Social Medicine Reference Toolkit

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SOCIAL MEDICINE
CONSORTIUM

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Introduction

Welcome from Dr. Michelle Morse and Dr. Michael Westerhaus

Dear Friends and Colleagues,

At a time when we are facing the erosion of human rights, at home and abroad, we are called to raise our voices through our teaching, our practice, our research, our advocacy and our activism. The Social Medicine Consortium was created to address the need for a more holistic and comprehensive approach to the teaching and practice of the precepts of social medicine due to the ongoing miseducation of health professionals about the root cause of illness.

The time for action is now in the United States and globally. The recent American presidential election leaves no question about the direction of the American government with regard to the idea that health is a human right. We at the Social Medicine Consortium invite you to join us to grow the social medicine movement in response not just to the American elections, but to the hundreds of years of oppression that have created the health inequities that we face today. Our collective voices and actions are required to serve as a counterweight to the forces that would deny these most basic human rights. We are counting on each and every one of you to lend your voices and attention to the social medicine cause, which is more urgent than ever.

We believe that this toolkit will serve as a compelling reference for those interested in social medicine education, and will facilitate dialogue and advocacy around social medicine education that each of you will lead in your respective communities. We hope that it reflects the collective voices and vision of global colleagues around social medicine education, which have been expressed during many months of dialogue and many years of teaching social medicine.

Our hope is that you will use this toolkit to convince stakeholders of the need for social medicine education, recruit more friends and colleagues to the social medicine movement, and inspire institutional and structural change in your world to correct the miseducation of health professionals.

We now turn towards Chicago, where we will host our second annual Social Medicine Consortium conference, entitled *"Beyond Reimagining, Accelerating Praxis: Social Medicine In Practice Today"* on **April 27 to 29, 2017**. We invite you to stand together, walk together, and find the way with us.

Onward and upward,

Michelle Morse, MD, MPH and Michael Westerhaus, MD, MA

Best Practices: Developing a Social Medicine Education Program

Leigh Forbush and Cassidy Stevens

This compilation of best practices was developed through a comprehensive review of social medicine literature and a qualitative survey of social medicine professionals within the Social Medicine Consortium.

Definition of Social Medicine

Social Medicine is the practice of medicine that integrates:
1. Understanding and applying the social determinants of health, social epidemiology, and social science approaches to patient care;
2. An advocacy and equity agenda that treats health as a human right;
3. An approach that is both interdisciplinary and multi-sectoral across the health system;
4. Deep understanding of local and global contexts ensuring that the local context informs and leads the global movement, and vice versa (learning and borrowing from distant neighbors);
5. Voice and vote of patient, families, and communities.

What should a social medicine program accomplish?

A clinical training program with social medicine as a core program element should produce professionals that have:

- Developed ways to recognize and challenge their own biases, sources of power and privilege.[1, 2]
- Learned how to work collaboratively with other professions.[3-9]
- Understood the relationship between the individual and population and how this relationship is affected and shaped by social and systemic forces.[2, 4-5, 7, 10-14, 19]
- Recognized that interventions and strategies are meaningless unless they match local needs and conditions.[3, 8, 10-11]
- Practiced skills that challenge and correct societal, structural, and political forces that create health disparities.[5,7,12]
- Advocated for patients and the community to improve the social determinants of health.[1,6,10,13,15-16, 19]

How should social medicine be integrated into a clinical training program?

If possible, social medicine should be fully integrated into curriculum at both the undergraduate and graduate levels.[9-11, 17] During preclinical years, social medicine should be a theoretical framework rooted in praxis, which is education combined with action.[2] During clinical years, trainees can practice social medicine tools as part of rotations, such as narrative medicine, expanded social histories, advocacy training, and community organizing.[12, 18]

With social medicine as a core part of the training program, trainees have adequate time to develop self-awareness and community-based competencies that are key to their success as advocates for their patients and community.[8,15] To achieve health equity, residents must understand how both clinical medicine and health systems affect patients. Ultimately, trainees recognize that social medicine isn't just an 'add on' or elective, but a central part of their training.[11]

How can institutional and community support be gained to begin or strengthen social medicine curricula?

Institutional support for the integration of social medicine can be difficult in an environment that focuses on 'hard science'.[11] Some ways to gain support for social medicine include:

- Highlighting the research around the importance of social determinants of health [9]
- Attaining the support and buy-in of curriculum committees at your institution[9, 11]
- Developing a larger community of departments, organizations and individuals that believe in a broad, multidisciplinary approach to health[9, 10]
- Implementing both bottom-up approaches that begin with residents, faculty, and patients and top-down approaches that incorporate social medicine education into the accreditation process[10]

Community support is also a crucial piece of any social medicine program. It is ideal to first use community-based participatory research to understand the context, needs, and strengths of the community.[2, 7, 12] Your academic institution should also meet with local leaders and discuss what their felt needs are.[4] Once key community stakeholders and community needs are identified, your academic institution should begin building the social medicine curriculum in collaboration with these stakeholders and local community groups.[8, 10, 12] Stakeholder meetings should also occur at all sites where there will be trainee placement, to ensure there is an understanding of the purpose of the placement and the role that the trainee should have while there. Additional stakeholder consultations like meetings, workshops and follow-up communication should happen throughout the life of the social medicine program to adjust course if needed and adapt to newly identified needs.

What should the demographics of trainees and faculty be to foster a productive learning environment?

A diverse set of faculty and trainees are fundamental to a successful social medicine program. Diversity should exist at every axis possible including gender, sexuality, race, socioeconomic status, immigration status, and more, because that is the reality of patient populations.[9] Social medicine relies on discussions and experiences that challenge privilege, power and bias. If your faculty and trainees are similar in background and life experience, your social medicine program is less likely to foster an environment of self-reflection through challenging conversations. It is recommended that the faculty is not only comprised of clinicians, but also includes public health practitioners and social scientists.[11] One way to ensure a diverse set of trainees and faculty is through exchange programs with other academic institutions, although this is not always logistically and financially feasible for every social medicine program.[3]

Additionally, it is important that clinicians with whom the social medicine trainees work model socially responsive practices to reinforce skills and attitudes fostered in their social medicine training.[15] Without the opportunity for trainees to apply what they are learning, and see others doing the same, they are less likely to practice social medicine upon completion of the training program.[1]

What are the best teaching methodologies for social medicine?

Social medicine is best taught with a small class size that allows for rich discussion. A successful social medicine training program should combine the following three elements: classroom-based learning, community-based experiential learning, and reflection.[12, 15, 17]

<u>Classroom-Based Learning</u>

It is recommended that trainees be introduced to social medicine theory, however briefly.[12] To this end, rather than using didactic teaching methodologies, faculty should incorporate interactive awareness-building activities into their classroom-based learning: guest speakers, role playing, viewing multimedia, reading groups, and small group discussions.[5,19] Guest speakers might include journalists, policy makers and politicians.[2] The classroom-based learning should be student-directed rather than teacher-directed, and be held in a space that allows for movement and open, inclusive discussion.[8,17] The social medicine course should incorporate the use of teams or small groups within the class to facilitate dialogue and ensure everyone has a chance to be continually participating.

Case studies are another common medium to spur discussion and debate, especially when groups must take different positions on an issue than they would normally. However, it is important that case studies not only focus on patients and their lives, but also on the trainees and their understanding and perceptions. Cases should exist to evoke reflection, rather than serve as a medium to teach topical content about an individual or group (like a minority culture) which can reinforce stereotypes and lead to "othering".[1, 14]

Community-Based Experiential Learning

It is vital that trainees become engaged in the community issues they are learning about– whether through a rotation at a community clinic, community quality improvement project or placement at a community organization. The local context should drive the trainee's activities.[7, 11] A key competency that the trainee should gain is the ability to advocate and increase advocacy mechanisms in the community in which they are working.[5] This advocacy should be rooted in a synergistic understanding of the assets, strengths, and capacity identified by the community.

Additionally, community rotations provide unique opportunities for trainees to observe and learn clinical skills from the local population, such as narrative medicine and interdisciplinary collaboration.[7, 12] The trainee should be placed in an environment in which there is problem-based learning for all parties involved – the trainee, the community and other health professionals.[10] These service learning activities should stress the reciprocity and interdependence between academic institutions and community.[8, 10]

Reflection

Reflection should be performed throughout the social medicine training, both during the classroom-based learning and community-based experiential learning. Students need dedicated time to listen to others' reflections, examine their own beliefs and biases honestly, practice skills for critical self-awareness and understand how their values and assumptions affect the care of their patients.[1-2, 7, 11] There also should be focused reflection on the systems and social forces within academia, hospitals and communities that are barriers to effective care and social justice.[5, 7]

Reflection should happen on an individual basis and in mixed discipline groups, with trainees from various years grouped together if possible.[4, 17] Reflection activities may include reflective journaling, small-group discussion, letter writing to local officials, role-playing or forms of artistic expression.[5] Reflection, particularly after the community-based experiential learning, should be supported by concrete ways to continue taking action.

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Definition of Social Medicine

Leigh Forbush

Although social medicine has been around for over 150 years with many definitional iterations, its integration into health care delivery is still a revolutionary concept. [1] Biomedicine and its emphasis on microbes, pathology, and natural science has long been the crux of medical education and practice, and this is true across healthcare professions. Despite the increasing evidence asserting that health and illness are undeniably linked to the social contexts in which they exist, the widespread integration of social medicine training into medical education has been minimal.

Social medicine challenges us to think beyond prolonging life and curing disease. The Social Medicine Consortium has defined social medicine as:

1. **Understanding and applying the social determinants of health, social epidemiology, and social science approaches to patient care**

The social determinants of health are the forces beyond biology, which impact health outcomes, such as educational status, physical environment, income, etc. To address the social determinants of health we must focus on five areas based on the Rio Political Declaration including 1) adopting improved governance for health and development, 2) promoting participation in policy-making and implementation, 3) further reorienting the health sector towards promoting health and reducing health inequities, 4) strengthening global governance and collaboration, and 5) monitoring progress and increasing accountability. Social medicine consists of integrating and applying these disciplines to ensure an effective and holistic response to patient, family, and community needs.

2. An advocacy and equity agenda that treats health as a human right

Social medicine considers and advocates for the holistic needs of patients, families, and health systems with a rights-based approach that pushes aggressively for global health equity. Social medicine practitioners ensure healthcare delivery that corrects inequities and human and systems gaps, and strives to attain the objective of quality healthcare including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity.

3. An approach that is both interdisciplinary and multi-sectoral across the health system

Social Medicine combines both interdisciplinary and multi-sectoral approaches to strengthen the health system and to better support the health system by engaging all relevant stakeholders. To do so, it requires a multidisciplinary approach within the heath system while taking into account perspectives from all sectors, which have a direct or indirect impact on health.

4. Deep understanding of local and global contexts ensuring that the local context informs and leads the global movement and vice versa

Social Medicine is rooted in a deep understanding of local contexts to better inform and lead the global movement towards improved health and health equity. It ensures that the practice of medicine is based on the contextual knowledge of the people and countries of interest. It ensures that the global movement is informed by local knowledge and expertise.

5. Voice and vote of patients, families, and communities

Social medicine prioritizes engaging civil society, ensures community ownership of health initiatives, and values active participation of patients, families, and communities towards effective healthcare delivery and health systems strengthening. Advocating for integration

of the voice and vote of our patients, families, and communities means activating and expanding their influence to ensure that healthcare meets their needs and rights.

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Key Terms in Social Medicine

Developed by Thea Lacerte, Cassidy Stevens, Michelle Morse, MD, MPH, Hugo Flores, MD, Mike Westerhaus, MD, MA & Amy Finnegan, PhD, MALD

Guiding Principles for Definitions

- These terms were developed collaboratively to serve as a starting point for critical dialogue amongst social medicine leaders, educators, trainees and other constituents.
- Our goal is not for all professionals to adopt these definitions wholeheartedly. This is a set of well-referenced terms we found to be helpful in our consensus establishing process.
- We hope that educators and students discuss and debate these definitions in their communities as an early step in social medicine movement building and course work in order to have essential but difficult conversations about some of the most challenging topics in social medicine.
- We ask that constituents consider how these terms may be edited, adapted, and applied in their prospective teams, communities, and institutions to reflect the values of social medicine.

Key Terms

1. Structural violence: The social, economic, and historical forces that 'structure risk' for suffering (from diseases, hunger, torture, etc.) and constrain agency of certain people. It is a form of violence that is invisible, embedded, and normalized. Like direct violence, there is clear harm and identifiable victims, but there are often not physical acts of aggression or a clear perpetrator. [16]
2. Prejudice: An unfavorable opinion or feeling formed beforehand or without knowledge, thought, or reason.[4]
3. Structural Competency: Trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases... also represent the downstream implications of a number of upstream decisions about such matters as healthcare and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health [12]
4. Structural analysis: A method in which health professionals consider all of the social structures/institutions that are affecting a patient's health and effective interventions to counteract the effect of these structures [12]
5. Centering at the Margins: In order to eradicate and correct the inequitable consequences against those people who have been historically disadvantaged through structural violence and policies, it is necessary to center those who have been pushed to the margins. Its goal is to center the experiences of the oppressed, have their voices in positions of leadership, and to shape the movement.[2]

6. Structural Humility: The trained ability to recognize the limitations of structural competency. Acknowledgment meant that many of the responses to mitigate the structural effects of health are beyond the network and skill-set of many clinicians [12]
7. Social Vulnerability: The distinct likelihood of facing forces that may have negative effects on health outcomes due to economic and political situations [12]
8. Social Exclusion: The society wide, multi-dimensional, lack or denial of resources, services, rights, goods that are available to most people- alters the life of the affected individual and the society as a whole. This unequal access leads to health care inequalities [14]
9. Stigma: A mark of disgrace associated with a specific person, circumstance or quality. In considering health effects and stigma it is important to consider the stigmas within different cultures of various health conditions, but a more robust approach of understanding the structural components that create this health effect are essential- clinicians must acknowledge how stigma and structural systems co-exist to effect health [12]
10. Privilege: An unearned advantage granted to certain members of a society to the disadvantage of others; White privilege specifically pertains to advantages and immunities enjoyed by people racialized as white; this is an important topic to consider when considering how privilege affects health outcomes and how access to these privileges in society are largely structural [4]
11. Stereotype: A standardized mental picture that is held in common about members of a group that represents an oversimplified opinion, attitude, or unexamined judgment, without regard to individual difference.[4]
12. Health Disparities: The differences between the health of one population and another in measures of who gets diseases, who has a disease, who died from disease, and other adverse health conditions that exist among specific population groups in the US.[1]
13. Health inequity: The differences in health status or in the distribution of health determinants between different population groups, and these differences are systematic, avoidable, unfair and unjust, and are rooted in racial, social and economic injustice, and are attributable to social, economic, and environmental conditions in which people live, work and play.[7]
14. Health equity: The opportunity for everyone to attain his or her full health potential. No one is disadvantaged from achieving this potential because of his or her social position (e.g class, socioeconomic status) or socially assigned circumstance (e.g race, gender, ethnicity, religion, sexual orientation, geography, etc.) [4]
15. Social Medicine: The practice of medicine that integrates: understanding and applying the social determinants of health, social epidemiology, and social science approaches to patient care; an advocacy and equity agenda that treats health as a human right; an approach that is both interdisciplinary and multi-sectoral across the health system; deep understanding of local and global contexts ensuring that the local context informs and leads the global movement, and vice versa (learning and borrowing from distant neighbors); voice and vote of patient, families, and communities.[6] In short, how to address the statement, “inequity kills.”
16. Social Justice: The struggle towards acknowledgment and attainment of dignity and autonomy for all members of society, regardless of gender, race, ethnicity, religion,

sexual orientation, language, geographic origin, or socioeconomic background.[10] Social justice is often understood to require a "historically deep" and geographically broad" analysis.[17] It recognizes that suffering is often due to structural causes and seeks to address it by attacking underlying structures that perpetuate suffering and justice.

17. Medicalization: The process by which human conditions and problems are defined and treated as medical conditions. Adopting a medical framework to address a problem.[11]
18. Social Determinants of Health: The circumstances in which people are born, grow, live, work, play, and age that influence access to resources and opportunities that promote health. The social determinants of health include housing, education, employment, environmental exposure, health care, public safety, food access, income, and health and social services [4]
19. Racial Justice: The creation and proactive reinforcement of policies, practices, attitudes, and actions that produce equitable power, access, opportunities, treatment and outcomes for all people, regardless of race.[4]
20. Race: A socially constructed way of grouping people, based on skin color and other apparent physical differences, which has no genetic or scientific basis. This social construct was created and used to justify social and economic oppression of people of color by Whites.[4]
21. People of Color**:** A political construct created by Women of Color at the National Women's Conference in the United States in 1977 to express solidarity among people who would generally not be categorized as White and acknowledge the relational dynamic between oppressed populations globally.[3]
22. Racial Discrimination**:** The unfair treatment because of an individual's actual or perceived racial or ethnic background.[4]
23. Implicit Bias: The learned stereotypes and prejudices that operate automatically, and unconsciously, when interacting with others. Also referred to as *unconscious bias.* When a person's actions or decisions are at odds with their intentions this is implicit bias.[4]
24. Racism: A system of advantage based on race [4]
    i. Internalized Racism: A set of private beliefs, prejudices, and ideas that individuals have about the superiority of Whites and the inferiority of people of color. Among people of color, it manifests as internalized racial oppression. Among Whites, it manifests as internalized racial superiority [4]
    ii. Interpersonal racism: The expression of racism between individuals. These are interactions occurring between individuals that often take place in the form of harassing, racial slurs, or telling of racial jokes [4]
    iii. Institutional racism: Discriminatory treatment, unfair policies and practices, and inequitable opportunities and impacts within organizations and institutions, based on race[4]
    iv. Structural Racism: Racial bias across institutions and society over time. Its cumulative and compounded effects of an array of factors such as public policies, institutional practices, cultural representations, and other norms that work in various, often reinforcing, ways to perpetuate racial inequity [4]
25. White supremacy: White supremacy is a historically based, institutionally perpetuated system of exploitation and oppression of continents, nations and peoples of color by

white peoples and nations of the European continent; for the purpose of maintaining and defending a system of wealth, power and privilege.[4]

26. Sexism: Prejudice, stereotyping, or discrimination, typically against women, on the basis of sex; for our context we will consider the effects of institutional sexism on women's health. [4]
27. Patriarchy: A system of society or government in which men hold the power and women are largely excluded from it. [4]
28. Misogyny: Ingrained prejudice against women [4]
29. Feminism: Political, economic, and social equality of the sexes [15]
30. Intersectionality: The manner in which multiple forms of inequality and identity interrelate in different contexts and over time, for example, the interconnectedness of race, class, gender, disability, etc.[8]
31. Classism: Prejudice against or in favor of people belonging to a particular social class, for our purpose we will consider the effects of classism on health.[5]
32. Class system: The system that stratifies people according to their income sector that does not necessarily depend on individual merit. People are usually born in one class and die in it. People also have friends, work and marry within the same class.[5]
33. Social Mobility: The ability of people to move between social classes. It is very limited and happens by accidental or multifactorial conditions. It usually cannot be achieved by individual effort.[5]
34. Neoliberalism: An economic and political philosophy that suggests that free markets lead to open and free governments. It is an ideology that emphasizes the principles of free markets, smaller government, deregulation, and privatization.[18] Neoliberal policies have facilitated the extreme accumulation of wealth by very few individuals. Today, 8 men have the same wealth as the poorest 50% of the population.[9]
35. Gender: The state of being male or female that is socially created and is not biological [4]
36. Transgender: When the gender a person feels they are differs from the sex their parents were told at birth. Gender identity is fluid; a person can identify as both male and female or identify with neither.[4]
37. Homophobia: Fear and discrimination against gay and lesbian people [4]
38. Heterosexism: Systematic discrimination or prejudice against non-heterosexual people on the assumption that heterosexuality is the normal/only sexual orientation.[4]
39. Climate justice: Recognition that climate change solutions must be community-led and centered on the wellbeing of the global poor, indigenous peoples, biodiversity, and ecosystems. [13]
40. Minority: A group that is oppressed by the majority. It can be of any kind and the same group can be a majority in one place, and a minority in a different place.[5]
41. Enormity: When aid workers realize that the problems of the world or communities they work in are huge and the impact themselves have is limited, they can become discouraged, cynical, depressed, etc., this moment is when they face the enormity and it is something we need to process by re-defining our concept of the world and the universe, and our roles in it. [5]
42. Poverty: A condition of scarcity that detriments human health, development and opportunities. It is structural and created by exploitation of some groups over others, and people can hardly escape it through individual means.[5]

43. Geosentiment: Identification felt toward one`s home city, country, etc. Geosentiment presents in many forms: geopolitics, geoeconomics, geopatriotism, georeligion, etc.[5]
44. Ethnosentiment: Identification felt toward one's ethnic group.[5]
45. Sociosentiment: Identification felt toward one's own family, nation, or other social grouping (economic, linguistic, religious, political, and so on).[5]
46. Praxis: From the work of Brazilian educator Paolo Friere, praxis is the iteration between reflection and action. [19] By giving the title "Accelerating Practice" to this conference, we are referring to building momentum in reflective practice.

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4 Developed by Abby Ortiz, MSW, MPH at Southern Jamaica Plain Health Center

5 Developed by Hugo Flores, MD, MPH

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Key Themes in Social Medicine Curricula

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Review: Analysis of Themes in Social Medicine Education Programs

So what serves to be gained from a paradigm shift where health and illness are viewed as inherently biosocial as opposed to purely biomedical? The application of social medicine to care delivery creates a more effective, efficient, and equitable system for both individuals and communities. Recognizing this, institutions around the world have begun to develop social medicine training for healthcare professionals of all levels. As the need for such educational programs continues to grow, it is becoming increasingly apparent that there is not yet a consensus on what or how to teach when teaching social medicine.

By comparing 12 social medicine curricula, this report attempts to assess what role social medicine education currently serves for different audiences and members of health care delivery teams. It represents an essential step in determining the necessity for a standardized framework around which social medicine might best be taught.

This report also highlights the potential need for agreement on the purpose of social medicine training globally and in terms of specific parts of the health care delivery chain. What objectives and course content should be universal? What aspects should be catered to specific audiences (clinicians vs. non-clinicians, health professions trainees vs. working professionals)? How much should a social justice and human rights agenda be ingrained into social medicine training? Continued exploration of these questions will allow for the development of educational programs that collaborate and work in concert towards a shared goal: establishing a social medicine scaffold in all aspects of health care delivery.

Programs

Table 1 lists the 12 social medicine curricula included in this report. It is important to note that these programs were not randomly selected and that this analysis does not include all social medicine programs.

Programs were divided into four categories according to the level of training of participants: (1) university, (2) undergraduate medical, (3) graduate medical, and (4) continuing education (Table 1).

A. Thematic Categories

Upon review of course objectives and content, several different thematic perspectives through which social medicine is currently being taught emerged. Course objectives and content topics from all programs were placed into one of the three categories described below. How different programs pulled from these categories in their objectives and content will be reviewed throughout this report.

These thematic categories were somewhat arbitrary and are not meant to be exact or mutually exclusive; instead, they serve as a baseline for evaluating similarities and differences across curricula. Therefore, data reported should be understood as a means of showing trends rather than precise quantitative measures. It is also important to remember that just because a course does not list something in their stated objectives or content topics does not mean it is not embedded within the course; this is an important limitation of comparing programs based on written descriptions which may not fully illustrate the breadth or depth of the coursework.

1. **Patient Care.** These objectives and course topics are concerned with the clinical application of social medicine with regards to individual patents; they reflect a holistic approach to medical care where the patient is viewed within his/her social context.

   Examples

   Objectives: Disease management, communication skills, primary care provision

   Topics: Health promotion/disease prevention, rural health care, health education, clinical topics

2. **Local Systems for Care.** These objectives and topics stress the comprehension of local health systems, programs, policies, and players. Broadly speaking, most of these are related to understanding and providing country-specific public health and population care at the community level.

   Examples

   Objectives: Public health, community level care, local health care systems/policy

   Topics: Population health, models of health financing, local program interventions, research processes

3. **Big Picture.** This category of objectives and topics focused on higher-level assessment that examines the determinants of health and illness as well as the practical action steps to addressing these factors.

   Examples

Objectives: Global context of issues, understanding care delivery, analyzing global health interventions, advocacy

Topics: Quality of care improvements, health care system strengthening, program design, health value, health economics, health and human rights

B. Course Objectives

No single objective was shared across all programs, although 11 out of 12 (92%) curricula specifically included social determinants of health and illness in their listed objectives. The only program that did not was the Global Health Delivery Leadership, which may have assumed that knowledge or embedded it directly into its learning modules. Several other objectives were common, irrespective of the audience. Most programs (83%) emphasized country-specific health issues (the 2 that did not were university courses) and a majority (58%) included health issues in a global context (the 5 that did not were all undergraduate medical programs). Interestingly, how much a human rights agenda was woven into course objectives varied greatly across programs, irrespective of audience. Advocacy was mentioned in 50% of programs' objectives, and health equity was only mentioned in 25% of them.

The degree to which individual programs drew their remaining objectives from each of the 3 categories of Patient Care, Local Systems for Care, and Big Picture was—not surprisingly—largely reflective of audience type. For example, undergraduate medical programs tended to draw objectives that revolved around Patient Care and Local Systems for Care, whereas continuing education programs drew more from the Big Picture category. It was clear that there were some overarching themes that were important for specific audiences.

However, this was not strictly true, and there were other global differences that could not always be accounted for based on audience. In other words, the overall application of social medicine was clearly different for medical students than for working professionals, but even within those groupings there was some additional unexpected variation. This will be described in more detail below in audience specific sections.

C. Course Content

As was the case for course objectives, some course content across social medicine programs was universal, irrespective of course audience. Social determinants of disease were included in 92% curricula content topics (it was again GHDL that did not include it). Models of payment and health financing were taught in 66% of programs. Harvard Medical School teaches health financing as part of their program, even though it was not labeled specifically as "social medicine content" in their course breakdown. Also, the four programs that did not include it in

their listed content were all undergraduate medical programs. Population health and research were less common but still represented in over half of the programs (58%).

Since the thematic objectives guided program content, categories of content topics (Patient Care, Local Systems for Care, and Big Picture) roughly followed patterns of objectives. However, individual course content is where the nature of social medicine teaching really began to vary, even more so than with objectives. Specific content varied widely and was much less predictable than objectives based on audience. There was also a difference in the approaches—the amount of theoretical vs. practical knowledge content and training differed both across and within audiences.

D. Teaching Methods

Ten out of 12 (83%) programs used a combination of didactic lectures and group discussion with or without tutorials/field experiences. The two exceptions were CES Mexico, where the social medicine section consists entirely of group discussions, and PIH Engage. Although these data provide some insight into overall methodology, teaching style and facilitation methods between programs could not be fully appreciated from syllabi or course descriptions. For example, it's certainly true that "Group Discussion" in CES Mexico and in PIH Engage mean two very different things. Reports of "tutorial and field sessions" do not differentiate the significantly different methods of, say, bedside teaching vs. group visits to a health center. These are important considerations that warrant further examination elsewhere. Also, in the case of CES, there is an important clinical proportion of topics that are covered in small group lecture/discussions and case presentations.

Analysis by Audience

A. University

There were two programs that were taught to university undergraduates, Harvard University and PIH Engage. Harvard's course serves to provide students with "a toolkit of analytical approaches to examine historical and contemporary global health initiatives with careful attention to a critical sociology of knowledge". The second program is PIH Engage, which is PIH's community organizing program. This is an optional curriculum—more so a set of resources—that team leaders from chapters of volunteers all over the country can share with their team to better understand the PIH philosophy of care delivery as a human right.

Both of these curricula are introductory global health courses that study social determinants of health in a broad context of social theories and health equity. The programs actually shared most of their objectives, all of which were drawn from the Big Picture category (e.g. global context of health issues, understanding care delivery, health advocacy). Neither of them had stated course objectives related to Local Systems for Care or Patient Care.

Despite these shared objectives, some of their specific content varied. While both programs utilized a health and human rights agenda to discuss health financing and population health in local and global contexts, Harvard's undergraduate course goes more into global health players and their roles. PIH Engage focused instead on program design, leadership, political engagement, and research.

Both courses were largely theory-based and neither had a field or practical component. The Harvard semester-long course is taught through didactic sessions by leaders in global health with a small component of open discussion. Conversely, PIH Engage's curriculum is purely group discussion facilitated by team leaders (who are not global health professionals).

B. Undergraduate medical education

The programs providing social medicine training for undergraduate medical education represented 7 curricula in total from Harvard Medical School, SocMed, EqualHealth, Zanmi Lasante (2 separate curricula for nursing and medical students), and University of Rwanda (old and revised curricula, both currently in use).

As EqualHealth was developed as a site expansion of SocMed, these programs are very similar in their overall structural framework. These non-profit organizations provide optional rotations for students interested in working in global health settings and accept applications from both local and international students. They focus on theoretical frameworks of social medicine, global health, social justice, advocacy, and patient-centered medicine. Their objectives and content topics fell into all three categories of Patient Care, Local Systems for Care, and Big Picture.

These two programs differ from the Zanmi Lasante and University of Rwanda courses, which are taught as required rotations for medical students and focus on the practical application of social and community medicine in primary care. The combined 4 curricula of these 2 institutions have similar objectives of providing students with the practical and theoretical skills for social and community care, especially in rural populations within their respective countries. There is much less of an emphasis on global health. Unlike the SocMed and EqualHealth, neither University of Rwanda courses nor Zanmi Lasante courses included "Big Picture" objectives (although they do have Big Picture content in their course topics).

Notably, the University of Rwanda program is the only longitudinal course that is integrated through multiple years of medical school. It was developed under the premise that continued exposure to social medicine concepts would allow students to gain a greater appreciation for its relevance in the practice of medicine. Also, social medicine can be used as the platform to teach other important content such as professionalism, research, etc.

Harvard Medical School offers a required rotation for Harvard students and represents some sort of combination of the two groupings listed above. It is perhaps more similar to the EqualHealth/Socmed model as it uses a broad conceptual framework to prepare students to meet the challenges of practicing medicine in the US and elsewhere. However, the included course content that is not specifically labeled as "social medicine content" includes much of the practical knowledge that Zanmi Lasante and University of Rwanda emphasize to their students. Overall, Harvard uses Big Picture themes as a way to teach students to understand and work within the realm of individual patients. The Harvard program pushes students to think both abstractly and practically in order to apply lessons from the social sciences to pragmatic solutions to improving patient care.

There were several other observations that are worth noting about these programs. Six out of seven utilized a combination of didactic lectures, group discussion, and community activities (though it is unclear how individual student participation in each of these varied). The Harvard program, based on its syllabus, did not include bedside teaching or outings with health care workers as the other programs did. All of the programs included medical students. EqualHealth included other health professional students in the same course, and University of Rwanda included some pharmacy students in the first year of its new longitudinal curriculum. Zanmi Lasante was the only program to have a separate program for nursing students. SocMed, EqualHealth, and University of Rwanda each allowed foreign visiting students to apply to their programs.

C. Graduate Medical Education

Compañeros En Salud, the sister organization of Partner's In Health located in Mexico, provides a certificate course with a Global Health and Social Medicine component and represents the only course for graduate medical training that was included in this analysis. The course is taught to Mexican physicians and nurses during their compulsory social service year. Physicians are taught to view global health as a series of problems across disciplines, and the overarching goal is to help these new doctors to become change agents for Mexico.

Like almost all programs, CES Mexico had social determinants of disease woven into its objectives and course topics. The goal of this course is to get physicians to think broadly and to become advocates for a health and human rights equity agenda. The other objectives for CES drew from the Local Systems for Care category and the Big Picture category. This is a major difference between this program and most of the undergraduate medical education programs that emphasize the use of social medicine in one-on-one patient interactions. Moreover, CES focused on medicine as an avenue for social change, while most undergraduate courses focused more on the practical application of social medicine for the average physician or health care professional. The CES program content topics drew from each category of Patient Care, Local Systems for Care, and Big Picture.

This curriculum is unique from most of the others in that it includes no didactic component and relies on transformative learning entirely through dynamic exercises. Another unique attribute is that CES makes it a point to surround these trainees with mentors in the field so they can see firsthand what it means to deliver care as a human right. The program has been successful in motivating physicians to pursue careers in global health. Inspired to participate in the shaping and creation of a different system, many of the graduates of this program have gone to graduate programs in global or public health, departing from the regular track to do residency and private medicine after completing the social service year. This is very unusual in Mexico.

D. Continuing Education

There were two programs that constituted Continuing Education which were created for significantly different audiences. The HEAL Initiative Bootcamp provides an intensive orientation to global health equity to physicians, pharmacists, nurses and other health care professionals who have been selected as 2-year HEAL initiative fellows. The program aims to equip participants with "practical knowledge and skills needed to work in low-resource settings, while simultaneously promoting critical thinking, and fostering collaboration across all HEAL sites". The Global Health Delivery Leadership program was created for high potential directors and managers (clinicians and non-clinicians) at PIH to gain practical experience with leadership and project development.

These differing program priorities were reflected in the objectives and topics for each of the programs. HEAL objectives and topics fell into all 3 thematic categories while GHD objectives did not include any Patient Care ones (which makes sense, because GHDL included non-clinicians). Although there is some overlap in topic category of Big Picture (e.g. both programs teach project design theory and leadership skills), they also have different specific focuses. HEAL emphasized quality of care improvements, political engagement and advocacy; GHDL stressed monitoring and evaluating health programs, priorities and health values, and health economics.

The HEAL program was a 140 hour course with a fairly even distribution of didactic, group discussion, and field activities. GHD included 30 hours of "coursework", 2/3 of which were didactic lectures, along with a challenge project that takes place over several months with program supervision.

Conclusion

Although it may be possible to define social medicine (as stated in the background section of this report), it is yet to be seen how that definition will continue to translate into educational programs for individuals working in health care delivery. As seen in this report, there are some very different objective frameworks that can be used to teach the same content. For example, one can take either a Patient Care or a Big Picture approach to teaching models of health financing. Moreover, a single framework of patient advocacy can be used to teach very different Big Picture content, from the practical applications of program development to a theoretical understanding of structural systems that impact health. In many cases, such as in leadership courses or in undergraduate medical education courses that have other priorities, social medicine acts less like a discipline and more like a backdrop for teaching other skills. Overall, this report is a preliminary step in determining the need for:

1. An overarching Social Medicine framework that context-specific and audience-specific curricula could fit into;
2. A package of content topics that represents a sort of "social medicine core" that goes beyond basic social determinants of disease;
3. A "best practice" for transformative learning of these topics.

Understanding how program priorities and teaching methods can (and cannot) be adjusted for specific audiences will allow for the continued expansion of social medicine in education—and therefore, in health care delivery—around the world.

Table 1. Social Medicine programs included in this analysis.

Program	Location	Audience
Harvard University	USA	Undergraduate (and graduate university Students)
PIH Engage	USA	Undergraduate university students (also a smaller number of high school students and young professionals)
Equal Health	Haiti	Medical, nursing, public health students
Faculté de Médecine et de Pharmacie de l'Université d'Etat d'Haïti/Zanmi Lasante	Haiti	Medical students
Faculté de Médecine et de Pharmacie de l'Université d'Etat d'Haïti/Zanmi Lasante	Haiti	Nursing students
Harvard Medical School	USA	Medical students
SocMed	Uganda	Medical and Nursing students
SocoMed (old curriculum)	Rwanda	Medical students
iSOCO (new curriculum)	Rwanda	Medical, Dental, Pharmacy students
Compañeros En Salud	Mexico	First year physicians (interns)
Global Health Delivery Leadership	PIH sites (Boston, Rwanda, Haiti)	High potential directors and managers at PIH
UCSF HEAL	USA	Physicians, pharmacists, nurses and other health care professionals

*Harvard University's course also allows graduate university students, and PIH Engage is technically open to any PIH Engage volunteer, including high school students and young professionals. Both of these include predominantly undergraduate students and did not fit other categories.

Social Medicine Consortium Member Programs – Educational Profiles

This is an overview of Social Medicine education programs within the Social Medicine Consortium that have been developed around the world over the past few years. It is not representative of all Social Medicine programs, but is meant to serve as a learning tool for educators and trainees who are interested in developing a Social Medicine program. This is a living document and we intend to continue to revise this overview of programs as more organizations join the Social Medicine Consortium and bring their expertise into implementing Social Medicine programs.

Equal Health - Haiti

I. Brief Overview

This course represents the first site expansion of a course that has been offered since 2010 in Gulu, Uganda by SocMed. EqualHealth is a non-profit organization dedicated to empowering Haiti's next generation of health professionals through professional development and continuing education. The Haiti-based course shares a core curriculum with the SocMed Uganda course, with a focus on the theoretical frameworks of social medicine, social justice, advocacy, and patient-centered medicine. Additionally, the Haiti-based course focuses on the history of Haiti, the modern-day economic policies that impact it, and the role of NGOs in Haiti, particularly after the January 2012 earthquake.

At a glance:

- Medical, nursing, public health, and other allied health profession students
- 20 students
- 3-week long course
- Started 2013

Website: *http://www.equalhealth.org/socialmedicine*

II. Objectives

1. To promote international solidarity and partnership for generating solutions to global health
2. To foster reflective dialogue between Haitian and international medical students as a means of strengthening ties between the next generation of Haitian health professionals and a global network of their peers

3. To provide a structured global health experience for medical students with dedicated supervision and teaching in clinical medicine and social medicine
4. To study issues related to global health in a resource-poor setting with an emphasis on local and global context
5. To foster critical analysis of global health interventions in resource-poor settings
6. To facilitate the development of a clinical approach to disease and illness using a biosocial model through structured supervision and teaching
7. To build an understanding and skill set associated with physician advocacy

III. Structure & Methodology

A. Course Breakdown

120 hours total = 70 hours didactic + 50 hours tutorial/field

Overall structure includes a combination of field visits, classroom- based presentations and discussions, group reflections, student presentations, films, and bedside teaching. Participants include 10 students from Haitian medical and nursing schools, and 10 other students from around the world.

B. Training Location.

The course has been held on the campus at the University of the Aristide Foundation, the Partners in Health/Zanmi Lasante hospital in Cange, and the Cultural Center in Mirebalais. Future locations will depend on political climate and space availability.

C. Materials

Readings, film (Please see appendix for specifics)

IV. Content

Course Curriculum. The course structure brings together diverse teachings in fields such as history, economics and community organizing along with clinical perspectives. The curriculum is roughly divided into the following parts:

Part 1 – Determinants of Health Beyond Biology: Social and Economic Causation of Disease

Part 2 – Global Health Interventions: Paradigms of Charity, Humanitarianism, and Structural Change

Part 3 – Social Justice in Health Interventions: Models of Community-based Healthcare

Part 4 – Health and Human Rights and the Healthcare Worker as Advocate

Part 5 – Tools for Effective Application of Global Health Experience: Writing, Photography, Research, and Political Engagement

Clinical topics will include cholera, tuberculosis, HIV/AIDS, and other relevant diseases implicated in social determinants of health.

V. Means of Evaluation and Assessment

A. Group Project Evaluation

Based on the the following criteria:

1. Applying the concepts of social medicine course
2. Creativity
3. The feasibility of the project

B. Participation grade (reflects engagement in class project and discussions, field visits, etc)

C. Narrative Medicine Paper

VI. Course Faculty | Roles and responsibilities

A group of course leaders from both the U.S. and Haiti with expertise in tropical medicine and public health make up the core faculty, and will teach the course in French.

Faculté de Médecine et de Pharmacie de l'Université d'Etat d'Haïti/Zanmi Lasante Nursing Program - Haiti

I. Brief Overview

This is rotation for nursing students at one of the five medical schools in Haiti, Faculté de Médecine et de Pharmacie de l'Université d'Etat d'Haïti in partnership with PIH's sister organization Zanmi Lasante. This module sets an overall objective to introduce students to community health and the practical and theoretical skills for the social and community care in rural Haiti.

At a glance:

- Final year (third year) nursing students
- 2 groups of 18 students
- 2-week long course per group
- Established in 2012

II. Objectives

General objectives

1. Help public health institutions to enhance learning abilities of nursing students with internship opportunities in community health and social medicine.
2. Facilitate nursing students to experience rural practice.
3. Create a space for interaction between students and health care providers in the field through the everyday practice and implementation of some priority programs MSPP such as tuberculosis, HIV, the national immunization program, the malnutrition, and reproductive health
4. Introduce students to field research methodologies by documentary research, quantitative and qualitative method, action research, quality improvement methodologies and community diagnostic approaches.

At the end of the course students will be able to:

- Make a community diagnosis
- Amply discuss the strengths and weaknesses of the Haitian health system
- Understand the role of the nurse in community care

- Understand the various priority programs of the Ministry of Public Health and Population
- Analyze the moral and ethical aspects of the medical profession and nursing in particular.

III. Structure and Methodology

A. Course Breakdown

80 hours total = 20 hours of lectures and 60 hours of tutorials

20 hours of theory classes will be filled through participatory presentations. The remaining 60 hours will be filled by tutorials, and community intervention, or clinical observation and accompaniment on a subject that students will choose and present end of the course.

B. Training Location

The course will be conducted primarily in Hinche, in a service care unit of the Hospital of St. Teresa Hinche Departmental Hospital Centre. For pedagogical reasons, this course can be done in other departments or hospitals Zanmi Lasante / MSPP in the departments of Centre and Artibonite.

C. Materials

Readings, film

IV. Content

Topics covered:

- Priority Programme for MSPP
- TB program
- Monitoring and Evaluation of programs (HIV / TB, Malnutrition)
- HIV Program
- Reproductive Health Program
- Vaccination program
- Malnutrition program
- Social Medicine
- Home visit

- Some indicators of Health to master
- Taking over Psycho social
- Pre and post-test counseling for HIV testing and syphilis
- Research methodology
- Community Diagnosis

V. Means of Evaluation and Assessment

Students will conduct their training under the guidance of managers and instructors Zanmi Lasante. This course will lead to a validating assessment based on an evaluation sheet previously designed by the Directorate of ENIP, duly signed and sealed by the Head of the training course. The evaluation will include:

- Student relationship - Monitor
- Student's participation and integration
- Note on the research work on a subject relating to the objective of the course.
- Oral presentation of research work
- The student paper or a placement report
- The theoretical course posttest

The validation of the course will be given by the Directorate of ENIP.

VI. Course Faculty

For Zanmi Lasante:

- Etienne Vernet, MSc Ed. Director of the National Training Centre
- Kerling Israel, MD Director of Medical Education at ZL
- Ralph Ternier, MD, Head of the Department of Care and Support Community.

To the National School of Nurses of Port-au-Prince:

- Mireille Sylvain, Director ENIP
- Christine D. Neptune, Assistant Director

Faculté de Médecine et de Pharmacie de l'Université d'Etat d'Haïti/Zanmi Lasante Medical Program – Haiti

I. Brief Overview

This is a required rotation for one of the five medical schools in Haiti, Faculté de Médecine et de Pharmacie de l'Université d'Etat d'Haïti in partnership with PIH's sister organization Zanmi Lasante. It serves to enhance learning abilities of graduating students in 6th year of medicine with internship opportunities in Community Health and Social Medicine.

At a glance:

- 6th year medical students
- Groups of 6-8 students
- 3 weeks duration
- Established 2011

II. Objectives

General objectives

1. Enable medical student to receive practical training in rural areas
2. Provide an ideal learning environment to address health problems specific to underdeveloped countries and marginalized people.
3. Create an interactive space between students and field caregivers, especially community health workers and attendants.
4. Facilitate understanding and contact with some internal priority programs such MSPP NACP, NTP, EPI, malnutrition and reproductive health.
5. Encourage the comprehensive practice of medicine including all relevant health.
6. Create opportunities to help students make a community diagnosis.
7. To introduce students to research and scientific presentations.

III. Structure and Methodology

A. Course breakdown:

120 hours total = 20 hours theory + 100 hours tutorial/field

B. Training Location

- Cange and National Training Center (CNF / CHART)

  The course will be conducted on campus, in a service / care unit of the Hospital Good Savior of Cange or at the National Training Center in Hinche.

- In another institution network Zanmi Lasante / MSPP

  For pedagogical reasons, this course can be done in other services or Zanmi Lasante hospitals in Central departments and Artibonite.

C. Materials

Readings, film

IV. Content

20 hours of theory classes will be filled through participatory presentations. The following topics will be covered but can be addressed in other contexts throughout the course:

- The socio-economic determinants of health.
- Global health initiatives (eg. PEPFAR, Global Fund)
- Making Model supports community-based.
- Planning and implementation of community activities
- Research Methodology.
- Improving the quality of care (HealthQual, CYPRESS)
- Health Information System and notifiable disease.

The emphasis will be on the illustration of the comprehensive management of HIV infection, cholera, tuberculosis, cervical cancer and reducing maternal and infant mortality.

The other 100 hours will be filled by tutorials (community education, mobile clinic, health campaign activity) and also conducting a research on a topic chosen in consultation with the tutor in relation to objectives.

V. Means of Evaluation and Assessment

This course will lead to a validating assessment based on an evaluation sheet previously designed by the Dean's Office, duly signed and sealed by the director of the training course.

It will focus on:

- The relationship between student and patients/populations
- The student's participation and integration with the care and service team
- Attendance
- The effective acquisition of specific skills covered by the objectives of traineeship
- The evaluation will also include a note on the research work on a subject relating to the objective of the course.

The evaluation will be based on the life skills (containing 10 criteria previously defined by the FMP / UEH) quoted at 30%, the community diagnosis of duty to duty at 30% and the final duty to 40% research.

VI. Course Faculty

- **Director of the course:**
  - Dr. Ramilus St-Luc, Regional Coordinator ZL / Central Plateau (Slucram2002@yahoo.fr)
  - Dr. Daniel Dure, DCBET (duredaniel@gmail.com)
- **Logistics Manager:**
  - Joseph Wilde, Asst-adm (joseph.wilde9@gmail.com)
- **Internship coordinators:**
  - Dr. Patrick Ulysses, regional coordinator ZL / Bas Artibonite (superning12@hotmail.com)
  - Nicole Emilien Nicolas, CHW training coordinator, (nicoleemiliennicolas@yahoo.fr)

There are several stage monitors and guest presenters that are also considered faculty.

Compañeros en Salud - Mexico

I. Brief Overview

The certificate course is comprised of 4 main sections: a global health and social medicine curriculum (GHSM; discussed here), a medical skills curriculum, a humanistic curriculum, and a quality care delivery curriculum. In the GHSM there are minimal lectures and an emphasis on information, formation, and transformation as the basis of transformative learning.

At a glance:

- Graduate physicians and nurses doing mandatory social service year (pasantes)
- 16 students per course
- 12 month-long program
- 12 sessions for 3 hours each (GHSM part)

II. Objectives

1. Teach trainees to learn broadly and think widely: global thinking for global impact
2. Encourage transformative learning based around interactive discussions
3. Teach participants to become educators and to be powerfully active on many fronts, from service, to systems development, to training, to research, to advocacy
4. Help participants develop a broad understanding of global health as a series of problems across disciplines
5. Create master practitioners that will become the change agents creating the knowledge, systems and policies that actually move us towards “health for all”

III. Structure and Methodology

A. Course Breakdown

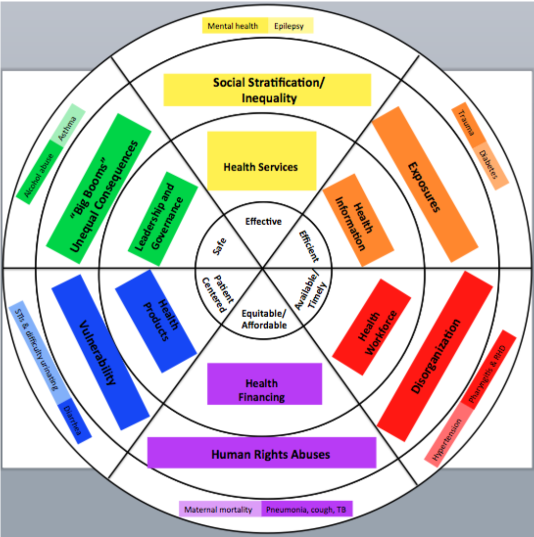
The Global Health and Social Medicine portion of the certificate program is around 230 hours, including 12 individual 3-hour dynamic group discussion sessions. These 230 hours are embedded within 2000 hours of experiential learning.

B. Training Location

Mexico.

C. Materials

The PDFs of the manual are not published in an open access format; instead, CES hopes to partner with interested programs and accompany them through the process of adopting and adapting these materials. This may open up new opportunities for program graduates who were the most talented and motivated facilitators to gain employment in larger global health efforts.



Our GHSM curriculum is entirely based on "dinámicas," or dynamic exercises. PowerPoint is used only to show pictures, almost never words. People learn by talking, playing, acting, laughing, and teaching each other. Our guiding theory is that global health started as "a collection of problems," and that between these problems we have the opportunity to see new connections and new solutions. To organize the mass of themes and ideas inherent to global health equity delivery, we made a "mandala" (or pictorial representation of our philosophy in action); each color has four 3-hour sessions from which to choose, for a total of 24 individual 3-hour sessions. With 6 colors, the course begins at month 1 of 12 on yellow, and then proceeds through the colors until on month 7 of 12 the colors start over again. This allows themes to be re-explored by a new cohort of students coming in each month; it allows students hitting the halfway point to become the teachers and "teach-back" what they learned to the new students. Indeed, the best way to learn something is to teach it.

Each ring groups around a theme: the inner ring lists the components of quality care delivery, the next ring lists the WHO 6 building blocks of health care system strengthening, the next ring lists some of the key processes by which the social determinants of disease cause disease, and the final ring grounds this all within a few key disease entities that serve as examples. Each dynamic session will lead the students through some activity that explores all the themes in the wedge. For example, yellow sessions will explore effective health care, health services, social

stratification and inequality, epilepsy, mental health disorders individually or the interactions between them. Any one student will see maximum 12 sessions of the 24 available, but may see less if prior sessions are "taught-back" in their second 6-month period.

IV. Content

1.- Understanding and applying the social determinants of health, social epidemiology, and social science approaches to patient care.

- Definitions class: social determinants, social structure, structural violence, structural vulnerability, asymmetry of information, privilege, naturalization of inequity.

- Inequity and Oppression

- Understanding poverty: Poverty Simulation

- Social construction of Reality

- Culture. Elements of ethnography. Visions on health, disease, healing, death.

2. An advocacy and equity agenda that treats health as a human right.

- Discussion on health as a human right. Alma Ata, comprehensive and selective primary care.

- Discussion on socialization of scarcity and risk inversion

- Elements of quality in a health system.

3. An approach that is both interdisciplinary and multisectoral across the health system.

- International cooperation for health (NGOs, multilaterals, bi laterals, public private partnerships)

- Health financing, distribution of resources, examples of health systems.

4. Deep understanding of local and global contexts, ensuring that the local context informs and

leads the global movement.

- Global warming. Big threats to health.
- Globalization and health – Macroeconomic influences (Coffee, malnutrition)
- Patents and big pharma, availability of medications
- Policy design, examples of failed policies (nutrition pyramid)

- Burden of disease, allocation of resources, human resources training (1st, 2nd, 3rd levels), examples of health systems (DALYs).
- Value chain
- Political map (who is who)

5. The voice and vote of patients, families, and communities.

- Bio power
- Unintended consequences

V. Means of Evaluation and Assessment

There is no evaluation tool at the moment. The evaluation consists in observing and mentoring the pasantes who are doing clinical work through the year. Supervisors focus in individual growth, capacity building and troubleshooting with each pasante, and hand in monthly performance evaluations and SOAP forms.

VI. Course Faculty Roles and responsibilities

Daniel Palazuelos: lesson plan and curriculum development for GHSM portion.

Patrick Elliott: curriculum development and oversight of clinical portion of the course.

Hugo Flores: lesson plan, curriculum development and facilitation of GHSM portion.

University of Rwanda/Inshuti Mu Buzima Community Medicine Course Rotation - Rwanda

I. Brief Overview

In 2014, Rwanda's medical training began to transition from a 6-year program to a 5-year program, with students now in both cohorts. For the students still in the 6-year track, social medicine is taught for 2 weeks in year 4 and again for 1 month in year 5. Please refer to University of Rwanda's iSOCO factsheet for more information on the new social medicine curriculum associated with the 5-year program. Social medicine programs are hosted by University of Rwanda and supported by PIH's sister organization Inshuti Mu Buzima.

Year 4

This is a two-week module to prepare students to understand the basic elements involved in medical care at the level of the community and community health center. Core topics will be presented as an initial orientation to community medicine.

At a glance:

- 4th year Medical students
- Students are divided into 13 sub-groups; also taught as a class
- 2 weeks duration

Year 5

This module of 4 consecutive weeks will prepare students in small groups to understand the unique issues and challenges of medical care at the level of the community, community health center, and district hospital, and to function more effectively in the health system of Rwanda.

At a glance:

- 5th year Medical students
- Approximately 11 students per rotation
- 4 weeks duration

II. Objectives

<table>
<tr><th>YEAR 4</th><th>YEAR 5</th></tr>
<tr><td>The overall objective:
To lay the foundation of knowledge and attitudes regarding population based medical care at the community level</td><td>The overall objective:
To train Rwandan physicians knowledgeable in social medicine, and capable of delivering high quality community health care that is continuous and integrated in all levels of care, in order to improve the overall health of the Rwandan community.</td></tr>
<tr><td>The specific objectives:
1. Explain the role and elements of primary health care
2. Describe the different research techniques available for use in general and in public health.
3. Understand the methods for inducing changes favourable to the promotion of the healthy life styles and preventive measures of common diseases in a given community.
4. Utilize the basic concepts and tools of public health
5. Apply effective communication skills in a variety of settings
6. Discuss the control of common epidemic or recurrent health problems within the community context
7. Describe population based methods of promoting health of a community</td><td>The specific objectives:
1. Health System of Rwanda
2. Health care provision
3. Health care providers
4. Community health /Community and individual people
5. Social determinants of health
6. Communication and teambuilding skills
7. Disease prevention and health promotion
8. Care delivery improvement and Community Health Policy
9. Management and leadership skills
10. Specific parts of the health care system
11. The Desired Rwandan Health care provider
12. INTEGRATE THE ABOVE OBJECTIVES INTO THE DAY-TO-DAY PRACTICE IN DEALING WITH PATIENTS, COMMUNITIES AND COLLEAGUES IN ANY DISCIPLINE, ANY SETTING AND ANY LEVEL OF CARE</td></tr>
</table>

III. Structure and Methodology

<table>
<tr><th>YEAR 4</th><th>YEAR 5</th></tr>
<tr><td>A. Duration
2 weeks
40 hours total = 2/3 lecture and 1/3 presentations

Methods:
1. self-learning in groups.
2. standard illustrated lecture and discussion</td><td>A. Duration
4 weeks
Approximately 150 hours contact time:
30 hours interactive presentations
40 hours group discussions
80 hours community activities</td></tr>
</table>

B. Training Location: Rwanda **C. Materials** Readings, film (see appendix for specifics)	The community medicine rotation is split up in two parts; 3 weeks will take place in Rwinkwavu district hospital, health centres and communities, 1 weeks will take in the Kigali urban community. **B. Training Location** Rwinkwavu District Hospital and Kigali urban setting **C. Materials** Readings, film (see appendix for specifics)

IV. Content

YEAR 4	YEAR 5
Core topics will be presented as an initial orientation to community medicine, and will include themes such as: • Basic elements of primary health care • Public health • Basic epidemiology • Population health • Health education • Common public health challenges in the community • Community based research methodologies. These topics will form the foundation for further development of Community Medicine principles which will be presented during the Community Medicine experiential rotation of the Doc III year of medical training.	In the three weeks the students are in Rwinkwavu District Hospital, the focus is on health care provision in district hospitals, health centers and communities and all the aspects that influence health, disease and health care delivery in the community. In the one week in Kigali the focus is on community urban health, different partners in health care delivery and communities will be visited for students to explore and experience care delivery for the urban poor. Content follows stated objectives: 1. Health System of Rwanda 2. Health care provision 3. Health care providers 4. Community health /Community and individual people 5. Social determinants of health 6. Communication and teambuilding skills 7. Disease prevention and health promotion 8. Care delivery improvement and Community Health Policy 9. Management and leadership skills 10. Specific parts of the health care system 11. The Desired Rwandan Health care provider

V. Means of Evaluation and Assessment

<table>
<tr><th>YEAR 4</th><th>YEAR 5</th></tr>
<tr><td>The evaluation and final mark of the students will consist of 3 elements:
• Attendance and participation in discussion – 20%
• Scoring of student presentations – 40%
• Final written examination – 40%</td><td>The evaluation of the participants will consist of 3 elements:
• Participation in discussion during training, 30%
• Scoring of presentations, 30%
• Final written examination, 40%</td></tr>
</table>

VI. Course Faculty

<table>
<tr><th>YEAR 4</th><th>YEAR 5</th></tr>
<tr><td>Principal teachers:
• Dr Mieke Visser (miekevisser47@gmail.com)
• Dr Jane Frances Namatovu (drnamatovu@gmail.com)

Supporting teachers:
• - Dr Maaike Flinkenflögel
• - Dr Vincent Cubaka
• - Dr Claude Uwamungu
• - Dr Eva Arvidsson
• - Dr Marian Holtland
• - Mr Edouard Munyamaliza

Training material development:
• - Dr Calvin Wilson and all teachers</td><td>• Mr. Emmanuel Ngabire, Partners in Health, Rwinkwavu Hospital
• Dr. Maaike Flinkenflögel, Partners in Health, Rwinkwavu Hospital
• Dr. Mieke Visser, Partners in Health, Rwinkwavu Hospital
• Dr. Vincent Cubaka, Aarhus University, Kabgayi Hospital
• Dr. Michael Schriver, Aarhus University, Kabgayi Hospital
• Dr. Eva Arvidsson, Jönköping Research and Development Unit, Sweden
• Visiting lecturers,
• General Practitioners
• Community Health Nurses
• Community Health Workers
• Social workers</td></tr>
</table>

University of Rwanda/Inshuti Mu Buzima iSOCO - Rwanda

I. Brief Overview

As of 2014, medical school in Rwanda began to transition from a 6-year program to a 5-year program, with students now in both cohorts. For the students still in the new 5-year track, social medicine is taught throughout years 1-4. Social medicine programs are hosted by University of Rwanda and PIH's sister organization Inshuti Mu Buzima.

Please refer to University of Rwanda's Doc II/Doc III factsheet for more information on the old social medicine curriculum associated with the 6-year program.

At a glance:

- 1st – 4th year medical students
- All enrolled medical students
- Longitudinal course over 4 years (and continuation as a theme in year 5)
- 2014

II. Objectives

The overall aim of social and community medicine training in undergraduate medical curriculum is to develop patient-centered and community-oriented professional health care providers. It will prepare students to understand the basic principles of social and community health care which they will need within the practice of medicine. The module is divided into 5 main sections (Population Health, health systems, social medicine, communication skills and professionalism) that are further divided in key elements

Full list of objectives available upon request.

III. Structure and Methodology

A. Course Breakdown

Year 1 & 2

100 hours total (each year) = 18 lecture + 18 tutorial + 18 peer education + 18 assignments + 26 self-directed learning + 2 exams

Year 3

150 hours total= 15 lecture + 38 tutorial + 20 peer education + 15 assignments + 16 presentations of project + 44 community medicine field visits + 2 exams

Year 4

160 hours total= 8 district hospital ward rounds +36 health center/OPD, social health service + 8 discussion with staff + 4 health education + 16 comprehensive presentations + 12 home and community visits + 20 feedback/reflection + 10 tutorials/didactic + 20 peer education + 26 self-directed learning

Year 5

In year 5, our department has no teaching time. But within the senior clerkships of the main specialties, there will be a continuation of the principles and practices of social and community medicine as a theme.

B. Training Location

Sites all around the country where PIH Engage chapters have been established.

C. Materials

Readings (See appendix for specifics)

IV. Content

YEAR 1: Introduction to social and community medicine within the practice of medicine

Theory-based

- Population Health
    - Disease prevention/ health promotion 1, 4
- Health Systems
    - Health system models - Rwandan health system 1
    - Roles and responsibilities of all health care workers 1
    - Interdisciplinary care
        - coordination of care 1, 4
    - Primary Health Care 1, 4
    - Rural Health/Community Health/District HC
        - referral systems 1, 4
    - Health Financing 1, 4
        - insurance system 1, 4
- Social Medicine

    - Social determinants of health 1
    - Bio-psycho-social medicine 1
    - Doctor-patient-Community 1
    - Social accountability - Dr as advocate 1
    - Health equity 1
- Communication skills
    - Patient-centered communication & consultation 1, 2, 3, 4
    - Relationship building - empathy, sympathy 1, 2, 3, 4
    - Interdisciplinary communication 1, 2, 3, 4
- Professionalism:
    - Personal role 1, 2, 3, 4
    - Reflection 1, 2, 3, 4
    - Feedback 1, 2, 3, 4
    - Medical Ethics 1, 2, 3, 4
    - Medico-legal issues 1, 2, 3, 4
    - Medical mistakes 1, 2, 3, 4

Year 2: Introduction to social and community medicine within the practice of medicine

Theory-based

- Population Health
    - Demography 2
    - Epidemiology 2
    - Research Methods
        - Biostatistics 2
        - Quantitative/qualitative 2
        - Critical appraisal 2, 3
    - Patient Oriented Evidence that Matters (Evidence Based Medicine) 2, 4
- Health Systems

- Traditional medicine 2
- QI (quality improvement), implementation of qi projects 2, 3
- Supervision and mentorship of community programs 2

- Social Medicine
    - Occupational health 2,4
    - Environmental health 2,4
    - Gender issues 2,4
    - Adherence 2,4
- Communication skills
    - Patient-centered communication & consultation 1, 2, 3, 4
    - Relationship building - empathy, sympathy 1, 2, 3, 4
    - Interdisciplinary communication 1, 2, 3, 4
    - Health education 2, -3-4
    - Teaching and mentoring skills 2, 4
- Professionalism:
    - Personal role 1, 2, 3, 4
    - Reflection 1, 2, 3, 4
    - Feedback 1, 2, 3, 4
    - Rational prescribing 2
    - Medical Ethics (1, 2, 3, 4)
    - Medico-legal issues (1, 2, 3, 4)
    - Medical mistakes (1, 2, 3, 4)

YEAR 3: Developing population health care
Transition from theory to practice

- Population Health
    - Research Methods
        - Critical appraisal 2, 3
    - Disease prevention/ health promotion 1, 3

        - Community oriented primary care (COPC) 3
- Health Systems
    - QI (quality improvement), implementation of qi projects 2, 3
- Communication skills
    - Patient-centered communication & consultation 1, 2, 3, 4
    - Relationship building - empathy, sympathy 1, 2, 3, 4
    - Interdisciplinary communication 1, 2, 3, 4
    - Difficult consultations (e.g. delivering bad news, domestic violence) 3, 4
    - Health education 2, 3, 4
    - Patient empowerment, patient groups 3, 4
- Professionalism:
    - Personal role 1, 2, 3, 4
    - Reflection 1, 2, 3, 4
    - Feedback 1, 2, 3, 4
    - Medical Ethics 1, 2, 3, 4
    - Medico-legal issues 1, 2, 3, 4
    - Medical mistakes 1, 2, 3, 4

YEAR 4: Primary health care and community medicine in practice
Transition from theory to practice

Similarities with Doc III Community Health Rotation in old curriculum

- Population Health
    - Patient Oriented Evidence that Matters (Evidence Based Medicine) 2, 4
    - Disease prevention/ health promotion 1, 4
- Health Systems
    - Interdisciplinary care
        - Coordination of care 1, 4
    - Primary Health Care 1, 4
    - Rural Health/Community Health/District HC

        - Referral systems 1, 4
- Social Medicine
    - Occupational health 2, 4
    - Environmental health 2, 4
    - Gender issues 2, 4
    - Adherence 2, 4
    - Disability 4
- Communication skills
    - Patient-centered communication & consultation 1, 2, 3, 4
    - Relationship building - empathy, sympathy 1, 2, 3, 4
    - Interdisciplinary communication 1, 2, 3, 4
    - Health education 2, 3, 4
    - Difficult consultations (e.g. delivering bad news, domestic violence) 3, 4
    - Patient empowerment, patient groups 3, 4
    - Teaching and mentoring skills 2, 4
- Professionalism
    - Personal role 1, 2, 3, 4
    - Reflection 1, 2, 3, 4
    - Feedback 1, 2, 3, 4
    - Medical Ethics 1, 2, 3, 4
    - Medico-legal issues 1, 2, 3, 4
    - Medical mistakes 1, 2, 3, 4

YEAR 5: The professional medical doctor
Transition from theory to practice

In year 5, our department has no teaching time. But within the senior clerkships of the main specialties, there will be a continuation of the principles and practices of social and community medicine as a theme.

Year 1 to 5

During the four years of social and community medicine training (and continuation as a theme in year 5) we will emphasize on the overall creation of the "Desired Rwandan Medical Doctor" who is a patient-centred and community-oriented health care provider with the knowledge and skills of Collaborator, Communicator, Manager, Health advocate, Scholar and Professional as has been described in the "Undergraduate Medical Training Framework" from the University of Rwanda.

V. Means of Evaluation and Assessment

Year 1 & 2:

- Formative assessment (scoring of assignments) – 60%
- Summative assessment (final written examination) – 40%

Year 3

- Formative assessment
    - Evaluation of presentations of proposal – 40%
    - Continuous evaluation of individual/ group performance – 20%
- 2. Summative assessment
    - Evaluation of final written proposal – 25%
    - Individual theoretical examination – 15%

Year 4

- Summative assessment
    - Participation in discussions during the training – 30%
    - Scoring of presentations – 30%
- Formative assessment (Final written examination) – 40%

VI. Course Faculty

Year 1 & 2

- Dr. Aoife Kenny, Visiting teacher, University of Rwanda
- Ibra Muhumuza, Senior Lecturer, Oral health, University of Rwanda
- Dr. Ingeborg Zijdenbos, Visiting teacher, University of Rwanda
- Dr. Jean Claude Uwamungu, Partners in Health

- Dr. Maaike Flinkenflögel, University of Rwanda, Partners in Health
- Dr. Michael Schriver, Aarhus University, University of Rwanda
- Dr. Mieke Visser, University of Rwanda, Partners in Health
- Saasi Rajab, Lecturer, Oral Health, University of Rwanda
- Dr. Vincent Cubaka Kalumire, University of Rwanda, Aarhus University

SocMed – Uganda

I. Brief Overview

This course aims to ensure that aspiring health professionals interested in working in global health settings, in rich and poor countries alike, are adequately prepared to take into account and address, alongside biological diagnosis, the critical social, economic, and political causative factors linked to illness and healing.

At a glance:

- Medical students
- Approximately 20 students
- 1 month duration
- Established in 2010

II. Objectives

1. To provide a structured global health immersion experience for health professional students with dedicated supervision and teaching in clinical medicine and social medicine
2. To study issues related to health in Uganda with an emphasis on local and global context
3. To foster critical analysis of global health interventions in resource-poor settings
4. To facilitate the development of a clinical approach to disease and illness using a biosocial model through structured supervision and teaching
5. To build an understanding and skill set associated with health advocacy
6. To promote international solidarity and partnership in generating solutions to global health challenges facing societies throughout the world

III. Structure and Methodology

A. Course Breakdown

Total course: 4 weeks (8 hrs per day x 20 days = 160 hrs)

25% didactic

50% group discussion/group work

25% hospital/community activities

Mornings are generally dedicated to explicit engagement with social medicine topics. These topics are covered through small and large group discussions, panels with invited guests, films, and lectures from individuals actively involved in work related to the day's topics. Afternoons are generally dedicated to structured clinical teaching in the hospital wards through a biosocial perspective that links biological understandings of disease with the social determinants of health. During the four weeks, field visits are also organized.

B. Training Location

Gulu, Uganda

C. Materials

Readings

IV. Content

Part 1 – Social Determinants of Health: Accounting for Local and Global Context

Part 2 – Health Interventions: Paradigms of Charity, Development, and Social Justice

Part 3 – Core Issues in Social Medicine: Primary Health Care, Community Health Workers, Health and Human Rights, and Models of Payment

Part 4 – Making Social Medicine Visible: Writing, Narrative Medicine, Photography, Research, and Political Engagement

V. Means of Evaluation and Assessment

During our inaugural year, our course evaluations demonstrated tremendous success. The majority of the course participants reported an improvement in the level of knowledge/experience with global health and social medicine. Specifically, 83% of local students moved from minimal to moderate/advanced levels, while 63% of the international students reported that they had improved their levels of knowledge. At the end of the course, most of the students also stated that they had gained exposure and familiarity with social justice models of health care provision.

In addition to personal reflections that reveal noteworthy learning, the members of each year's course organize themselves into small working groups for continued collaboration on issues such as drug shortages and malnutrition. Furthermore: two of the international students returned to Gulu and Lacor Hospital for clinical rotations and time with their new Ugandan friends; five Ugandan students alongside one of the American instructors participated in further health advocacy training held in Kisumu, Kenya; and three forthcoming scholarly papers, each

related to the course content, have been written collaboratively by course participants and instructors.

VI. Course Faculty | Roles and responsibilities

Not available.

Harvard Medical School – United States

I. Brief Overview

The course has four components, which will run in parallel. These disciplines are interrelated and complement each other as applied to clinical care: Clinical Epidemiology, Social Medicine, Health Policy, and Medical Ethics. We have also designed a series of sessions that integrate the approaches of these components (e.g., social determinants of disease, health disparities, responsibility for treatment outcomes). The components, and the integrated sessions, are visible on the session grid on the course homepage. All materials needed for the course are also available from that grid: if you click on a specific session, you'll be taken to a page that provides background information, instructions, guiding questions, and links to the resources and readiness assessment exercises.

At a glance:

- Sessions as a full class and others in small groups of 10-11 students
- 1 month course

II. Objectives

This course will allow students to develop the skills and perspectives needed to:

1. Critically evaluate medical evidence and use it appropriately in their clinical decisions
2. Apply multiple perspectives to understand the social, economic, and political forces that affect both the burden of disease for individuals and populations and the ability of the health system to ameliorate them
3. Understand the health policy context (including insurance, quality measurement, and care delivery models) in which they will practice
4. Become grounded in the ethical principles that underlie clinical care, research, and professionalism generally, with the facility to recognize and analyze ethical issues in practice.

III. Structure and Methodology

A. Course Breakdown

4 weeks = approximately 90 hours

Essentials uses three types of sessions. We will have a few sessions in the amphitheater (Armenise) in which one professor presents material or leads an exercise for the entire class.

Most of the teaching for Clinical Epidemiology, and some of the teaching for Social Medicine, will take place in the learning studios. Ethics, Health Policy, and Social Medicine will do much of their teaching in small groups (10-11 students plus an instructor). Here are links to your small group assignments and table groups for the learning studios

B. Training Location

Boston, MA (USA)

IV. Content

This is the content for the overall course. It includes topics from Social Medicine as well as from Clinical Epidemiology, Health Policy, and Medical Ethics.

Those that are underlined below specifically make up the Social Medicine component of the course.

- **Burden of Disease**
  - Bedside Rationing
  - Critically Appraising What We Think We Know: Associations and Causality
- **The Social Determinants of Disease**
  - Interpreting Statistics in Clinical Research: The Basics I
- **Race and Class**
  - Interpreting Statistics in Clinical Research: The Basics II
- **The History and Ethics of Human Subjects Research**
  - Research Ethics
  - Bias, Confounding, and Effect Modification
- **The Puzzles of Treatment Efficacy**
- **The History of Health Care in America**
  - Introduction to Health Policy
  - Rationing and Futility
- **The Role of Medicine**
  - Health Insurance: Role of Consumer Incentives, Moral Hazard, and Benefit Design Features
  - Multivariable Modeling

    - Private Health Insurance: Role of the Employer
    - Randomized Controlled Trials and Power
    - Adverse Selection in Competitive Insurance Markets
    - Deciding for Others
    - Quiz and Diagnostic Testing
    - Paying Providers: Incentives and Challenges Created
    - Screening, Thresholds II, and Summarizing Evidence
    - Provider Organization
    - Ethical Distinctions in End-of-Life Care
    - Peer Review Exercise/Application of Evidence to Patient Care
    - Technological Innovation, Health Care Spending Growth, and the Quality of Health Care
- **Disparities in Treatment Access and Outcome**
- **Eliminating Health Care Disparities**
- **Ethics of Disparities and Health Inequalities**
- **Achieving Value in Health Care**
    - Quality Measures and Their Uses
    - International Health Care Systems and Lessons for the U.S.
    - Taking Medicine Beyond the Clinic
    - Reproductive Ethics
    - Assessing Health Policy Issues and Health Policy Wrap Up
    - Responsibility for Disease -- Should There Be Consequences?
    - Ethics and Genetic Testing
    - Communicating Evidence to Patients
- **Responsibility for Achieving Optimal Treatment Outcomes**

V. Means of Evaluation and Assessment

- 15% Readiness Assessment Exercises
- 15% Social Medicine essays

- 15% Ethics essays
- 15% Clinical Epidemiology quiz
- 15% Health Policy assignment
- 25% Final Exam

VI. Course Faculty Roles and responsibilities

Because of our commitment to the small groups sessions, we have many faculty involved in the course (at least 16 per component, approximately 80 total).

The course leadership includes:

- David Jones, M.D., Ph.D. course director, A. Bernard Ackerman Professor of the Culture of Medicine (HMS/FAS), dsjones@harvard.edu
- Anthony Breu, M.D., Instructor in Medicine, Anthony.Breu@va.gov
- Emma Eggleston, M.D., M.P.H., Assistant Professor of Population Medicine, emortoneggleston@partners.org
- Jonathan Finkelstein, M.D., M.P.H., Professor of Pediatrics and of Population Medicine, Jonathan_finkelstein@childrens.harvard.edu
- Edward Hundert, M.D., Dean for Medical Education
- Daniel D. Federman, M.D., Professor in Residence of Global Health and Social Medicine and Medical Education, Edward_Hundert@hms.harvard.edu
- Jennifer Kasper, M.D., M.P.H., Assistant Professor of Pediatrics, jkasper1@partners.org
- Haiden Huskamp, Ph.D., Professor of Health Care Policy, huskamp@hcp.med.harvard.edu
- Barbara McNeil, M.D., Ph.D., Ridley Watts Professor of Health Care Policy, mcneil@hcp.med.harvard.edu
- Ateev Mehrotra, M.D., M.P.H., Associate Professor of Health Care Policy and Medicine, Mehrotra@hcp.med.harvard.edu

Harvard University Case Studies in Global Health: Biosocial Perspectives – United States

I. Brief Overview

This interdisciplinary course is designed to introduce students to the field of global health. One among a number of courses discussing global health, it aims to frame global health's collection of problems and actions with a particular biosocial perspective. It first develops a toolkit of analytical approaches and then uses them to examine historical and contemporary global health initiatives with careful attention to a critical sociology of knowledge.

At a glance:

- University undergraduate students
- Course meets for 3 hrs/week for 14 weeks

II. Objectives

This course addresses the following questions:

1. What is global health?
2. What is the history of the field of global health?
3. How is global health studied?
2. How is global health practiced?
3. Who works in global health, and what do those people do?
4. In what direction is the field of global health moving, and how can I get involved?
5. How does social theory practically contribute to understanding specific global health and health delivery problems, and thereby lead to specific interventions?

III. Structure and Methodology

A. Course Breakdown

(estimation based on course description):

Approximately 52 hours over 14 weeks = 42 hrs didactic + 10 hrs group discussion

B. Training Location

Harvard University, USA

C. Materials

Readings (See appendix for specifics)

IV. Content

- So You Think You Have A Plan: Using Social Theory to Imagine the Unexpected in Global Health
- The History of Colonial Practices and "Good Intentions:" Global Health from the Colonial Period to the Present
- The Biosocial: A Framework for Case Studies
- Acting in a World of Unintended Consequences: Case Studies in Global Health
- Cross-Cutting Themes in Global Health

V. Means of Evaluation and Assessment

Undergraduate Grade Distribution

- Four short papers: 10% each, at the end of the semester the paper with the highest mark will be weighted at 15%
- In-class midterm: 20%
- Final paper: 30% (proposal: 5%. TF meeting: 5%, written paper: 20%)
- Attendance and participation: 10%

Graduate Student Grade Distribution

- Final Paper: 70%
- Participation: 30%

VI. Course Faculty Roles and responsibilities

- Dr. Paul Farmer, Department of Global Health and Social Medicine, Harvard Medical School Contact: paul_farmer@hms.harvard.edu
- Dr. Arthur Kleinman, Department of Anthropology, Faculty of Arts and Sciences Contact: kleinman@wjh.harvard.edu
- Dr. Salmaan Keshavjee, Department of Global Health and Social Medicine, Harvard Medical School Contact: salmaan_keshavjee@hms.harvard.edu

- Dr. Anne Becker, Department of Global Health and Social Medicine, Harvard Medical School
  Contact: anne_becker@hms.harvard.edu

Partners In Health Engage – United States

I. Brief Overview

PIH Engage is PIH's community organizing program with the overarching goal of advancing the right to health by organizing, educating, generating, and advocating. It is mostly undergraduate students but includes high school students and young professionals.

Part of the aim of this curriculum is to help Engage teams better understand the work and philosophy of PIH and its model of global health care delivery. This is an optional curriculum—more so a set of resources—that team leaders from chapters of volunteers all over the country can share with their teams. All lessons revolve around the right to health and can be done alone or throughout the year.

At a glance:

- PIH engage volunteers (mostly undergraduate students)
- Small groups, numbers vary depending on chapter size and number of attendees
- 15 self-paced modules, about 1 hour each
- Established several years ago; current version
- 2016

Website: *http://engage.pih.org/curriculum*

II. Objectives

Goals (one for each lesson):

1. Explore the history and values of PIH in order to contextualize how PIH Engage advances PIH's Mission.
2. Understand how social, cultural, economic, and political factors influence health
3. To inspire PIH Engage to act in accordance with the social justice approach to global health
4. Explore global health history to inspire teams to commit to the Right to Health Movement
5. Explore how PIH Engage will use the work of PIH to advance the right to health movement
6. Acquire a toolkit of social theories to reframe or contextualize arguments in global health
7. Dissect this framework for health care delivery and the importance of best-practices
8. Explore these approaches and how to overcome the challenges they pose
9. Explore ways to bridge the "know-do gap" when scaling up in global health

10. Understand equitable global health research and how research can be used to build local capacity.
11. Explore care delivery and equitable research interventions conducted alongside the poor.
12. Understand how the AIDS movement played a critical role in advancing the field of global health
13. Understand how advocacy led to the success of the AIDS movement including the passage of PEPFAR
14. Question the term global health and explore health equity in high income countries
15. Explore foreign aid and how PIH Engage can help stabilize global health financing

III. Structure and Methodology

A. Course Breakdown

15 hours total = 15 modules, 1 hour each, meant to be done as discussion sessions

B. Training Location

Sites all around the country where PIH Engage chapters have been established.

C. Materials

Readings

IV. Content

- **Foundational Mission and Values of PIH and PIH Engage**
  - History and Values of PIH
  - Structural Violence: Addressing the Root of Illness
  - A Social Justice Approach to Global Health
  - The Right to Health Movement
  - Leadership and Organization in the Right to Health Movement
- **The PIH Approach to Health Care Delivery: PIH Engage's Role to Echo, Amplify, & Advocate**
  - Global Health: From Theory to Practice
  - Health Care Delivery: Staff, Stuff, Space, and Systems

- Horizontal and Vertical: Challenges in Approaches to Global Health
- Scaling Up in Global Health: Bridging the "Know-Do" Gap
- Ethical Global Health Research

- **Case Studies and Global Health Priorities: Contextualizing with History**
  - MDR-TB: Redefining Health Care Delivery
  - The AIDS Epidemic Launches Global Health
  - Activists and the Success of PEPFAR
  - Structural Violence and Health Equity at Home
  - Global Health Financing: The Need for Advocacy

V. Means of Evaluation and Assessment

None

VI. Course Faculty Roles and responsibilities

Team leaders serve as group facilitators. Discussion sessions were designed for easy use by anyone with access to module materials.

UCSF HEAL Bootcamp – United States

I. Brief Overview

The HEAL Initiative Bootcamp is designed to provide an intensive orientation to global health equity to physicians, pharmacists, nurses and other health care professionals who have been selected as 2-year HEAL initiative fellows. HEAL fellows include recent graduates of US residency programs (rotating fellows) as well as fellows from partner sites (site fellows) in Navajo Nation, domestic federally qualified health centers, and international non-profit organizations.

At a glance:

- Health care professionals
- Average of 25 participants
- 3 weeks duration
- Established in 2015

Website: *https://healinitiative.org/curriculum/bootcamp/*

II. Objectives

HEAL Core Competencies:

1. Provision of high quality care focused on local burden of disease
2. Incorporation into and effective engagement with local health system
3. Demonstration of leadership and interprofessionalism
4. Development of strong and diverse teaching skills
5. Advocacy for communities, health systems, and patients
6. Adherence to principles of health equity and ethics in clinical and academic work

The objective is to equip HEAL Fellows with practical knowledge and skills needed to work in low-resource settings, while simultaneously promoting critical thinking, and fostering collaboration across all HEAL sites. It introduces many of the concepts that will be further developed in the ongoing curriculum over the 2-year program. Most fellows participate in an online MPH program and all fellows participate in ongoing discussions, readings, and case presentations over their 2-year fellowship.

III. Structure and Methodology

An integral part of the HEAL Initiative curriculum is 3 weeks of intensive coursework at the beginning of the first year intended for both Rotating and Site Fellows. The July Bootcamp consists of a combination of didactic lectures, interactive case studies, clinical skills training, simulations and facilitated mentorship.

A. Course Breakdown

140 hours total. Approximately 1/3 didactic, 1/3 workshop/small group, and 1/3 simulation

B. Location

San Francisco Bay Area

C. Materials

Readings, film (see appendix for specifics)

IV. Content

- Provision of high quality care focused on local burden of disease
  - Local Burden of Disease
  - Provision of Care
  - Quality Care and Improvement
- Incorporation and effective engagement in local health system
  - Understanding the health system
  - Engagement in the health system
- Demonstration of leadership and interprofessionalism
- Development of strong and diverse teaching skills
- Advocacy for communities, health systems, and patients
- Adherence to principles of health equity and ethics in clinical and academic work

V. Means of Evaluation and Assessment

Fellows complete individual evaluations for each session immediately. They complete a cumulative end of bootcamp survey reviewing the whole course. They also receive surveys at 6 months and 12 months to assess effectiveness of the course in the field.

VI. Course Faculty Roles and responsibilities

- Robin Tittle, curriculum director and course leader
- Phuoc Le, HEAL co-founder
- Sriram Shamasunder, HEAL co-founder
- Large curriculum team, including over 40 instructors from multiple disciplines

New York University Social Emergency Medicine – United States

I. Brief Overview

Bellevue and NYU SEM (Social Emergency Medicine) Scholarly Academy provides exposure to social emergency medicine through a two-year curriculum with structured talks, lectures, journal clubs and workshops in key topics of social emergency medicine. The academy seeks to provide residents with knowledge, resources and skills for residents to apply in their practice of emergency medicine. Residents will gain the skills to become future leaders in advocacy, education, and social emergency medicine research focusing on the social determinants of health to improve the lives of their patients and communities. Through the scholarly academy, residents will build bridges with community members and engage with vulnerable populations. Residents will learn about social justice and how complex social environments affect the health of patients presenting to the emergency department. Residents will continue the struggle for a human rights model of health and be at the forefront of the historical arc of justice.

At a glance:

- 60 residents
- Six-unit curriculum with sessions ranging from 30 minutes to 1.5 hours
- Two-year program

Website: *Internal website being developed.*

II. Objectives

- Educate residents to become future leaders in the field of Social Emergency Medicine
- Provide opportunities for residents to become engaged in research and scholarly work to expand the practice and knowledge of the Social Emergency Medicine field
- Increase knowledge of the practice of Social Emergency Medicine so that emergency residents can become agents to improve the health of their emergency medicine patients and activists to improve the health of communities and populations
- Mentor residents in the field of Social Emergency Medicine and provide them with the skills and tools to incorporate Social Emergency Medicine into their practice and future careers as emergency medicine practitioners

III. Structure and Methodology

SEM curriculum is a six-unit curriculum with formal lectures and workshops to 60 residents in the emergency medicine program during the year. The SEM Scholarly Academy is a monthly educational curriculum designed by residents and faculty with a curriculum that runs over a two-year period with sessions each month that last one hour.

A. Course Breakdown

Two-year program. Formal lectures and workshops.

B. Location

New York University

C. Materials

Readings, conferences, journal clubs.

IV. Content

Scholarly Academy Curriculum Topics Include:

- Advocacy
- Social Determinants of Health
- Social Justice
- Health Rights
- Prison Health
- Research
- Epidemiology
- Vulnerable Populations
- Homelessness
- Alcohol and Substance Abuse
- Social Justice
- Health Inequity
- Racism in Healthcare
- Gender and Health
- Gun Violence
- Prevention
- Forced Migration and Health

Expectations and Requirements:

- Involvement of residents in SEM Academy events both during Wednesday Conference as well as throughout the year participating in SEM Slack Forum

- Participation in 50% of the Scholarly Academy Monthly Resident Meetings
- Involvement in a scholarly research Social Emergency Medicine activity during the year
- 2nd year residents are expected to identify an area of interest and identify a mentor in the SEM academy engaging in a project, program, or research in the area of SEM
- 3rd year residents are expected to lead a journal club, discussion, or reading on a topic for the Scholarly Academy
- 4th year residents are expected to submit an abstract, peer-reviewed article, blog, e-book, or published article at the end of the year
- 4th year residents must complete a SEM Scholarly Project and present their work to the residency on Scholarly Research Day. 4th year residents will also have to complete and submit documentation to residency leadership

V. Means of Evaluation and Assessment

- Collection of resident pre and post data on knowledge, behavior, and attitude from six-unit SEM curriculum
- Resident qualitative reflections
- Residents must meet expectations and requirements as well as mid-year and year sheets

VI. Course Faculty Roles and responsibilities

- Dr. Aaron Hultgren, faculty co-director
- Dr. Larissa Laskowski, faculty co-director
- Dr. Timothy Greene, faculty
- Dr. Francis Coughlin, resident leader
- Dr. Timothy Gallagher, resident leader

Cambridge Health Alliance Internal Medicine Social Medicine & Research Based Health Advocacy Curriculum – United States

I. Brief Overview

The Cambridge Health Alliance Internal Medicine Social Medicine & Research Based Health Advocacy Curriculum is a required, longitudinal curriculum that was developed 11 years ago. We deliver the curriculum over 100 didactic hours including 2 immersion blocks. It is anchored

a research based health advocacy project that has produced significant scholarship over the last 5 years.

The course was initially developed as an elective in 2006 by Danny McCormick by residents interested in topics in health disparities. In 2011, the internal medicine program, recognizing the importance of health equity medical education, transformed the course into a required course for all residents. The course relies on many of our local expertise in health services research. it attempts to expose residents to inspiring health advocacy working both within our institution an around Boston.

At a glance:

- 26 sessions
- Two 2-week immersion blocks
- Didactic hours and immersion blocks for residents

Website: *n/a*

II. Objectives

- Clarify and further develop the values that brought residents to train in a residency program committed to the care of underserved populations
- Explore the role physicians can play in addressing systemic health inequities
- Improve knowledge of topics in health equity, social determinants of health, and health policy
- Develop skills in research methodology, leadership, and health advocacy
- Provide mentorship and role modeling to support career development that incorporates health advocacy

III. Structure and Methodology

There are a total of 26 sessions with two 2-week immersion blocks. In each block, the course includes residents for ten 4 hour blocks, and then we have other didactic AM sessions. About 50% of of the course time is dedicated in topics on health equity such as human rights, healthcare reform, global health delivery, and study of vulnerable populations. The other 50% is dedicated to developing and executing a research based health advocacy project.

A. Course Breakdown

Didactic hours and immersion blocks.

B. Location

Cambridge Health Alliance

IV. Content

Topics Include:

Health Equity, Social Determinants of Health & Health Policy

- Health equity
- Social Determinants of Health & Health Policy
- Health Disparities
- US Healthcare Reform
- Massachusetts Healthcare Reform
- Safety Net Hospital Financing
- Human Rights
- Global Health Development
- Race, Policing & Health
- Women's Health
- Refugee, Asylum and Immigrant Health
- Homelessness & Health
- FDA & Regulations of Dietary Supplements
- Humanitarian Aid & Disaster Relief
- LGBTQ Health
- Prison Health
- Mental Health & Addiction
- Community Health & Partnerships
- Cultural Awareness
- Health Literacy
- Pharmaceutical Industry & Health

Health Services Research Methods

- Introduction to Research Methods
- Study Design
- Review of Large Dataset Sources
- Introduction to Biostatistics
- Introduction to Epidemiology
- Introduction to SPSS
- Introduction to Qualitative Methods
- Introduction to Dedoose

Social Change, Leadership & Advocacy

- Community Organizing
- Public Speaking
- Power Mapping

- Using Media for Advocacy
- Legislative Process Lobbying
- Ethics
- Leadership & Management

Field Trips

- Media: Boston Globe or NPR
- Advocacy: Physicians for Human Rights
- Community Organizing: Healthcare Now

Government

- Meeting legislators at the Massachusetts State House

Lobbying

- Healthcare for All

Advocacy

- Partners in Health
- FXB Center for Health and Human Rights
- Harvard School of Public Health

V. Means of Evaluation and Assessment

- Collection of qualitative evaluations for course
- Pre and post-test evaluations

VI. Course Faculty Roles and responsibilities

- Danny McCormick, MD, MPH - course director
- Gaurab Basu, MD, MPH - course director
- Guest lecturers

University of Minnesota Global Health in a Local Context – United States

I. Brief Overview

The University of Minnesota's Center for Global Health and Social Responsibility (CGHSR), in partnership with the organization SocMed, offers *Global Health in a Local Context: Social Determinants, Community Engagement, and Social Action in Minnesota* each fall. This course

immerses students in the study of health equity, the social determinants of health, global health in a local setting, and community-based healthcare.

Global Health in a Local Context merges unique pedagogical approaches including community engagement; classroom-based presentations and discussions; group and individual reflection; theater, film, and other art forms; and prioritization of narrative to understand patient, community, and health professional experiences. The curriculum promotes a biosocial approach to health and illness, thereby drawing on the disciplines of anthropology, sociology, economics, history, public policy, biomedicine, public health, and the arts. These approaches create an innovative and interactive learning environment in which students participate as both learners and teachers to advance the entire class's understanding of the interactions between the biology of disease and the myriad social, cultural, economic, political, and historical factors that influence illness presentation and social experience of health and well-being.

In order to examine the social determinants of health, this course engages with local context through in-depth study of particular historical, political, and cultural narratives important to the locale, in this case Minnesota. The course curriculum places considerable importance on building partnerships and encouraging students to reflect upon their personal experiences with power, privilege, race, class, and gender as central to effective partnership building in the health professions and health-related fields. In the spirit of *praxis* (a model of education that combines critical reflection with action) these components of the course give students the opportunity to discern their role as health professionals concerned about health equity and justice through facilitated, in-depth conversations with core faculty, community members, and student colleagues.

At a glance:

- Classroom-less class with UMN Students and community members
- The core faculty include both traditional academic faculty and community faculty.
- Medical, public health, dental, nursing, and pre-pharmacy students
- Community health workers, international medical graduates, primary care managers, education specialists

Website: *globalhealthcenter.umn.edu/global-local*

II. Objectives

Following this course, students will be able to:

1. Analyze and articulate the social determinants of health that influence health outcomes amongst different communities in the Twin Cities.
2. Differentiate behavioral, societal/cultural, and structural etiologies of health outcomes and explain how and why these etiologies are at times conflated.
3. Evaluate various models of health intervention to respond to health disparities in Minnesota.

4. Engage in critical self-reflection on one's personal relationship with social inequities and one's future role in responding to inequity.
5. Demonstrate the ability to engage in deep listening, perform a root-cause analysis, participate in constructive dialogue, and generate a strategy to act for social change.
6. Utilize an established network of diverse peers, faculty, and community members to dialogue on health challenges and solutions.

III. Structure and Methodology

A. Course Structure
The course content structure is divided into the following interwoven parts:

- **Part 1** – Social Determinants of Health: Accounting for Local and Global Context
- **Part 2** – Health Interventions: Paradigms of Charity, Development, and Social Justice
- **Part 3** – Core Issues in Social Medicine: Primary Health Care, Community Health Workers, Health and Human Rights, and Health Financing
- **Part 4** – Making Social Medicine Visible: Writing, Narrative Medicine, Photography, Research, and Political Engagement

The class delivery consists of two components:

- **Experiential Weekly Sessions** – these 3-hour sessions will take place on Wednesday evenings each week. These sessions are held in the community and provide experiential opportunities for exploring neighborhoods and interacting with people and organizations doing work related to the course topics.
- **Full day immersion sessions** – Twice during the semester, the class meets for an extended class session. These meetings serve to "open" the class by building community, setting expectations, sharing a unique experience, and cooking food as a group, and then "close" the class by offering an extended period for discussion, reflection, next-steps, putting concepts into practice, and sharing a closing meal.

This unique course structure derives from a philosophical commitment to:

- **P**raxis – inspired by Paulo Freire, we believe that constant interplay between reflection and action generates critical analysis of the world and deepens our ability to effectively respond.
- **P**ersonal – who we are and where we come from matter deeply in health delivery. Critical self-awareness enhances our ability to undo harmful structural and societal factors of which we are all part.
- **P**artnership – community-building amongst individuals with varied demographic backgrounds offers the most innovative and just means of moving towards health equity.

B. Location

This is a classroom-less course that takes place at a different community-based venue in the Twin Cities each week.

IV. Content (Site Locations and Content during Fall 2016)

September:

- Seward Coop Friendship Store/ Sabathani Community Center: Complexity of Community Engagement
- Minnesota Department of Health and Center for Health Equity: Introduction to Social Medicine and the Social Determinants of Health in Minnesota
- Hmong Farm of Xong Mouacheupao: Our Stories – Who We Are and Where We Come From
- West Minnehaha Recreation Center: Race and Racism as a Structural Determinant of Health

October:

- UMN Moos Tower: Neoliberalism and Health
- Center for Social Healing: Where We're at and Where We're Headed
- Flamingo Restaurant: Behavior vs. Structure – The Politics of Food
- HealthPartners Conference Center: Power and Privilege, No Single Story, Charity, Development, and Social Justice

November:

- East Side Family Clinic/SoLaHmo: Community-Based Participatory Action Research
- Mixed Blood Theater: The Arts as a Response to Social Injustice
- Community University Health Care Center: Primary Care as a Social Change Strategy, The Social Determinants of Mental Health, Narrative Health

December:

- Center for Social Healing: Community Health Workers, Accompaniment, and Pragmatic Solidarity
- The Third Place Gallery: Engaging Our Neighbors to Build Partnerships and Social Cohesion
- Center for Social Healing: Social Movements and Activism, Where Do We Go From Here – Staying Engaged, Maintaining Energy, and Harboring Optimism

Course sessions draw on the following body of literature:

1. Roberts, Maya. 2006. "Duffle Bag Medicine." *JAMA* 295: 1491-1492.
2. Porter, Dorothy. 2006. "How Did Social Medicine Evolve, and Where Is It Heading?" *PLoS Medicine* 3(10): e399.

3. Commission on the Social Determinants of Health.*Closing the gap in a generation. Health equity through action on the social determinants of health.* Geneva. World Health Organisation. 2008. http://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf
4. Virchow R. Report on the Typhus Epidemic in Upper Silesia. *Am J Public Health*. 2006;96(12):2102-2105. doi:10.2105/ajph.96.12.2102
5. Minnesota Department of Health. 2014. Advancing Health Equity in Minnesota: Report to the Legislature. http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf
6. Kleinman, Arthur and Benson, Peter. "Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It." *PLoS Medicine* Oct 2006 3(10): 1673-1676.
7. Fanon, Frantz. 1994. "Medicine and Colonialism." In: *A Dying Colonialism.* Grove/Atlantic Press.
8. Kleinman, Arthur. 2010. "Four Social Theories for Global Health." *Lancet* 375: 1518-1519.
9. Foucault, Michel., 1973. *The Birth of the Clinic: An Archaeology of Medical Perception.* Tavistock Publications, pp 3-4.
10. Ta-Nehisi Coates. 2014. "The Case for Reparations." *The Atlantic.*
11. Hardeman, R. 2016. "Structural Racism and Supporting Black Lives – The Role of Health Professionals." *New England Journal of Medicine.*
12. Farmer P, Kim J, Kleinman A, Basilico M. *Reimagining Global Health*. Berkeley: University of California Press; 2013.
13. Keshavjee, Salmaan. 2014. "Epilogue: Reframing the Moral Dimensions of Engagement," In: *Blind Spot: How Neoliberalism Infiltrated Global Health.* University of California Press, pp. 136-144.
14. Farmer, Paul. 1995. "Medicine and Social Justice." *America* 173(2):13-17.
15. Heywood, Mark. 2009. "South Africa's Treatment Action Campaign: Combining Law and Social Mobilization to Realize the Right to Health." *Journal of Human Rights Practice.* 1(1): 14-36.
16. Latour, Bruno. 1979. Selections from *Laboratory Life: The Social Constructions of Scientific Facts.*
17. McEwen, Bruce. 1998. "Protective and Damaging Effects of Stress Mediators." *NEJM* 338(3): 171-179.
18. Cueto, Marcos. 2004. "The Origins of Primary Health Care and Selective Primary Health Care." *American Journal of Public Health* 94(11): 1864-74.
19. Declaration of Alma-Ata. 1978.
20. Bleiker, Roland and Kay, Amy. 2007. "Representing HIV/AIDS in Africa: Pluralist Photography and Local Empowerment." *International Studies Quarterly* 51(4): 1003-1006.
21. Pérez, Leda, and Martinez, Jacqueline. 2008. "Community Health Workers: Social Justice and Policy Advocates for Community Health and Well-Being." *Am J Public Health* 98: 11-14.
22. Aviv, Rachel. 2015. "The Refugee Dilemma." *The New Yorker.* December 7, 2015.
23. Sampson, Robert J., Raudenbush, Stephen W., and Earls, Felton. "Neighborhoods and Violent Crime: A Multilevel Study of Collective Efficacy." Science 277(5328): 918-924.

V. Means of Evaluation and Assessment

1. Students are expected to communicate with the lead instructor if they will need to miss a week of class. Missing more than two class meetings will result in a conversation with the lead instructor about participation expectations, obstacles to full participation, and determining whether it makes sense to continue in the course.
2. **Class Participation:** 20% of grade: Each student will earn participation credit through full attendance, being on time, participating regularly in class discussions and activities, bringing course readings into discussion, acting courteously towards others, and through following directions. Being respectful of different learning styles, we are mindful to not distribute participation points solely on how often you speak in class but rather the quality of your engagement. Students are expected to miss no more than two class sessions.
    i. Small Discussion Groups – Each student will be assigned a partner to work with throughout the semester. Partner pairs will then be combined into small groups (4-6 students). Each week, the instructors will provide groups with 1-3 discussion questions connected to the week's readings. Groups are expected to meet (in person or remotely) and discuss the readings/discussion questions. Groups should come to class prepared to share their discussion summaries if called upon to do so.
3. **Bi-Weekly Journal:** 15% of grade: Each student will respond to journal prompts provided by the course instructors that promote deeper reflection on course themes. Students will submit journal reflections every two weeks, due on Sept 20; October 4 & 18; Nov 1, 15, & 29; and Dec 13.
4. **Knowing Yourself and Others – Building Social Cohesion**: 25% of grade: Each student will participate in a series of guided activities that deepen knowledge of self and others. These activities, drawing on the work of street photographer Wing Young Huie, aim to provide a framework for increasing social cohesion, which has been shown to strengthen neighborhood health. Activities related to this component of the course will take place both in and outside of class. Evaluation will be based on full participation in the activities, the ability to identify how the social determinants of health and social cohesion interact, and sharing your experience of these activities with the class. Concrete deliverables include:
    i. Photograph of something familiar and something unfamiliar in your neighborhood, each with a one-paragraph description (Due Sept 16)
    ii. "Chalk talk" photograph in your neighborhood with two-paragraph description and in-class sharing (Due Dec 13)
    iii. Final Reflective Paper (max 1000 words, due Dec 16)
5. **Refugee Health and Advocacy Project** (Team-based): 25% of grade: Students will be connected to refugee resettlement agencies to witness the refugee resettlement

experience. This activity will provide the opportunity to participate in supporting newly arrived refugees (airport pick-ups, housing set-up, cultural orientation classes, etc.) as well as health-related experiences related to refugee care (visit to refugee clinic, visit to the MN State Refugee Health Office). Based upon those experiences, students will work in teams to analyze the impact of one social determinant of health on refugee health and develop an advocacy strategy based on that analysis. Teams of 4-6 learners will be assigned by the lead instructor. Team members will not be required to attend refugee resettlement activities together, but will draw on their individual experiences to generate a collective understanding of the social/structural determinants of refugee health. Concrete deliverables expected as a group include:

    i. Social/Structural Determinants Ring and Root Cause Analysis (wall chart, Due Oct 25)
    ii. Advocacy Strategy Proposal (maximum 1000 words, Due Dec 6)

6. **Final Exam**: 15% of grade: Each student will take a multiple choice and short-answer exam at the end of class, immediately preceding the Immersion Day 2 on Dec 16. The purpose of the exam is to evaluate your acquisition of the body of knowledge associated with social medicine.

VI. Course Faculty Roles and responsibilities

A Core team of faculty (3-4) coming from academic settings and the community orchestrate the course and oversee content delivery. Numerous guest speakers also participate in class sessions. The core faculty typically meet with each week's teaching team 5-6 days in advance to plan the session and promote a smooth, high-impact delivery of course content. In addition, the core faculty work constantly to stretch pedagogical boundaries.

University of North Carolina Chapel Hill Social Medicine – United States

I. Brief Overview

The course began in 1979-80 as Social and Cultural Issues in Medical Practice in its current format--weekly, 2 semesters, required, team taught by clinician and social science/humanities faculty. In 1992-3 the course was renamed Medicine and Society. The course title was changed to 'Professional Development' as part of a major curriculum revision in 2014. The Selective Seminars began in 1979 and continue in the same format as PD 3. Throughout, we offer electives to interested students. Beginning in 2017, a fourth year Scholarly Concentration in Social Medicine will be launched for students who apply with a specific area of inquiry in mind.

Year 1
PD 1 Professional Development: Social Dimensions of Illness & Doctoring
PD 2 Professional Development: Medical Ethics & the Health Care System

Year 2

PD 3 Professional Development: Advanced Seminars in the Medical Humanities & Social Sciences

Year 3
Intensive Integration: Reflection, Interprofessional, Critical Analysis, Ethics (RICE)

Year 4
Individualization Phase Scholarly Concentration in Humanities and Social Sciences
Humanities and Social Sciences Coil
Behavior Sciences Coil

At a glance:

- 15 students per seminar
- One faculty member per seminar
- 28 sessions, 80 minutes each

Website: *http://www.med.unc.edu/socialmed*

II. Objectives

1. To demonstrate knowledge of and analyze the ways in which social and cultural contexts affect disease, experiences of illness, and roles of physicians;
2. To demonstrate knowledge of and analyze the historical, educational, and ethical forces that shape physicians and doctor-patient relationships;
3. To demonstrate knowledge of and critically evaluate the social, political, and economic forces that influence organization and delivery of medical services, and opportunities for health care reform.

III. Structure and Methodology

We engage issues through readings, discussions, and a lecture. The core of this course is the directed discussion that takes place in seminar groups. We expect students to read carefully and critically all assignments made by seminar instructor/s, and to come to class prepared to discuss the issues fully and freely. We invite students to bring examples, experiences, and knowledge to bear in addressing issues and assigned materials.

A. Course Breakdown

Readings, discussions, and lectures.

B. Location

University of North Carolina Chapel Hill Medical School

IV. Content

PD 1-2

- Social and Cultural Factors that influence health, illness, and treatment of populations and individuals
- Health Care Equity and Disparity, and deepening mastery of gender, race/ethnicity and class as social causal influences of illness and as factors in clinical care
- Histories of medicine, illness, and knowledge of the body
- Ethics: foundations of moral theory and basics of clinical and research bioethics Categories of Difference: Chronic illness and disability, sexualities,
- Health Care Policy: what it is, how it works, costs and the political economy of health care, resource allocation and equity issues, translations to clinical practice; cultures of biomedicine
- Physicians as Citizens and Advocates: Local and Global Health
- Dr/Pt and Dr/Family relationships in context

PD 1 – 2 Schedule 2016- 2017

1. Intro Immunology
2. Experiencing Illness Immunology
3. Culture Immunology
4. Families Hematology
5. Race Hematology
6. Sexualities Hematology
7. Sex, Gender, Health & Illness Hematology
8. Social Inequalities Hematology
9. Sacred Practices Cardiology
10. Death & Culture Cardiology
11. Labeling, Classification, Disability, Stigma Cardiology
12. Evidence Cardiology
13. Clinical Learning Cardiology
14. Moral Reflection Respiratory
15. Ethics in Medicine Respiratory
16. Truthtelling Respiratory
17. Privacy & Confidentiality Respiratory
18. Coercion & Invol. Treatment Urinary
19. Ethics in Medical Research Urinary
20. Moral Management of Death Urinary
21. Issues in Clinical Practice GI
22. Resource Choices GI
23. History of Health Insurance GI
24. Uninsured Lecture Neuro
25. HCRE: Role Caucuses Neuro
26. HCRE Hearing Neuro
27. Boundaries Neuro

PD 3
Students Select One Seminar:

- American Struggle for Health Care Reform
- Experiences of Deviance, Disability and Chronic Illness
- The Revenge of the Sick: History of Medicine from the Patient's Point of View
- Health and Human Rights
- Anticipating Personalized Genomic Medicine
- History and Ethics of Human and Animal Experimentation
- Death and Dying in America
- Pharmaceuticals, Politics, & Culture
- The Ethics and Politics of Clinical Research
- Global Health and Medical Ethics
- Writing Narrative Medicine
- How Social Forces Shape the Facts of Biomedical Science

V. Means of Evaluation and Assessment

Written Component - Personal Illness Narrative: 10%
Home Visit Narrative & Analysis: 25%
Ethics Essay: 20%
Oral Component: Overall Attendance and Participation in Class Discussion: 35%
Health Care Reform Exercise (Oral Presentation and Discussion Participation): 10%

School of Medicine requires standardized evaluations of all courses.

VI. Course Faculty Roles and responsibilities

Course faculty members come from clinical, social science, and humanities backgrounds, and all bring to the seminar sessions significant experience in interdisciplinary research and teaching. Faculty are responsible for organizing each seminar session based on a common syllabus and readings or other materials, making assignments, grading written assignments, writing narrative assessment, and giving ongoing feedback.

Faculty Disciplines: Anthropology, Bioethics, Clinical Epidemiology, Comparative Literature, Family Medicine, Geriatrics, History, Internal Medicine, Neurology, Ob/Gyn, Philosophy, Political Science, Psychiatry, Public Health, Religious Studies, Sociology, Psychology.

Research Areas of Faculty: Bioethics research, clinical bioethics, clinical teaching and practice, advising, teaching across the campus and across disciplines, writing fiction, policy analysis, engaged research in health disparities and inequalities, genomics and society, local and global consultation and research collaboration, health justice advocacy and research, science and technology studies, disability studies

Resources

The following list of key social medicine articles should be used as a reference for those seeking to more deeply explore various social medicine topics. This list is not exhaustive, but we intend to add to the list as Social Medicine Consortium members identify new resources.

Access and Universal Health Coverage

Berkowitz, A. (2015). All for one. *JAMA, 314*(13), 1341-1342.

Woolhandler, S. et. al. (2003). Costs of health care administration in the United States and Canada. *The New England Journal of Medicine, 349* (8), 768-775.

World Health Organization. (2008). Now more than ever. *The World Health Report.*

Economics

Allard, J., Davidson, C., & Matthaei, J. (2007). Solidarity economy: Building alternatives for people and planet. *The US Social Forum 2007.*

Farmer, P. (2015). Health-care financing and social justice. *To Save Humanity: What Matters Most for a Healthy Future.*

Farmer, P. (2015) Who lives and who dies. *London Review of Books, 37*(3), 1-13.

Massachusetts Institute of Technology. (2011). The price is wrong: Charging small fees dramatically reduces access to important products for the poor. *Abdul Latif Jameel Poverty Action Lab.*

Gender

Krieger, N. (2003). Genders, sexes, and health: What are the connections – and why does it matter? *International Journal of Epidemiology, 32,* 652-657.

Global Health

Crump, J. A., Sugarman, J., & Working Group on Ethics Guidelines for Global Health Training (WEIGHT) (2010). Ethics and best practice guidelines for training experiences in global health. *The American Journal of Tropical Medicine and Hygiene*, *83*(6), 1178-1182.

Farmer, P. (2004). Political violence and public health in Haiti. *The New England Journal of Medicine, 350*(15), 1483-1486.

Frieden, T. R. (2015). The future of public health. *New England Journal of Medicine*, *373*(18), 1748-1754.

Hayward, A. S., Jacquet, G. A., Sanson, T., Mowafi, H., & Hansoti, B. (2015). Academic affairs and global health: how global health electives can accelerate progress towards ACGME milestones. *International journal of emergency medicine*, *8*(1), 1.

Holmes, S. M., Greene, J. A., & Stonington, S. D. (2014). Locating global health in social medicine. *Global public health*, *9*(5), 475-480.

Kaplan et. al. (2009). Towards a common definition of global health. *The Lancet, 373,* 1993-1995.

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