenge of processing curriculum change.[25] In reality, the curriculum development and change process can be quite dynamic and may begin at any point in the curriculum.

The following case studies illustrate some of the approaches presented above and reflect differing methodologies and levels of integration.

Case Study 1. A service learning approach: academic and community service partnerships developing a unit within a larger curriculum.[26]

In 1997, following a major course revision at the School of Nursing at the University of Colorado Health Sciences Center, the concepts of social justice and responsibility emerged as a 'core thread' of the curriculum.

A course focusing on minority health, poverty, environmental health and underserved groups was designed as a distinct component of the School's four nursing programmes (BS, MS, ND, PhD). The service-learning approach was selected, to allow students to directly experience civic engagement in community agencies. The faculty ran workshops for teaching staff, students and community workers on the service-learning model and curriculum objectives. The same learning objectives were applied across programmes and required students to analyse social justice issues, apply theoretical concepts in interpreting those issues and provide evidence of civic engagement and personal reflection. Students had to complete at least 15 to 20 hours in partnership with a community agency, demonstrate advocacy for an underserved population and engage in dialogue and reflection with peers and teaching staff on their experiences and as they related to social justice.

Group work and collaboration between students of different educational levels was encouraged. A distance education mode was offered and, for external students, some assessments were conducted online. Importantly, many students found the community experience professionally transforming. Establishing and maintaining partnerships with community agencies working for social justice and placing students was found to be resource-intensive and difficult with limited infrastructure support.

Case Study 2. An academic and community partnership focused on cultural competency and community service

The Medical College of Georgia in the United States, in collaboration with the local community and the Area Health Education Center (AHEC), established a faculty-supervised migrant health elective course to give medical students the opportunity to apply their clinical skills in a community with a population representing different ethnic and economic backgrounds.[27] The initiative focused on promoting cultural competency and understanding the needs of vulnerable population groups, through community-based, experiential learning.

The initiative began through an AHEC organized one-day clinic for migrant workers, implemented by a local physician and allied health students and progressed to the establishment of a partnership with the local community to expand health services to migrant labourers. The elective course was to be further strengthened through integration into a longitudinal curriculum focused on migrant health care. Such community-academic partnerships can offer a window of opportunity towards more formal curricular integration of learning competencies related to poverty and gender in health. It can also help fill gaps in service provision to underserved communities or populations.

Case Study 3. A problem-based curriculum

In 1996, the University of Liverpool in the United Kingdom introduced an integrated and problem-based curriculum for first year medical students.[28] The curriculum was conceptually organized around four themes: structure and function in health and disease; population perspectives; individuals, groups and society; and professional values and ethics.

Within this framework, 58 modules were developed, each addressing a different health issue. Consensus group planning was the method adopted for curriculum development. An interdisciplinary consensus group was convened for each module, with membership restricted to one per disciplinary area. Each group formulated learning objectives, teaching content and skills. Vertical integration was achieved by taking the objectives from one health issue (for example, palliative care) and locating all other modules with common or shared topics. Thus, common learning objectives were highlighted. An important element in the process was allowing all contributing disciplines to identify core content for each module.

Integrating poverty and gender into health curricula

Core educational and health professional competencies and their links to poverty and gender

Educational programmes typically aim to develop student competency in literacy and communication; critical thinking and problem-solving; interpersonal and human relationship skills; and the management of information and new technologies in a rapidly changing world. They also promote the development of a commitment to lifelong learning and cultural sensitivity.

The goal of health professional curriculum development is to address student learning needs based on population health needs and health care characteristics. Clinical competencies are essential, as are competencies related to improving the health of populations. Health professional students must also be trained to address national health issues and their poverty and gender dimensions. Core competency areas of the latter type include:[29,30,31]

- Epidemiology, health determinants, public health, population health;
- Communication, collaboration, team-building, building and sustaining community relationships;
- Accountability, organizational effectiveness, quality improvement, cost of care analysis, economics;
- Cultural competence in working with diverse communities;
- Health promotion and disease prevention; and
- Strategic planning, advocacy, politics and policy formulation, coalition-building and mobilization.

Key curriculum development questions

The choice of approach for developing a poverty- and gender-responsive curriculum depends on a range of considerations. The curriculum design processes originally described by Ralph Tyler in 1949 are still relevant today. Tyler posed several key questions relevant to curriculum development decisions, as follows:[32,33]

1. What are the purposes of the educational programme? This question encourages one to think about, justify, and delineate curricular content and its relevance to the purposes of the discipline; students' wants and needs; and the needs of the community or society served.

2. What educational experiences are related to those purposes? This question helps clearly identify the available and most suitable content, experiences and instructional methods to teach the needed knowledge, attitudes and skills.
3. What organizational methods will be used in relation to those purposes? This question relates to the context of the educational purpose and how learning experiences can be organized to better maximize relevance and effectiveness.
4. How can one determine whether the intended purposes are being attained? This question highlights the importance of designing assessment and evaluation measures to determine if the objectives have been achieved.

Rassekh argues, however, that curriculum planning is not the purely technical matter that is characteristic of Tyler's work.[34] Rather, a synthesis of the technical and critical perspectives (the latter as posed by Freire, for example) is appropriate in considering curriculum content. The following additional questions prompt more in-depth critical reflection on the place and form of an integrated poverty, gender and health curriculum:

- How and why is it valuable for students to think about and assimilate the concepts of gender, poverty and health into their way of looking at the world?
- How important to existing health care subject areas are the concepts of gender and poverty?
- To what degree might students better learn about poverty and gender if these concepts were taught as discrete subjects?
- To what degree should the curriculum contribute to broader outcomes, that is, to the health care workers overall approach to knowledge, to their development as practitioners and to their roles in society?
- How important are the concepts of justice, equality and citizenship to the existing curriculum and do poverty and gender relate to these concepts?

A key objective in developing poverty- gender-inclusive curricula is to create educational experiences for students that are meaningful in their living and working contexts. A second important objective is to establish standards in learning and content across a programme of study. Effective curriculum development reduces duplication of content areas and maximizes the scope and sequence of content across subject areas. It also allows the acquisition of knowledge and competencies associated with poverty and gender and health, ensures adequate quality, and enables students to meet both societal and professional expectations.

The process of curricular change

Curricular development for integrating poverty and gender into health professional education may be approached in a variety of ways: an existing course(s) may be modified or new content added; a series of courses may be modified; or overall curricular change may take place. Sufficient time is a necessary condition of a successful outcome, whatever type of course or curricular change is undertaken. Successful curricular change requires a series of logical steps, as well as a schedule that permits input from a range of sources and provides definite timelines for all involved.

A curricular development plan that includes the five steps necessary for integrating poverty and gender issues is outlined in Table 1. The headings represent a guide to the change process within a framework of collective involvement and consultation. Ideally, the process should follow the plan outlined, where appropriate, in order to ensure a systematic process. Nevertheless, discussions on the need for curricular change could start in either phase one, two or five.

The process begins with initial assessment and planning and continues through to continuous review and evaluation. It stresses collaboration and participation, with input and decision-making by all stakeholders, including students. It emphasizes the need for evidence-based change and for ongoing evaluation of needs and specific requirements. Suggestions for faculty development workshops focused on curriculum development and capacity-building to promote

gender and poverty integration into health professional curricula are provided in Section 4.

Step 1: Raising awareness and building stakeholder commitment

The first step involves raising awareness of the need for curricular change. Sufficient time is needed to explain and justify what is proposed. For example, decision-makers such as the Dean, Head of Department, the appropriate curriculum coordinator, or committee chairperson, will need to endorse in principle a process to determine the feasibility of integrating poverty and gender into the curriculum. The establishment of an informal group of interested persons is recommended, as

Table 1. Integrating gender and poverty into a health curriculum

1 Assessment and planning	2 Curricular development and review	3 Piloting and evaluation of the revised curriculum	4 Implementing the revised or new curriculum	5 Continuous review and evaluation
Integration of gender and poverty begins with recognition of a need, raising awareness and the formation of an informal working group, for building stakeholder commitment to change. Preliminary clearance for the proposed project is sought and a schedule for curricular development is formulated. An external situational assessment of factors driving the need for curricular change is carried out, as well as an internal curricular and institutional assessment, to determine the need for poverty and gender inclusion. Based on the assessment findings, a proposal for curricular development or revision is drafted and presented to relevant decision-makers.	A curriculum development team takes up curriculum writing and review. The committee nominates a chair, as well as relevant teachers, clinicians, students and other stakeholders. Expected learning outcomes, course objectives, teaching/learning and assessment methods and supportive resource materials are developed. Curricular documents are presented to decision-makers for formal endorsement, a process normally requiring approval of the Dean. In some countries, approval by a national health professional council, ministry or regional or institutional curriculum advisory board is also necessary, in the case of substantial curricular change. It is important to include representatives of such councils or boards on the curriculum development committee.	A group of selected teachers and clinicians undertakes piloting of revised curriculum. Modifications will be based on the feedback, comments and reflection of teachers, clinicians and students.	An organized and planned process of implementation of the curriculum takes place across all designated subject areas in the school or department.	The curriculum chairperson continues to coordinate ongoing curriculum renewal, evaluation and refinement. Curricular alterations are based on regular feedback and ongoing curriculum evaluation.

well as a preliminary review of evidence from clinical practice, regional bodies, health care policy, research and literature in order to establish the need for curricular change.

Gather information. When there is a felt need for curricular change, a useful next step is to begin gathering information to further explore the need for change, through informal reviews of data, reports or literature and discussions with peers, students, community representatives, clinicians and others. The process of gathering information and raising awareness will play an influential role in the eventual outcome. Therefore, it is helpful to solicit viewpoints from a variety of sources. Key stakeholders are listed in Resource 2 (Section 5).

Form an informal working group of interested parties. Establishing an informal working group helps lay the foundation for the change process. If there is a recognized need for curricular change, it is worthwhile talking about the perceived need with other teachers, students, clinicians or health planners. Persons interested in working on the curricular change are then invited to participate in a working group.

Build commitment. During phases one and two, small and larger group discussions are set up, where all stakeholders and interested parties, including students, have the opportunity to discuss and examine the need for a poverty- and gender-inclusive health curriculum. Conveners are expected to have examined data, evidence, reports, literature and trends beforehand, to build a commitment to change.

Create a schedule. A systematic schedule is formulated, with input from various sources, to provide definite timelines for all persons involved in the curricular change process. A working group of interested parties and stakeholders is often formed at this point, to plan a schedule and assessments to be carried out. The following considerations should be taken into account:

- How much time is available for curriculum development?
- What poverty and gender expertise exists within the department or institution?
- What poverty and gender resource materials are available?
- What budget is available to support curriculum development, staffing, and materials acquisition?
- What model of gender and poverty integration best reflects the views of the community, district, department, and majority of teachers?
- What support from key individuals or groups is needed? How will staff members respond to change and innovation?
- How should the administration be involved and informed?
- What personal concerns do stakeholders have about their involvement in the integrated curriculum design and implementation process?

External situational assessment

This phase involves external assessment of the situation, factors and needs driving the proposed change, and of the institutional philosophy, existing curriculum and resources. Planning is undertaken for the change process through assessment, analysis, goal formulation and building of stakeholder commitment. The appropriate integration model for the given educational, geographical and social context is determined after assessing cultural, population and social needs; student clinical and community practice needs; human and material resources; gaps in the existing curriculum; and faculty capacity-building needs.

A critical aspect of this phase is the development of a rationale for change, through review and analysis of factors influencing health professional education. The rationale is based on social, cultural, demographic and economic changes, significant alterations in disease patterns, new technologies, health system reforms, and environmental changes. Decline or stagnation in the health status of vulnerable groups may indicate the need to review the poverty and gender aspects of curricula, as may mismatches between educational and health system requirements; changing community and students' needs; the institution of new policies or legislation; new

research findings; technological advances; or changing educational approaches.

Internal assessment

An internal assessment is carried out to determine:[35]

- institutional values, culture and philosophy and administrative and decision-making structure;
- relevance of existing programme aims and course objectives, compared to current and future population needs and expectations;
- students' educational needs, attitudes and skills, including those identified by students;
- perceived and actual strengths and gaps in the curriculum;
- teachers' values, skills, knowledge, attitudes, strengths and weaknesses; and
- resources, including facility, equipment, teaching/learning and community resources, and potential for resource enhancement.

The fundamental principles that drive a poverty- and gender-responsive health curriculum must be consistent with the institution's values and purposes. The following points also need to be considered when developing the objectives for such a curriculum:

- The overall philosophy and values that will support the integration of poverty and gender in a curriculum. This is reflected in the rationale for curriculum change and the understanding of the importance of gender and poverty concerns as they relate to health professional education.
- The relationship between the concepts of poverty and gender and the content in each discipline/subject area.
- The expected outcomes of incorporating gender and poverty into the curriculum and levels at which these will be demonstrated.
- The types of learning environments that will produce the most effective outcomes from such a curriculum.

Defining shared academic aims requires effective leadership to promote collaborative efforts to introduce successful curricula change. It is therefore critical that input on the aims and objectives for the curriculum is obtained from all staff.

Evaluate existing curriculum

Existing disciplines and subjects are examined to determine the poverty and gender content and process or skills to be included. Methods used may include formal and informal focus group discussions with students, teachers, community workers and professional leaders. Past reviews and subject evaluation records are reviewed to identify strengths and weaknesses. In addition, questionnaires can help ascertain the appropriateness of the current curriculum and areas for change.

The opinions of key stakeholders (see Resource 2, Section 5), including students, should be obtained to assess their level of understanding and support for curriculum development related to poverty and gender, as well as the perceived quality of existing health service provision and education. Recommendations will include information gathered from stakeholders, current research and the opinions of experts or organizations working on gender and poverty.

A template to guide curricular evaluation in relation to poverty, gender and health is found in Resource 6 (Section 5). Examples of questions to be asked when evaluating existing curricula are:

- Are gender and poverty concerns adequately addressed in existing programmes?
- Can we justify why existing courses are teaching (not teaching) specific content associated with poverty and gender?
- Can you identify issues/topics for gender/poverty mainstreaming?
- Can you identify knowledge, attitudes and skills related to poverty and gender that should be included in curricula taught currently?
- Are gender- and poverty-related teaching/learning activities integrated into teaching and assessment?
- Do the recommended references, resources or research drawn upon in existing subjects reflect gender and poverty concerns? Please provide examples.

- What do you believe constitutes gender and poverty mainstreaming in your programme or subject?

Formulate goals and objectives

Once the need for curriculum change or development is established, based on the external and internal assessments, recommendations are made for the curricular development process. Goals are derived to guide the development of a revised curriculum that includes poverty and gender. It is important to consider how the identified objectives of a poverty- and gender-integrated curriculum might differ from an existing or traditional curriculum. Suggested goals or aims for the development of a poverty- and gender-inclusive health curriculum are as follows:

- Review and refine health professional education in accordance with international good practices and health policy development.
- Develop health professional education consistent with democratic ideals.
- Review and refine health professional education in line with the demands of social and economic circumstances.
- Develop knowledge of the relationship between health, gender and poverty.
- Develop analytical, critical and creative thinking skills.
- Develop learning and assessment methods relevant to poverty, gender and health.
- Expand the competencies of health care workers to include gender and poverty in health.
- Develop poverty- and gender-related competencies that are directly relevant to and readily translated into practice.
- Improve the quality of health services for specific target population groups, with particular emphasis on poverty and gender.
- Produce lifelong learners.
- Produce health professionals prepared for change.

Draft and present proposal for curricular change

In collaboration with stakeholders, a proposal document is drafted for review and comment. The proposal will be more effective if the potential benefits and workability of the change, as well as potential negative effects, are clearly delineated. Questions to consider when stating the potential benefits, impact and other effects of the curricular development are:[36]

- Will it adequately solve the problem or address the identified need?
- How many people will it help?
- How long will it help them?
- How much will it help them?
- Does it have any negative effects or might it make the problem worse?
- Are the costs reasonable in relation to the expected benefits?
- Is the curricular development/change acceptable?

Box 2: Keys to successful curricular change

Several key points contribute to the success of situational assessment and curricular change. These are:

- Vision and commitment is required from all levels. Consistent support from teaching staff, education administrators and government departments is essential.
- Supplementary and adequate resources are needed for funding curriculum development.
- Autonomy for educators is important in planning, designing and teaching in a poverty- and gender-responsive curriculum. Close collaboration among educators is essential in the development and implementation phases and all must be willing to participate with enthusiasm and commitment.
- Educator training and retraining must be provided. The overall plan must include supporting opportunities for educators to develop an understanding of a poverty- and gender-integrated approach to education and how this might be applied in the range of educational situations.

Sources: Stasz C. and Grub W. *Integrating academic and vocational education: Guidelines for assessing a fuzzy reform.* Berkeley, CA, National Center for Research in Vocational Education, 1991; Pritz S. *The role of vocational education in the development of students academic skills: An implementation guide.* Columbus, OH, ERIC Clearinghouse on Adult, Career, and Vocational Education, 1989 (Information series No.340).

- Are the development process and outcomes easy to describe and understand?
- Can the curricular change be piloted before a commitment to adoption is made?

The proposal is presented to the relevant institutional authority or curriculum committee chairperson for review. It is important to be prepared to argue the case well and to defend the need for the proposed changes. It will be useful to benchmark proposed changes to other curricula (within or outside the organization) that already lead in the area. Once the proposed curricular change is approved, the process of curricular development and review begins (Step 2). Box 2 provides a summary of key points that can contribute to the success of situational analysis and curricular change.

Step 2: Curricular development and review: a participatory approach

Form a curriculum development group. Once endorsement for project is obtained and needs identified, the proposed areas for development need to be communicated to relevant sectors, to obtain resource and management support for the innovation. A curriculum planning and development team or working group can facilitate these procedures. This involves the following processes and considerations:

Existing structures. First, consider the existing structures and responsibilities for curriculum development. Agreement among staff on any need for reforming curriculum committees is a necessary starting point.

Constitution of curriculum development committee. Those driving curriculum change will need to set up a steering group to oversee the curriculum development process. In a small country this may be a national steering group. In a large country, the steering group may be formed at the departmental or institutional level.

Membership of curriculum committee. The curriculum development team members can be nominated or elected. There are a number of points to consider in relation to committee membership:

- The chair should have expertise in curriculum planning and design related to the integration of the concepts of health, gender and poverty. The chair will be responsible for the overall management and communication with other parties, such as committees for assessment and resource development.
- Members should include qualified writers with recognized oral and written communication skills and a background in course development.
- Members should have collective expertise in educational methods, curriculum planning and design and gender and poverty.
- The committee should include students and those who are respected by peers and management and fully support curriculum change and development.
- Members should reflect diverse disciplinary and experiential backgrounds.

Roles and functions of the curriculum development committee or working group

The curriculum development committee formulates curricular objectives, content and methods in line with the situational assessment and the needs of stakeholders. Curricular design, content, methods and resources should give students the opportunity to acquire the knowledge and skills to respond to a variety of community health care needs including those that arise from poverty and gender.

The curriculum development committee will be partly or wholly responsible for:

- *Ensuring stakeholder and organizational commitment and support.* The committee secures organizational and government support by holding frequent discussions on the need and process for integrating poverty and gender into the curriculum. Success depends on support from a range of stakeholders from within the institution, the government, community organizations and the community (see Resource 2, Section 5). Faculty and department heads, administrative staff and students need to be involved.

- *Managing budget considerations*. A sustainable programme depends on a realistic and negotiated budget. The committee identifies existing resources and estimates the additional financial or human resources needed. These may include part-time teachers, training for staff and educational resources such as library facilities, up-to-date literature, audio-visual equipment and Internet access.
- *Identifying curricular resources*. The committee identifies and coordinates all research and resources related to the curriculum, including teaching expertise, resource persons, course content; learning and teaching models, evaluation tools and clinical or community practice sites.
- *Facilitating curriculum design*. The committee creates a process to facilitate curriculum redesign at a local level, directed by faculty, with input from a broad spectrum of interests.
- *Preparing curricular documents*. The committee develops documents, including objectives, expected learning outcomes, content, teaching/learning and assessment methods, based on relevant research and the requirements of students, the school and the community.
- *Providing professional development opportunities*. The committee orients persons involved in curriculum change. The orientation addresses process and content issues in relation to health, poverty and gender capacity-building.
- *Ensuring ongoing review and revision, including impact evaluation*. The committee ensures that the developing curriculum is subject to ongoing review, comment and revision.

Draft a poverty- and gender-responsive curriculum. As noted previously, the successful development of a gender- and poverty-responsive curriculum requires commitment and involvement from staff and students. In preparing a draft, a systematic approach considers the following:

- *Formulation of expected learning outcomes* or competencies, based on the situational analysis, recommendations and curricular revision goals. The learning outcomes should focus on the application of poverty- and gender-related content and critical thinking, independent learning and problem-solving skills. Suggested expected learning outcomes or competencies of a poverty- and gender-responsive curriculum are listed in Box 3.
- *Designation of small groups to develop modules or subject areas*. This depends on the choice of curricular model or approach. A fully integrated or problem-based curriculum usually requires interdisciplinary groups that develop a curriculum design for the sequencing and timing of poverty and gender content. Discipline-specific curricular change may use small groups, with external facilitation or input as required. The revision of a course or development of a new course or in-service programme may require only one group.
- Each group develops relevant *learning objectives* for their course or area, focused on a gender and poverty integrated view of health. They then develop appropriate *teaching/learning, assessment and evaluation methods*, linked to the expected learning outcomes and course or module objectives, taking into account programming, resources and contextual factors. Teaching/learning methods that support a

Box 3: Examples of learning outcomes of a poverty- and gender-responsive curriculum

At the end of the educational programme, the students will have:

- developed understanding and awareness of the importance of poverty and gender in health;
- demonstrated critical and analytical skills in addressing poverty and gender issues in health;
- demonstrated an ability to integrate poverty and gender concerns into the delivery of comprehensive, quality health services;
- developed attitudes that facilitate and promote a poverty- and gender-responsive approach to health practice; and
- demonstrated the application of advocacy skills that support improved health outcomes, especially for vulnerable or marginalized groups.

variety of learning styles are described in Resource 3 (Section 5). A range of assessment methods and opportunities to apply knowledge in community and professional settings are preferable (see Resource 4, Section 5).

- *Curricular resource materials are developed* for teachers, with current evidence supporting the educational content. The evidence includes national and international data on the relationship between poverty, gender and health; research and literature that reflect poverty- and gender-related content integration; and methods for poverty- and gender-related assessment and intervention.
- The curricular development committee compiles the work of each small group and *prepares a full draft document* for feedback by all stakeholders.
- Following any necessary revisions, a *final curriculum* and supportive documents are presented to the Dean and, where applicable, the institutional advisory board and/or professional council for formal endorsement.

Strategies for overcoming barriers to the integration of poverty and gender

Changing the curriculum may be viewed as an additional burden and requires an adjustment period. People are unlikely to welcome extra work, if they have low commitment to the idea of integrating poverty and gender into the curriculum. The transition may not only be

Table 2: Possible sources of resistance and strategies for addressing them

Possible sources of resistance	Strategies for addressing resistance
Lack of conviction about need for a poverty- and gender-inclusive curriculum	• Ensure active support from department heads and administration. • Clarify and justify the need for curricular change. • Ensure majority agreement that the present curriculum does not adequately address poverty and gender. • Be aware of existing work pressures.
Unresolved uncertainties about curriculum reform	• Involve teaching staff and community representatives in all phases of planning and development. • Document and make transparent all processes of change, including challenges and issues.
A strong sense of ownership of existing content	• Provide evidence of the links between poverty, gender and health as they apply to all subject areas. • Encourage broad-based debate on alternative curriculum models and the relevance of poverty and gender content. • Value existing skills. • Ensure curriculum development is open and inclusive.
The entrenchment of traditional teaching methods	• Organize information sessions and workshops on curriculum change and alternative learning approaches.
Concern about lack of resources to support curriculum change	• Make visible available resources. • Provide adequate assistance and resources for change.
Concern about lack of required skills/knowledge	• Invest in training and capacity-building.
An existing institutional culture which may reward research over other activities	• Integrate curriculum development and teaching scholarship into promotion and appointment decisions.

difficult for staff but also for students. They need a realistic idea of what to expect and how they will be supported in the process.

Success depends on effective communication, planning and orientation. Awareness-raising seminars provide an opportunity to discuss the need for change based on research and practical examples. They also encourage debate on the philosophical and technical aspects. It is important that all views be heard and acknowledged. Teaching staff and community and professional representatives will need to be involved in appropriate in-service training. Successful participation will bring broad based support for change and for effective implementation.

Staff members will need time to plan and develop subjects and the course. It is important to release staff from other duties or, at minimum, to recognize and give support for workloads. Options may include hiring temporary staff, drawing on subjects or units for existing courses, raising external funds to release staff, limiting the number of students taught at one time, or accepting increased workloads as a team decision.

The many reasons for resistance to change, such as those outlined in Table 2, must be acknowledged and addressed as they arise.[37,38] Such issues may arise more in teaching departments that are understaffed or where a project leader inadequately facilitates a team environment.

Successful curricular change

Without proper consideration, curricular change efforts may fail. For this reason, potential barriers to development and implementation must be considered. Constructive discussion on tensions that sometimes arise between students, academics and course developers, such as those related to course assessment or the utility of knowledge, can lead to new insights for all. An awareness of the likelihood of challenges and leadership skills are needed to resolve conflict. As with any change, the process will require clarity, conciseness and commitment

The success of integrating poverty and gender concerns into health curricula depends on a shared acceptance of changes. Therefore the primary proponents need to be prepared to address existing and potential barriers. In any process of change there will be key groups and people to whom you must explain your goals, set out proposals and defend aims and objectives. The following are key stakeholders that need to be consulted for the successful integration of poverty and gender into a curriculum and to reduce resistance to change:

- **Curriculum committee:** In what ways will the curriculum committee be an influential partner in curriculum development? The project leader will need to argue the pedagogical, social and professional reasons why the changes proposed are necessary for students, the discipline and the area. Members may raise questions such as budget limitations. Objections from academic staff should be anticipated and taken into account. It is helpful to speak with key people prior to proposing changes through the committee(s).
- **Leaders:** Consider how your leaders might respond to or resist change. Plan for the likelihood of resistance based on advice and your knowledge and experience.
- **Students:** Explore if students can help in encouraging change and overcoming resistance. Investigate ways to include the voice of supportive students.
- **Socio-cultural resistance:** Take into account the likely impacts of curriculum development on the cultural and socio-political environment. In what ways might stakeholders in the community resist an increased emphasis on poverty and gender? Plan for their objections and develop strategies to promote understanding of the importance of the changes proposed.

Step 3: Piloting and evaluating a revised curriculum

The curriculum should be piloted to refine content and approaches to instruction and assessment, particularly when the changes are significant. The purpose of piloting and

evaluation is to test the curriculum in action so that necessary improvements can be made based on input from teachers and students. Feedback received may relate to available learning resources, curriculum implementation, assessment or the relevance of the curriculum development process.

Staff are selected for piloting based on agreed criteria (for example, knowledge, expertise or interest in poverty, gender or the subject area). Staff will require orientation to the goals and expected outcomes of the changes, the teaching/learning and assessment methods, and processes for ongoing feedback and further curricular refinement or development.

When pilot evaluation is completed, the outcomes are reported back, with clear recommendations, to the curriculum development committee. Implementation occurs once the proposed curriculum has been evaluated, revised as required and endorsed by health, education and registering/governing bodies.

Step 4: Implementing a poverty- and gender-responsive curriculum

It is one thing to examine an existing curriculum for shortcomings in gender and poverty integration and to suggest ways to fill these gaps. It is a quite different and more challenging task to implement a gender- and poverty-integrated curriculum. Stage 4 of the plan involves the initiation of the agreed curriculum. Curriculum development is as much about altering the overt curriculum as about professional development and other levels of integration. For example, it must be ensured that the concepts that have been painstakingly integrated into the curriculum document are actually taught (and are not part of the null curriculum) and that the formal curriculum, as expressed in resources and learning activities, is designed to facilitate learning about poverty and gender in health.

Curricular change must be accompanied by the procurement of necessary resources, faculty capacity-building and establishment of links with community practice sites. It involves recognition of substantive knowledge; respect for the intellect of teachers; collaboration; local leadership and structured follow up; the opportunity for staff to make the transition; and a realistic and uninterrupted time span, projecting a lag between the beginning of curriculum change and full implementation in classrooms.

When beginning curriculum reform, it is best to start with areas where two or three units or subjects integrate well. A unit that simply touches on issues of poverty and gender is not a well-designed one, nor does it ensure full integration of poverty and gender concepts. It is therefore important that the objectives of an integrated unit, module or course all be equally important, equally taught, and equally assessed. As teachers and students become more comfortable with the new teaching/learning approaches, poverty and gender concepts can be integrated into more ambitious courses or subjects.

Box 4: Key steps of successful curricular design and implementation

- Ensure flexibility in designing the new curriculum. Approach implementation not dogmatically but as "work in progress."
- First revise content in areas that seem to be the most compatible and move toward the less obviously compatible.
- Decide on change strategies. Change can be applied across the curriculum or may start from a single subject, unit or stream of clinical practice modules, such as community-based care. It may be undertaken by a relatively small group of committed staff that introduces the changes to their courses.[39,40]
- Provide resources for training teachers to develop a thorough conceptual understanding of poverty and gender education and skills for teaching a poverty- and gender-responsive curriculum.
- Process and skills are what students must be able to demonstrate. Adopt or modify assessment measures as teaching staff reflect on ways to assess poverty and gender in each disciplinary area that are appropriate to the content, aims and objectives of the course.

Standards and benchmarks for each subject area must be reviewed to ensure consistent focus on rigorous lessons that target clear objectives. A schedule for the content that is practical for all teachers and students should be created. Finally, implementers need to continue meeting during implementation to discuss strengths, weaknesses, challenges and lessons learned and adjust accordingly. At the end of the term, each teacher might prepare a brief report of planning and teaching initiatives on the following questions:

- What changes did you make to integrate concepts related to gender and poverty into your course or subject area?
- How would you describe your inclusion of gender and poverty issues into the course or subject area?

The key steps of successful design and implementation of a new or revised curriculum are summarized in Box 4.

Step 5: Monitoring and evaluating a poverty- and gender-responsive curriculum

Evaluation is an integral component of any curriculum. The curriculum relates to the totality of the process of education, including: objectives, learning activities, learning outcomes, human and material resources, evaluation, the management of change and social and cultural practices. Curriculum evaluation involves gathering evidence to determine if the objectives are being fulfilled and to identify issues as a guide to ongoing decision-making. This process needs to be transparent, well documented and accessible to all stakeholders.

Key concepts in evaluation are *reliability* and *validity*. *Reliability* refers to the extent to which the same results are achieved through repeated evaluation. *Validity* refers to the accuracy of the evaluation results as they apply to practice. For example, the validity of health programmes can be judged from the extent to which they succeed in responding to the needs of the community. A detailed overview of curricular evaluation strategies, approaches and tools is found in Resource 5 (Section 5).

Evaluation of a curriculum is a complex and ongoing process that involves several components, including:

- **Monitoring**, which assesses whether a curriculum is implemented as planned and how curriculum change is managed. The process includes ongoing feedback on planning and implementation and enables the identification of problems as they arise.
- **Process evaluation**, which relates to the implementation and delivery of the curriculum. Key issues here include professional development and the availability of adequate staff and resources.
- **Cost-effectiveness evaluation**, which assesses the ongoing costs of curriculum change, particularly as they relate to the perceived benefits of instituting a poverty- and gender-focused curriculum. Justification of costs is essential and will be judged in part on the evidence of outcomes.
- **Impact evaluation**, which determines whether the revised curriculum produces the desired outcomes for students, the organization and the community. Of particular importance is the extent to which the objectives of a poverty- and gender-integrated curriculum can be judged to have been met.

It will be difficult in the short term to determine the socioeconomic benefits of a poverty- and gender-responsive curriculum. Students' successful completion of courses will provide some evidence of the development of knowledge and skills. However, a comprehensive evaluation process must also address current and future health needs of all people; the changing demands of the disciplines and students; staff expertise, knowledge and skills; and the requirements of registering or governing bodies. Good evaluation ensures that the curriculum remains dynamic and subject to continuous improvement. The curriculum development committee, in collaboration with the institutional curriculum committee, will be responsible for working with various stakeholders to identify and develop the required review and evaluation tools and methods.

Issues to be considered in monitoring and evaluating a curriculum include:

- **Feedback:** Assurance of feedback from a variety of sources and stakeholders, including students, teachers and consumers or communities.
- **The degree to which stated outcomes/objectives are achieved:** The traditional method is to demonstrate learning outcomes as measured by final grades and clinical practice performance. However, other approaches to evaluation are required for long-term outcomes, which may not be identified in the objectives of the curriculum.
- **Implicit and explicit objectives:** An emphasis on assessment of explicit objectives can produce good results but may obscure a general dislike of a subject area. Implicit or hidden outcomes, such as the social and cultural context of an educational process, may actually determine whether poverty or gender get more or less emphasis in health services. It is important to evaluate the broad focus and emphasis of the educational institution through a range of methods.
- **Intended and unintended outcomes:** All outcomes, whether intended or unintended, desirable and undesirable, should be identified. An unexpected outcome might include closer links between educational and clinical organizations in achieving poverty-, gender- and health-linked objectives. A positive result could be the creation of a credited course conducted in a clinical or community environment.

The preceding points indicate the need for a range of curriculum evaluation tools. The process of curriculum evaluation, however, must be practicable and manageable. It must also be carefully planned, systematic and ongoing. Most importantly, it must have the support of key people, in particular the educators involved.

The process of curriculum evaluation has never been more important or more complex. Education is not simply a set of techniques, but a process with direct implications for the social and economic well-being of a community and society. Health professional education must therefore be publicly and rigorously accountable to all sectors involved in the planning, provision and financing of health care. Methods of evaluation must be inclusive and flexible, to ensure the broadest range of feedback on curriculum development.

Exploring windows of opportunity for curricular change

Demonstrating that poverty and gender are relevant and appropriate for inclusion in the curriculum may result in agreement in principle to work on the changes needed. The following suggestions relate to some windows of opportunity to obtain evidence and support for integration:

- Develop collaborative clinical practice or rotations, that include health services provision inherently involving gender and poverty. For example, students could be rotated to a community setting located in a poor area.[41]
- If the programme has an elective as part of its curriculum framework, prepare a new elective focusing on poverty, gender and health issues.
- Establish links for support and guidance with any national or international institutions that have already integrated gender and poverty into their curricula. Use their achievements as an example of innovative and proactive curriculum development in response to global changes, demonstrated health care challenges, and professional leadership.
- If funds are available for small teaching and learning grants, start a project to develop a subject or curriculum to better educate students on key clinical practice knowledge and skills related to poverty and gender. Grants may be obtained, for example, for running workshops, seminars and other forums as both information and planning sessions.

Conclusion

The curriculum development process outlined in this module does not assume one definitive

approach to the integration of poverty and gender within a health curriculum. The type and length of the existing programme, the proposed scope of change, the existing content of courses and resources available will determine the form and level of integration.

At any level of integration, however, the primary objective will be to ensure a conceptual and practical understanding of the essential relationship between poverty, gender and health. A poverty- and gender-responsive curriculum needs to reflect local conditions, social structures and cultural norms. The goal is to educate health professionals to appreciate and develop competencies related to the real life context of their work.

This module has provided the bases for addressing the what, why and how of integrating poverty and gender into health curricula. It has reviewed key issues, approaches and strategies for facilitating curriculum change in order to prepare health professionals who have the capacity, and are committed to, bringing about social change.

4. Facilitator's Notes

4. Facilitator's Notes

These notes are provided to support facilitators as they work with learners on integrating poverty and gender issues into specific health topics. Facilitators are recommended to refer to Section 5 of the foundational modules of this Sourcebook, dealing respectively with poverty and gender, which contain additional notes on the target audience, role of the facilitator and suggested methodologies for learning sessions and for evaluation

Expected learning outcomes

By the end of the module, participating health professionals will be able to:

- understand what a curriculum is and be aware of a range of approaches to curriculum design;
- discuss why it is important to integrate poverty and gender concepts into health curricula;
- understand the importance of developing a participatory curriculum to foster student understanding of, and competencies related to, poverty, gender and health;
- discuss how poverty and gender concepts can be integrated into health professional education curricula; identify key issues related to developing a poverty, gender and health focused curriculum;
- monitor and evaluate the integration of gender and poverty into health curricula and the impact of curricular integration; and
- be aware of various training aids, their strengths and weaknesses, and possible ways to include them in training sessions.

Training workshops

The main goals of the suggested workshops are to develop knowledge and skills to promote the integration of gender and poverty into health professional educational curricula. The proposed workshops provide learning objectives and possible teaching activities that focus on a given area of the curricular change process. Each workshop is an opportunity to reflect and critically examine ways to integrate poverty and gender concerns into curricula.

The workshops aim to:

1. Enhance skills and knowledge for successful integration of gender and poverty into health professional educational curricula.
2. Foster strategies for collaborative development.
3. Develop reflective practice.
4. Strengthen planning, implementation and evaluation skills and knowledge.
5. Foster partnership between participants by creating formal and informal networks.

The workshops emphasize interactive teaching and learning methods and reflective practice. During each workshop, participants reflect upon their own education experiences, to promote curriculum improvement. Participants are encouraged to listen to the views of others and to relate their own views on curriculum change and on gender and poverty. The workshops focus on leadership, collaboration, consultation, shared decision-making and regular evaluation.

Workshop 1: Knowledge and skills for curriculum revision to integrate poverty and gender: Assessment and planning

Knowledge and skills in curriculum development: This workshop explores strategies through which the views, opinions and values of stakeholders are harnessed to inform the curriculum development process. Stakeholder and peer consultation is a key strategy in evaluating existing curricula and community and educational needs. Fundamental to any curriculum change is the need to consult with and consider the strengths and weaknesses of institutions and groups that will influence effective curriculum revision.

Objectives: Upon completion of this workshop, participants should be able to:

1. Plan for undertaking a process of integrating gender and poverty into curricula.
2. Undertake a stakeholder analysis.

3. Identify challenges within a current curriculum.
4. Identify planning objectives central to the successful integration of poverty and gender into curricula.

Possible learning activities

- Undertake a discussion and whiteboard exercise to identify key stakeholders and methods for including and consulting with them as part of curriculum revision.
- In small groups, identify your organization's strengths and weaknesses that may impact curriculum change.
- In small groups, list major challenges confronting plans for curriculum revision and suggest strategies for overcoming them. Report on findings and discuss in the larger group.
- In small groups, identify key challenges related to curriculum revision and the organization. In the larger group, list and prioritize the identified challenges to determine key themes, problems, areas for development and expected resistance related to curriculum development and organizational change. Based on the list generated, identify and record key objectives for the successful integration of gender and poverty into curricula.

Workshop 2: Managing the incorporation of gender and poverty into a curriculum

Managing curriculum development: This workshop examines current and future health care practice, shared governance, assumptions and reasoning behind curricular development and approaches to the development and review of curricula.

Objectives: Upon completion of this workshop, participants should be able to:

1. Identify key objectives central to the successful integration of poverty and gender into curricula.
2. Plan for the training and organizational change needed.
3. Provide participants with the skills and knowledge to foster shared decision-making in curriculum development.
4. Identify useful strategies to address resistance to curriculum development.
5. Develop a curriculum model for a poverty- and gender-focused health curriculum.

Possible learning activities

- Develop and act out a role-play entitled "what is in and what is out of the curriculum." Justify the focus of the role-play with particular emphasis on explaining how decisions were made within the group.
- Develop a curriculum map showing when and where you would integrate poverty and gender concepts and content into a health professional curriculum.
- Compare curriculum integration models and select one for your organization. The choice will depend on such factors as cost, availability of staff and resources. Justify your choice.

Workshop 3: Working effectively to bring about poverty and gender integration into a curriculum

Working to effectively bring about curricular change: Collaboration, awareness of gender issues, appropriate political action and reflective processes are keys to working effectively to integrate gender and poverty. This workshop fosters collaborative partnerships between stakeholders such as the government, local health care providers, health care organizations and grassroots health workers. This workshop provides an opportunity for participants to share relevant experiences and reflect on the social and educational challenges involved in revising health curricula to include poverty and gender perspectives.

Objectives: Upon completion of this workshop, participants should be able to:

1. Establish partnerships within educational organizations and with community bodies to undertake training, programme enrichment and project development.
2. Demonstrate the skills necessary to assess, plan and carry out gender- and poverty-responsive health curriculum development.

3. Communicate to relevant stakeholders an understanding and appreciation of how their efforts can affect the work environment and ongoing curriculum development.
4. Create a work culture that fosters partnership and minimizes conflict and misunderstanding.

Possible learning activities

- Create a script or scenario and present a role-play that expresses possible challenges when seeking to convince a head of school or division about the importance of integrating poverty and gender into the health curriculum. Discuss issues related to the theme and major characters included in the role-play. How realistic was the role-play? Why?
- Write a letter to a friend who is a famous educator. Explain your concerns about your current curriculum and outline how you might address them. Ask pertinent questions that come to mind. Exchange your letter with a fellow participant for a response. In a further session, outline to the group the questions each participant asked and list the answers that were received. Discuss the questions and answers within the group.
- Create a tourist brochure outlining key instructional goals and assessments to be used in your curriculum in order to integrate poverty and gender. Make a list of key sites (key assessment plans) to be included on the itinerary.

Workshop 4: Evaluating change and curriculum development for the integration of gender and poverty into a health professional curriculum

Evaluating change and curriculum development: The aim of this trainer's workshop is to enable participants to develop the skills and knowledge necessary for evaluation of the outcomes of curriculum integration and development. Evaluation of the integration of gender and poverty into health professional curricula requires methodologies that identify, assess, and interpret the consequences of such integration. Participants learn what such integration means, why it is important, and how evaluation can inform ongoing development and revision of a gender- and poverty-responsive curriculum. The goal of evaluation is to assess outcomes from strategies to revise the curriculum and identify directions for future policies, programmes, and projects.

Objectives: Upon completion of this workshop, participants should be able to:

1. Identify the strengths and weaknesses of curriculum evaluation methods.
2. Develop analytical tools to assess, plan and evaluate health care programmes from a gender and poverty perspective.
3. Apply analytical strategies to assess, plan, and evaluate the integration of poverty and gender into the health curriculum.
4. Demonstrate knowledge and insights into curriculum evaluation.
5. Document a programme for the ongoing evaluation of a poverty- and gender-focused curriculum.

Possible learning activities

- Dramatize a group situation where a curriculum that incorporates concepts related to poverty and gender is being designed. One of the participants is required to be resistive to change. Examine the concepts, conceptions and major issues that are presented by participants. Is their portrayal realistic? Why?
- In small groups, design an evaluation document based on a designated method. Pose the objectives of the evaluation, who is to be evaluated and the information to be gathered. Present to the larger group and discuss.
- Design a draft evaluation document that sets out timelines and is inclusive of all stakeholders.

Workshop 5: Longitudinal assessment: Reflecting on the challenges and successes of integrating poverty and gender into a curriculum

Evaluating long term change and curriculum development: Evaluation is key to developing,

maintaining and improving strong curricula that are responsive to societal and community needs. Focus groups, questionnaires, anonymous feedback and gaining the views and expectations of faculty members, students, the organization and the community, as well as the inclusion of outside experts in the evaluation process, are keys to the success of any course. Moser[42] suggests that an appropriate framework for evaluating the success of training addresses:

1. changes in the attitudes, skills, knowledge and behaviour of participants;
2. changes in the structure and operational procedures of institutions; and
3. external impact: more efficient use of resources and increased quality.

Although point 3 (the last part of the framework) requires a longitudinal approach and is difficult to assess in the early stages of any curriculum development process, it should be embraced, particularly within the establishment of a partnership model.

Objectives: Upon completion of this workshop, participants should be able to:

1. Identify the long-term economic and social objectives of a poverty- and gender-focused curriculum.
2. Identify methods for the evaluation of changes in participants, in institutions and in communities as a result of curricular change.
3. Prepare a document that sets out a plan for the long-term evaluation of a poverty- and gender-focused curriculum.
4. Analyse key indicators of the impact of the implementation of curricular change.

Possible learning activities

- In small groups, create a dialogue (skit) that communicates expected outcomes of integrating poverty and gender into a curriculum. Perform the dialogue (skit) for the larger group, highlighting both successes and challenges. Afterwards discuss each dialogue (skit) and list the major outcomes that have been portrayed. Identify major issues and ways to enhance integration, understanding and cooperation.
- In small groups, determine ways to best use established partnerships to further enhance integration of poverty and gender into health professional curricula.
- Discuss within the group approaches to further advance curriculum redevelopment. Determine long-term goals and how they should be measured.
- Design a draft document that sets out long-term objectives and methods for evaluating those objectives.

5. Tools, resources and references

5. Tools, resources and references

Additional resources

Resource 1: Curriculum models

What is a product- or subject-centred curriculum?

Contemporary learning recognizes that most work situations demand an integration of knowledge, skills and information and that deep learning occurs when links are created between knowledge disciplines. However, traditional subject- or product-centred curricula focus on transmitting specific knowledge, skills and information thought to be distinct to particular academic disciplines. Frequently, they rely on rote learning and pay little attention to applying the knowledge and skills in health service contexts.

This approach may not provide the opportunity to develop the critical thinking and problem solving skills that are central to learning. Nor does it necessarily encourage students to relate knowledge to the realities of communities. A subject-centred approach often has little room to introduce knowledge and skills on gender and poverty because these need to be drawn from a range of discrete discipline areas.

What is a student-centred curriculum?

A student-centred approach arises from the needs, interests and work of students and acknowledges their prior knowledge and experience. It emphasizes the content needed to meet the requirements of the profession, but the method shifts the focus from the content to the learner.

A student-centred curriculum is based on the assumption that deep learning occurs when students are actively engaged in constructing knowledge for themselves. The approach assumes that knowledge is used to solve problems and that knowledge, attitudes and skills need to be transferable and relevant to people's working lives and their roles as citizens. However, knowledge is not the only goal. Students also need to develop critical thinking skills and the ability to apply their knowledge and skills in various contexts. As Hubball[43] argues, a student-centred approach is part of a broader process of change.

A potential risk to this approach is the assumption that students dictate education, with the potential for a chaotic learning environment, if the teacher is not trained in student-centred methods. A student-centred approach does not mean full autonomy for students. While students are active participants, the teacher remains the authority and has a sound understanding of subject matter and methods.

What is a competency-based or core curriculum?

Competency-based education focuses on practitioner skills and the ability to work safely, efficiently and effectively. Competencies in core learning areas are achieved gradually as students develop and apply theoretical knowledge to practice, based on the best available evidence. Such a curriculum is usually developed in four steps: identify appropriate competencies, devise an education programme, establish agreed and appropriate assessment methods, and determine minimum standards.

This approach has become prominent in undergraduate and postgraduate health practitioner education in many countries.[44] For example, in the 1990s, groups such as the Australian Nurses and Midwifery Council (ANMC) established competency standards for nurse education and practice. The ANMC adopts an integrated perspective, interpreting competency as a complex combination of knowledge, attitudes, skills, and values displayed in the context of task performance. Competencies are identified at the levels of novice, beginner and expert practitioner. The International Council of Nurses has also developed core competencies for generalist nursing education.

Arguments for competency-based education emphasize the pragmatic nature of education and the necessity to ensure practitioners are trained so that they can meet the needs of society. Health professionals are educated to meet current health needs and acquire transferable skills.

Competencies are to be continually updated to meet future needs. The approach encourages individualized and flexible learning, adherence to established standards and increased public accountability. The approach focuses on competencies achieved rather than time taken. Ideally, competency-based programme candidates progress at their own pace.

Competency-based education is criticized for being 'reductionist' and techno-task-oriented. Critics claim that this approach teaches discrete *behaviours* without reference to the socio-economic context, discounts the qualities of students and focuses on training rather than education. The focus on discrete tasks rests on a functional analysis of work roles and may do little to meet higher-order learning goals. It may ignore connections between tasks, the individual attributes of practitioners that underlie performance, the intention behind actions, the health care context and interpersonal and ethical challenges.[45,46] Measurement techniques, when reliant solely on a "checklist" approach to assessing performance, highlighting achieved or not achieved, are simplistic and may not motivate students.[47]

The success of this approach depends on the identification of appropriate standards and an educational approach that meets the health needs of a changing society. Appropriate candidates need to be recruited and detailed curriculum content, objectives and goals developed for their education and assessment.

What is a problem-based or problem-centred curriculum?

Problem-based learning focuses on developing problem-solving skills so that students can address problems they are likely to encounter in their personal or professional life. The assumption is that learning occurs in the context of social interaction. In such a programme, students move through a process of defining problems, developing alternative hypotheses and evaluating strategies to address the problems. They are encouraged to obtain, evaluate and apply evidence to develop appropriate solutions.

Problem-based learning has been introduced as an alternative method that prepares students for the real world of clinical practice.[48] It is argued that solving real-life health care problems, as opposed to sitting through lectures that are taught out of context, assists students to address clinical challenges and fosters teamwork.

Problem-based curricula have distinct characteristics that include:[49]

- Reliance on problems as a basis for the curriculum: problems are not necessarily designed to test skills but to help develop them.
- There is no one solution to the problems, because of ever new and emerging information. Learning becomes reiterative and perceptions of problems and solutions grow.
- Students are the primary solvers of problems and the teacher works as facilitator and mentor.
- Performance-based assessment becomes part of the learning process.

A criticism of problem-based curricula is that it needs cultural change for successful implementation. Teachers must be prepared to alter the balance of power in the classroom, move their focus to students and change accepted teaching strategies.[50] The approach also relies on equal and high student commitment because it uses group contexts. Reluctance by teachers and students to make these changes can hamper success.

What is an integrated curriculum?

An integrated curriculum connects an area of study by cutting across subject lines, emphasizing unifying concepts and locating specialized fields of knowledge within a broader context. It identifies relationships between past and present experiences and future learning. Teaching subject areas across disciplines according to natural connections rather than in isolation from one another increases student understanding. An integrated curriculum that includes poverty and gender would explore knowledge in all subjects as related to poverty and gender.

Curriculum integration is planned and organized in advance to enable students to recognize how knowledge areas, concepts and skills are interrelated. It requires a shift from content-centred teaching, learning and assessment methods. This type of instructional environment enhances thinking, problem solving and integration of knowledge.

Resource 2: Potential stakeholders for inclusion in curriculum development

Individuals

- Head of school;
- Dean of Faculty;
- employers;
- general public;
- position holders in specialist organizations and professional bodies;
- overseas advisers and consultants;
- students;
- suppliers of services and equipment
- course coordinators;
- educational advisers;
- lecturers, teachers and coordinators of subjects or content areas;
- part-time or contract teachers involved in the curriculum;
- practitioners from practice areas;
- consumers of services;
- directors of specialist departments; and
- managers and administrators.

Organizations

- curriculum advisory committee;
- university, college, faculty and school curriculum committee;
- faculty and school staff;
- professional bodies and organizations;
- government departments;
- members of specialist groups;
- lobby groups;
- university, college, faculty and school administration;
- other schools and departments that service the curriculum;
- other universities and colleges that offer similar courses;
- members of associated professional groups and bodies;
- professional registering bodies; and
- government representatives.

Advocacy for change: Potential international and national bodies

At the international and national levels, advocacy for introducing changes in the curriculum may be directed to the following bodies:

At the international level:

- professional licensing bodies;
- professional associations: Commonwealth Medical Association (CMA), World Medical Association, Sigma Thea Tau;
- United Nations agencies (UNESCO, UNFPA, UNICEF, WHO, United Nations Commissioner on Human Rights) and the World Bank;
- International Council of Nurses;
- International Federation of Medical Students Associations (IFMSA);
- World Association of Medical Education (WAME); and
- networks of community-oriented medical/health institutions.

At the national level:

- medical and nursing licensing bodies;
- principals and deans of schools, faculties and colleges;
- national professional associations;
- national human rights institutions;
- national medical women's groups;
- religious leaders;
- ministries of health and education;
- funding agencies;
- national student organizations and groups; and
- media representatives.

Linking curricular change to evidence

There are numerous sources of evidence establishing the interrelationships between poverty, gender and health. Population, health and demographic statistics can all be used in teaching. Recommendations by key leaders in your discipline and international health organizations on integrating poverty and gender into the

curriculum will support local efforts to do so. Sources for evidence to support recommendations related to curriculum development in the area of poverty and gender are included at the end of this module.

Resources on the Internet

Instructional resources that contain language arts, visual arts, music and other teaching and curriculum resources can be found on the following websites:

- A Participatory Approach to Curriculum Development (http://www.fao.org/sd/EXdirect/EXan0017.htm, accessed 22 August 2005); (http://www.fao.org/sd/EXdirect/EXre0030.htm, accessed 22 August 2005).

Resource 3: Teaching and learning about poverty, gender and health

The integration of poverty and gender in existing health professional education curricula needs a methodology that supports a range of learning styles and an instructional model that teachers and participants find relevant.

Approaches to teaching poverty and gender in health curricula need to be based on adult learning principles and personal reflection. Methods must be interactive and draw upon strategies that stimulate, reinforce learning, draw on past experience, emphasize a vision for the future, and meet individual needs. Teaching strategies, therefore, must be student-centred. This will provide opportunities to engage in inquiry relevant to their context and learn from the experience of others. Gender and poverty issues differ across contexts and participants need to be encouraged to examine gender- and poverty-related curriculum development as they relate to their particular social climate.

Successful teaching methodologies draw upon various strategies, such as discussion groups, formal lectures, video/films/media, case studies, role-plays, and clinical visits to health care providers, facilities and communities. An important point to note is that it is a team endeavour and must meet the needs of the particular culture, practitioners and community. Teaching strategies suggested in this module are methodologically appropriate but should not be considered as the only roadmap for the journey.

Lectures and group work

Lectures provide a forum to deliver content essential for familiarization with key issues and concepts related to poverty and gender. However, though efficient for transmitting information, lectures are a passive form of learning. Information retention may also be limited, without sufficient feedback or discussion. Interactive teaching enhances student learning through discussions, group activities, exercises or games.

Interactive techniques, such as small group presentations, role-plays, discussion groups and simulation games, help explore experiences and allow expression of values and beliefs. For example, discussion groups provide immediate feedback and the chance to seek clarification or correct misunderstanding. Good facilitation of group discussion ensures open discussion and critical reflection on key issues relating to poverty and gender in health. An important objective is to consider how knowledge of these issues might be applied in practice. Van Ments[51] finds that group work:

- encourages the flexibility to modify opinions;
- provides an effective way to change attitudes;
- recognizes and values individual differences;
- encourages discovery of personal strengths and weaknesses;
- facilitates the identification of assumptions that underlie opinions and actions;
- provides an opportunity to compare personal beliefs and behaviour against standards held by others;
- provides the opportunity to extend communication skills;
- encourages commitment to the implementation of actions;
- supports the application of principles to problems;

- encourages a questioning attitude to research and evidence;
- encourages clear analytical thinking while allowing for explanation and clarification;
- serves as a powerful means of enhancing self-esteem; and
- satisfies social needs and provides motivation for further learning.

The following examples of scenarios could be adapted for teaching in large or small groups:

- Create a newspaper article that draws attention to some major findings in relation to poverty and gender in health. Discuss in a group what should be the major focus of the article and what information the article should draw upon.
- In small groups, analyse selected health journal papers and textbooks to establish whether they cover topics in a gender-balanced manner and how they could be improved. Present findings and recommendations to all participants for discussion.
- Create a conceptual map highlighting health issues related to poverty and gender. Discuss the map with the group, explaining the reasons for how it is organized.
- Create and perform a dialogue or skit between three health workers that focuses on poverty, gender and health. Discuss the interaction in the group to identify major issues and ways to enhance communication, understanding and cooperation.
- Choose a major concept or issue related to poverty and gender and in five minutes convince the class why it is important in relation to health.
- Engage in a debate where two teams argue for and against the significance of poverty and gender as major determinants of health.

Case studies

Learning through examination of case studies provides an excellent tool for developing knowledge and skills related to gender and poverty.[52,53,54] Case study learning originates from problem-based learning and refers to any structured learning strategy where theory is applied to simulated real life situations. The approach allows actual clinical case scenarios or social issues to be used as a template for learning.[55]

Written case studies range from just a few lines of text to in-depth and longer texts that cover psychological, social, cultural and physical assessment and history. Longer case studies are generally used as pre-reading or as an assessment strategy. Shorter case studies are used in a classroom or seminar for group work or as the basis of role-play. For example, a case study drawn from a typical health curriculum could be used to identify strengths and weaknesses related to content, references, associated clinical experiences and general assumptions inherent to the subject. It is useful to consider whether the content has a gender bias or the extent to which it supports an understanding of poverty and gender in health. Critical examination, reflection and constructive suggestions to improve the subject would be a useful learning experience. Focus might also be directed towards whether an entire curriculum and its aims and objectives integrate poverty and gender issues in health.[56] This type of exercise could be undertaken in large or small groups that report back after deliberation.

Audio-visual aids, such as videos and slide shows, can also be used to stimulate discussion. For example, a video case study presentation of a multigravida pregnant woman with five children living in a remote village, experiencing bleeding in the third trimester could be used as a case study. A seminar group might view the video, take notes and then move into discussion groups in order to plan treatment or examine broader and related issues. Other approaches to presenting case studies can include slide shows, internet web page evaluation, newspaper or magazine articles, journal papers, live accounts or presentations of health problems, or participant group development of a fictitious scenario based on prior experience and understanding.

The goal of a case study is to encourage problem-solving, decision-making, objective assessment, critical thinking, self evaluation of knowledge and

skills, self-directed learning strategies as well as information literacy skills such as retrieval, planning and synthesis.[57] Weiss and Levison note that case study learning is an excellent gender- and poverty-integration strategy because it:[58]

- encourages patient-centred approaches to problem-solving;
- addresses sex and gender-based differences in disease as well as differences in patho-physiology and pharmacology;
- integrates psycho-social issues, such as family dynamics, environmental stressors, access to health care, effective gender-based communication between patient and provider; and
- encourages a multidisciplinary approach to health care.

Facilitation of case studies

In using a case study, the facilitator encourages group discussion and evaluation to identify issues related to poverty and gender and solutions to address them. The facilitator should focus on **"what"** questions such as, What do you believe is…; What will be the outcome if …; What are the options for …; What does research tell us about …, etc.

Clinical practice: Partnerships for the future

Future health professionals need exposure to guided clinical experiences that aim to address gender- and poverty-based health issues. Interaction with practitioners working on gender- and poverty-related issues in health is an important part of curriculum change, education and professional development. The objective is to bring together key players such as universities, health providers and community groups to facilitate cooperation and shared responsibility.

Synder and Weyer[59] argue that partnerships improve educational outcomes and assist community groups to gain control over and improve their health. Structured field visits to various clinical environments or community agencies give comparative and first-hand experience with poverty and gender issues and the opportunity to meet clinicians, women, children and members of local communities. Well-targeted partnerships between a college and community health providers helps improve provider skills through the development of therapeutic knowledge and compassion for the experiences of others.

Community-driven partnerships are recommended as a way to foster new clinical experiences so that students can recognize and address the health needs of all people.[60] For example, students might undertake an assessment in a community-based clinical environment serving a diverse population.[61]

Partnership arrangements can include faculty-driven health programmes or extended clinical practice for specific community groups. However, successful partnerships depend on a genuine commitment to change and the inclusion of appropriate clinical experiences.[62]

Resource 4: Assessment strategies and methods

Assessment is a complex task and must be based on practice, specific competencies and the needs of individuals and the community. This module recommends participatory and partnership approaches, including for assessment. Assessment strategies should highlight all key content, including competencies related to poverty and gender.

In developed countries, assessment is increasingly competency-based and measures the ability to practice in an appropriate and endorsed manner. Competency implies achievement of a pre-determined level of performance. Competency standards can form a benchmark for assessment and the basis for nationally recognized qualifications. The aim is to develop a highly skilled workforce, whose practice reflects agreed levels of knowledge, skills, evidence, ethical standards and attitudes.

Examples of competency standards adopted in educational programmes to assess health professional students are those identified by the United States Institute of Medicine; the International Council of Nurses' competencies for generalist nurses; the American Association of

Colleges of Nursing standards; and the Australian Nursing and Midwifery Council (ANMC) standards. A number of the core competency areas or domains, including the core areas of public health competencies, cross disciplines.[63]

The Australian Nursing and Midwifery Council (ANMC) "is a peak body that was established in 1992 to facilitate a national approach to nursing and midwifery regulation. The ANMC works with state and territory nurse and midwife regulatory authorities in evolving standards for statutory nurse and midwife regulation. These standards are flexible, effective and responsive to the health care requirements of the Australian population."[64] While not identified specifically for their emphasis on gender and poverty, the ANMC standards are an example of a benchmark used by registering bodies for beginning nurse practice that inform the development and implementation of current nursing programmes in Australia.[65]

The ANMC emphasizes that competency standards are adopted by nurse regulatory authorities to:

1. Communicate to consumers the competency standards that they can expect of nurses.
2. Determine the eligibility for registration of people who have undertaken nursing courses in Australia.
3. Determine the eligibility for registration of nurses who wish to practice in Australia, but have undertaken courses overseas.
4. Assess nurses who wish to return to work after being out of the work force for a defined period.
5. Assess qualified nurses who are required to show they are fit to continue working.

Resource 5: Curriculum evaluation strategies and methods

The overall process of evaluation, as broadly adapted from Hughes, includes the following core components:[66]

Objectives. Ongoing review of the objectives and structure of evaluation ensures that the process remains relevant and is refined in response to findings.

Full participation of stakeholders. Evaluation must appropriately consider all legitimate stakeholders, including students, educators, health workers, government officials and personnel from relevant nongovernmental organizations.

Identification of information to be collected. The evaluation process needs careful planning to ensure that all relevant information is collected. The type and sources of information to be collected determine the range of methods to be employed. For example, it cannot be assumed that health workers and community groups have in-depth understanding of the objectives of a poverty- and gender-focused health curriculum. Nor can there be any presuppositions about the full extent of information such groups have to offer. For such groups, flexible methods that seek a broad range of views are indicated.

Documentation and reporting of evaluations. Evaluation outcomes need to be reported to all stakeholders in a transparent and systematic form. Different forms of reporting may be appropriate for different groups of stakeholders.

Recognition of long-term objectives. Evaluation must account for both short- and long-term objectives. An important component of evaluation of a poverty- and gender-inclusive health curriculum is a review of the long-term impact of the educational change.

Evaluation methods

- **Assessment**. Assessment of students is the traditional form of curriculum evaluation and its strength is its high degree of reliability. This strategy monitors the progress of both individual students and curriculum content. Its weakness lies in the area of validity, because student assessment will not reflect the long-term social impact of a poverty- and gender-focused curriculum.

- **Questionnaire**. A structured questionnaire is an effective and relatively inexpensive way of gathering feedback from a broad range of stakeholders. Questionnaires are

guided by a particular purpose, depending upon identified objectives, and are structured differently for different groups. For example, questionnaires when exiting a programme are appropriate for student evaluation of a curriculum. The method can also be used to survey staff to determine the extent of organizational commitment to educational reform. Questionnaires are reliable, but may be constrained because questions and responses are controlled.

- **Face-to-face interviews**. Interviews do not have high reliability or validity. They do, however, allow for in-depth feedback from key persons. They may be used to explore the views of individual health workers in relation to a poverty- and gender-focused curriculum. They can also be used to identify issues in relation to curriculum structure and the applicability of poverty and gender knowledge to health practice. This is important if the concepts of poverty and gender are to be applied beyond the educational setting.

- **Focus groups**. Focus group discussions are a valuable qualitative evaluation method that draws upon the attitudes, beliefs, experiences and reactions of selected small groups in a way that is not feasible through face-to-face interviews or questionnaires. Although not statistically reliable and valid, focus groups can elicit a range of views in a group context and gather a large amount of information in a short time. They can be used in the early stages of curriculum development, during curriculum development and to evaluate programme impact in particular educational, health care and community settings.

- **Document analysis**. This strategy involves an analysis of all documents related to a particular curriculum. The development of unit content in broad programmes often occurs in relative isolation. The value of this approach lies in monitoring ongoing curriculum development and in ensuring that components of the curriculum remain focused on stated objectives.

- **Education indicators**. This involves the collection of numerical information on key performance indicators, such as course enrolment, attrition and completion rates, and costs and resources. They are an important element of overall assessment of a curriculum and provide a basis for comparison with similar curricula.

Resource 6: An evaluation template for assessing the integration of poverty and gender and in a health professional education curriculum

Purpose: To evaluate the appropriateness, effectiveness and efficiency of a health professional education curriculum that integrates poverty and gender to improve future programmes.

Description: An evaluation of the implementation of a gender, poverty and health integrated curriculum in health professional studies.

Overall evaluation approach: Evaluation approaches may include the following:

- *Goal based evaluation*, to determine the extent to which the design and implementation of a health professional curriculum that incorporates poverty and gender has been achieved within a specified time period and circumstances.
- *Responsive evaluation*, to consider the impact of a poverty- and gender-inclusive health professional curriculum from the perspectives of key stakeholders. Issues, strengths and weaknesses of the programme identified by stakeholders provide a basis for ongoing development of the programme.
- *Utilization focused evaluation* provides information from students, educators and practice settings about the effectiveness of the programme and how it can be improved.

Questions and methods: The following questions may be used to determine the evaluation

methods to use. As noted, these include student assessment, questionnaires, face-to-face interviews, focus groups, document analysis and key indicators.

Questions	Methods
• To what extent does the curriculum demonstrate consideration of poverty and gender issues?	• Curriculum document analysis
• To what extent does the curriculum adhere to overall curriculum objectives in relation to poverty, gender and health?	• Curriculum document analysis by all stakeholders
• To what extent does the curriculum provide learning experiences, pedagogy and assessment procedures that are inclusive of poverty, gender and health?	• Student assessment, student programme evaluation, curriculum document analysis
• To what extent does the curriculum meet the needs of the key stakeholders in relation to poverty, gender and health?	• Key health care and community indicators, questionnaires, focus groups
• Have the poverty and gender objectives of the health curriculum been achieved?	• Questionnaires, focus groups, course evaluation, teaching evaluation, key community health care indicators
• To what extent are poverty, gender and health concepts integrated in the curriculum?	• Questionnaires, focus groups, interviews with health care practitioners and graduates
• Are the outcomes of the poverty and gender curriculum applicable in health care practice?	• Focus groups, document analysis, interviews with teaching and community representatives
• Is a poverty, gender and health integrated approach appropriate for all health professional education and practice areas?	• Key indicators, analysis of curriculum development documentation
• What is the evidence that resources have been adequate in planning, implementing and assessing the curriculum?	• Key budget indicators, questionnaires, focus groups
• To what extent has the programme drawn upon existing resources?	• Key performance indicators , such as course enrollment, attrition and completion rates; costs and resource analysis
• To what extent has the implementation of the revised curriculum occurred within given timelines?	• Timeline and document analyses
• Is the curriculum content obviously and readily translated into practice?	• Key health care indicators, interviews with community agency representatives and graduates

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