ELSEVIER
www.rhm-elsevier.com

© 2011 Reproductive Health Matters.
All rights reserved.
Reproductive Health Matters 2011;19(38):56–68
0968-8080/11 $ – see front matter
DOI: 10.1016/S0968-8080(11)38577-1

REPRODUCTIVE HEALTH matters
www.rhmjournal.org.uk

Sexual and reproductive health and rights in public health education

Pascale A Allotey,[a] Simone Diniz,[b] Jocelyn DeJong,[c] Thérèse Delvaux,[d] Sofia Gruskin,[e] Sharon Fonn[f]

a Professor of Public Health & Associate Director, Monash Global Health, Global Public Health, Jeffrey Cheah School of Medicine and Health Sciences, Monash University Sunway Campus, Kuala Lumpur, Malaysia. E-mail: pascale.allotey@monash.edu

b Associate Professor, Department of Maternal and Infant Health, Faculty of Public Health, University of São Paulo, São Paulo, Brazil

c Associate Professor, Department of Epidemiology and Population Health, Faculty of Health Sciences, American University of Beirut, Beirut, Lebanon

d Researcher and Lecturer, HIV/STI Epidemiology and Control Unit, Public Health Department, Institute of Tropical Medicine, Antwerp, Belgium

e Professor and Director, Program on Global Health and Human Rights, Institute for Global Health, University of Southern California, Los Angeles CA, USA

f Professor & Head of School, School of Public Health, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa

Abstract: *This paper addresses the challenges faced in mainstreaming the teaching of sexual and reproductive health and rights into public health education. For this paper, we define sexual and reproductive health and rights education as including not only its biomedical aspects but also an understanding of its history, values and politics, grounded in gender politics and social justice, addressing sexuality, and placed within a broader context of health systems and global health. Using a case study approach with an opportunistically selected sample of schools of public health within our regional contexts, we examine the status of sexual and reproductive health and rights education and some of the drivers and obstacles to the development and delivery of sexual and reproductive health and rights curricula. Despite diverse national and institutional contexts, there are many commonalities. Teaching of sexual and reproductive health and rights is not fully integrated into core curricula. Existing initiatives rely on personal faculty interest or short-term courses, neither of which are truly sustainable or replicable. We call for a multidisciplinary and more comprehensive integration of sexual and reproductive health and rights in public health education. The education of tomorrow's public health leaders is critical, and a strategy is needed to ensure that they understand and are prepared to engage with the range of sexual and reproductive health and rights issues within their historical and political contexts.* ©2011 Reproductive Health Matters. All rights reserved.

Keywords: sexual and reproductive health and rights, public health education, social justice, global health

HEALTH professionals interested in research and practice in sexual and reproductive health and rights, can receive formal post graduate training in many higher education institutions – mostly through schools or departments of public health. These, in turn, are often situated within faculties of medicine, with a tendency towards a technical and skills oriented

approach to education.[1] More than in most subject areas taught within these schools, sexual and reproductive health generates strong opinions that are steeped in social values, ideology, religion and morality.[2,3] The extent to which people can enjoy their sexual and reproductive health is invariably intertwined with issues of disadvantage, inequity and human rights.[4]

Given its highly political nature, the fit of sexual and reproductive health education within schools of public health that focus largely on the acquisition of technical competencies can be less than comfortable. In this paper, we explore the intersections between "apolitical" public health and sexual and reproductive health and rights education. Using a case study approach with an opportunistically selected sample of schools of public health, we examine the status of sexual and reproductive health and rights education and some of the drivers of and obstacles to the development and delivery of curricula that integrate an understanding of the history, values and politics of this area, as well as recognition of the role of advocacy and activism in achieving social justice and change.

Background

The history of public health emanates from multiple ideological and disciplinary perspectives, making it rich and highly nuanced but also difficult to define in disciplinary terms.[5] Histories from a religious perspective detail the development of public health in an era of colonialism, and focus on events that promote health through the purity of body and soul, to protect against spiritual defilement. Hippocratic traditions provide the basis for the development of environmental determinants of disease through theories of noxious effects of "bad air", weather, planetary alignments and so on. Social medicine in public health history explores the impact of social class and inequalities on health. Political historians establish the role played by bio-politics in the spread of disease through economic, military and political oppression. Administrative histories of public health focus on the development of regulations, reforms and technologies.[5] This list is by no means comprehensive and does not take account of cross-cultural histories of public health developed from non-western philosophies and disciplinary traditions.

Although there are different levels of emphasis across the various historical perspectives, three main themes appear to be prominent in public health training today:

- public health as hygiene,
- public health as administration, and
- public health as a political champion for social justice.

Public health as hygiene provides the basis for "scientific" public health as a discipline, training leaders to advance the fields of immunology, parasitology, epidemiology and disease control with little expectation that this training will fulfil the needs of state public health services.[6,7] This model of public health education was promoted largely within the US, and typically based in or allied to schools of medicine.[6,8] The development of schools of public health in the UK and parts of Western Europe, on the other hand, emphasised public health practice and administration, strongly informed by the advances in regulations for sanitation, food safety, quarantine, vaccination and community-based disease surveillance.[5,6]

Public health as political advocacy has its roots in social justice, growing from the European traditions of advocates like Virchow,[9] but is not a tradition which shaped public health education historically. Virchow brought together the fields of pathology and anthropology, recognizing the futility of medical care in the absence of efforts to improve the human condition. He actively engaged in political action to reform the social conditions of the working class. He promoted medicine as a social science challenging physicians to assume a role as natural advocates for the poor, even where this involved political dissent.[9]

Public health as a discipline has continued to evolve over the past century, increasingly bringing these three streams together. Medicine, however, has remained the dominant paradigm. This means essentially that communicable and non-communicable diseases continue to provide the core around which prevention and control are taught across the core subjects such as epidemiology. The extent to which these broad thematic areas (hygiene, administration and social justice) influence what constitutes public health, and therefore public health education, varies significantly across countries.[10] Although each may

play a role, the dominant paradigm is usually apparent. In many countries in Asia, Africa and the Middle East, for instance, public health is viewed predominantly as a specialisation of medicine with a focus on disease surveillance and control. These countries often train a mid- and lower-level cadre workforce such as environmental health workers, who are responsible for practice such as food inspection, sanitation and health education. Until the last decade, this was also the case for countries like the UK. Recognition of non-medically qualified professionals with public health training was accepted in 2003 with the establishment of a voluntary register to ensure that practitioners would be subject to appropriate regulation.[11]

Administration in public health also remains an important derivative of public health history, although much of the contemporary focus is on financing, health policy and health systems.[12] Public health activities of global institutions such as the World Bank, for instance, are strongly informed by the administrative history of public health. Similarly, offshoots of the sorts of social activism exemplified by Virchow endure; public health physicians and specialists often undertake advocacy roles in support of various health needs at the population level. More recently, public health advocates have attempted to forge stronger links between those disciplines that appear to be more efficiency oriented (economics), with those that are more competency driven (skills), and approaches driven by a concern for social justice, equity and human rights.[13]

It is critical that, at the very least, these tensions are recognised and explored as part of formal training in public health. A recent commission on the status of education of health professionals highlighted the general lack of opportunities within curricula to enable students to engage with complex and real life problems, leaving them ill-equipped to handle contemporary challenges.[1] This provides the broad context against which we explore the structure and content of sexual and reproductive health and rights education within schools of public health. Our interest was driven by a need to understand the historical and paradigmatic antecedents of current public health teaching programmes; to explore how and why particular choices are made about the curricula offered for sexual and reproductive health and rights education and the extent to which these choices are informed by and responsive to the needs, demands, politics and priorities involved in sexual and reproductive health and rights.

Methods

A case study design was used to explore sexual and reproductive health and rights programmes, focusing specifically on tertiary institutions that offer public health training within our regional contexts. Case study designs are most appropriate for in-depth analyses that aim to examine and explain complex issues in a real life context.[14] The design for this study is based on the analysis of multiple sources of data, which included curriculum materials and data from participant observation by the authors.[14] The authors are senior academics in public health, all with expertise in sexual and reproductive health and rights from disciplinary perspectives that include clinical women's health, gender and health, health and human rights, epidemiology, and medical anthropology. All of us have been responsible for developing and/or delivering modules and courses in the field.

The choice of institutions and regions was opportunistic, based on the countries and regions of practice and expertise of the authors – Belgium, Brazil, Egypt, Lebanon, Malaysia, South Africa, Sudan, UK and US. As is consistent with case study methodology, the institutions and the analysis are not intended to be representative of the countries where they are situated nor of schools of public health. The paper is also not intended as a medium for the promotion of the institutions and programmes they offer; for this reason, we avoid naming specific institutions. Case study design provides the opportunity to focus on explanatory processes and the institutions provide the settings to explore the contextual and process issues in the development and delivery of sexual and reproductive health and rights education within public health education settings, and offer critical insights into the differences and similarities between them. Further exploration of these themes would require a more comprehensive and representative investigation.

For this paper, we define sexual and reproductive health education as including not only biomedical aspects of sexual and reproductive health but programmes that provide some historical and

political context of the sexual and reproductive health and rights movement, are grounded in gender politics and social justice and address issues such as sexuality, sexual violence and place sexual and reproductive health within a broader context of health systems, global health and health sector reform. We recognise that there are many leaders in the field who are not trained in public health per se: however, our starting point is that public health education programmes are producing the next generation of practitioners and that opportunities to expose them to appropriate curricula in sexual and reproductive health and rights are being lost, even if their immediate passions lie elsewhere.

Our findings were analysed using a grounded theory approach.[15] A summary of commonalities amongst the institutions studied is presented here, followed by specific information pertinent to some of the institutions reviewed and an analysis of the global, national and institutional context of sexual and reproductive health and rights (SRHR) education. Detailed examples from various institutions are provided where relevant, to illustrate key points.

Commonalities amongst the institutions studied

All the public health institutions reviewed provided SRHR education as elective courses or modules within postgraduate training in public health. All these public health programmes offer a similar set of core competencies as stipulated by national or professional bodies of public health. Core subjects include: epidemiology (sometimes described as health measurement); biostatistics; social and behavioural sciences; health management, administration and policy; and research design and methods. Most programmes also cover environmental health. However, the institutions studied approach their teaching in different ways, with some integrating across disciplines, some being problem-based and others being more disciplinary-based in approach.

The institution studied in Belgium, is an independent institute for training, research and assistance in tropical medicine and health care in developing countries. Training includes doctoral and master's programmes, postgraduate courses and short specialisation courses. Until the late 1990s, a Master of Public Health (MPH) in Health Systems, oriented and coordinated by a team mostly composed of medical doctors, targeted health professionals working as district managers and policy makers in low- and middle-income countries. Sexual and reproductive health and rights started to be addressed as a course module in 1998, with the creation of a Master of Sciences in Disease Control, targeting health professionals involved in disease control or reproductive health programmes in low- and middle-income countries. The third term of this course has two options: tropical diseases or reproductive health. The reproductive health option addresses programmatic issues in the field of HIV/AIDS, sexually transmitted infections, family planning and safe abortion, maternal and neonatal health and integrated sexual and reproductive health services in low- and middle-income countries, and is also offered as a 10-week short course certificate on planning and management of reproductive health programmes. While medical, technical and political aspects are addressed, including controversial or sensitive issues such as unsafe abortion, there has been less of a focus on gender, sexuality, and sexual health and rights – mostly due to the limited number of social scientists at the institution and in the course coordinating teams. In addition, there was, and to a certain extent continues to be, a lack of knowledge or misunderstanding regarding gender, sexuality and related topics amongst those who teach public health. This has improved somewhat over the years through a fruitful collaboration with experts from NGOs and other academic institutions that teach gender and social sciences. In recent years, more social scientists have been appointed to the teaching staff. Nonetheless, there is some threat to the sustainability of the SRHR programme since it is entirely dependent on the experience and interest of individual faculty rather than the existence of an integrated core curriculum.

The institution explored in the US has as its mission to provide the highest level of education in the biological, quantitative, and social sciences to public health scientists, practitioners and leaders from around the world. Prior to 1996, there was little or no direct attention to sexual and reproductive health and rights. A working group was founded by faculty and students to address the lack of teaching concerning aspects of sexual and reproductive health and rights across academic departments. Couched in the more

politically palatable language of "women, gender and health", over a seven-year period, courses, seminars and presentations were initiated across departments, and an interdisciplinary concentration on women, gender and health was then approved by the full faculty, which includes courses covering all relevant aspects of sexual and reproductive health and rights. Students from any academic department are able to complete the concentration and the degree is conferred by the students' home department with a letter attesting to the student's completion of the concentration requirements. Thus, there is a lack of institutionalisation of the programme, in particular a dependence on the voluntary nature of the bulk of the work done by faculty and students alike.

In the Middle East and North Africa region, most public health programmes are within medical schools.[17] This is in the form of undergraduate level teaching and at the graduate level as a specialty track in departments of community medicine leading to Masters or Doctoral degrees in community medicine and public health. The biomedical approach with a focus on disease dominates. A limited number of independent graduate programmes in public health currently exist in Egypt, Occupied Palestinian Territories and Lebanon.[17] These institutions offer Masters in Public Health degrees as well as disciplinary-based MSc degrees in which students write dissertations, but none to date have degree programmes focusing on SRHR. To varying degrees they incorporate teaching in some aspects of reproductive health or gender and health although typically as electives, not required courses.

The programme reviewed in the UK offers an interdisciplinary, integrated doctorate in public health. Students are required to take courses that give them exposure to a range of global health priorities, including sexual and reproductive health and rights. Priority issues are analysed based on an exploration of available evidence, policy drivers, community, government and civil society perspectives. This approach was designed to facilitate integrated learning across disciplines and to provide students with "real life" perspectives on integration of research and policy in public health practice. However, the only opportunity to pursue a given priority area in any depth, such as SRHR, is for the student to select it as the area of focus for the research thesis component of the programme. It is important to note that this programme is atypical in its approach. Most public health courses in the UK offer a more traditional discipline-based programme, with a large suite of subjects from which students have a choice. Furthermore, and as highlighted in the previous examples, the model is designed and implemented by a small team and its sustainability going forward is unclear because of the heavy time commitment involved.

The South African institution offers a range of public health-related courses at the postgraduate level. There is a strong emphasis on a comprehensive understanding of health care systems and measures that can be taken to address public health problems at a regional, national and local level. Gender and health in some form is present in the programme MPH and MSc graduates would therefore have had some limited exposure by the time they complete the programme. There is little focus on sexual and reproductive rights per se, however. A number of short courses offered over the years have addressed SRHR specifically, but they are elective rather than compulsory and are dependent on particular staff being present and able to run the courses.

The Brazilian institution is a public health school created in the early 20th century independently of the medical school. Its mission is to contribute to the improvement of population health and the formulation of public policies through the production and dissemination of knowledge. The school provides training in public health and nutrition through research, education and service delivery. The core subject across all areas of specialisation is an introduction to public health. Students can then specialise in epidemiology, health services, environmental health, nutrition, or health and life cycles (where SRHR is introduced). Sexual and reproductive health and rights is offered as an elective module. The institution graduates approximately 100 students per year. Many students are engaged in public health work prior to starting their degree programme, as the Brazilian health system is the main employer of the health workforce generally. A new undergraduate programme in public health will be launched in 2011, receiving students after high school. This is a new approach to public health training in Brazil and the programme will include gender and health as a core area, and offer SRHR as an elective.

In sum, all the public health programmes reviewed offer a variety of sexual and reproductive health courses. Some institutions provide the option to take these courses within other academic departments, such as social sciences or development studies. Across the institutions reviewed, almost without exception, where sexual and reproductive health courses are offered by the public health programmes, they are largely dependent on the interest and initiative of individual faculty members. Sexual and reproductive health, gender and health, women's health and related courses are most commonly offered as electives rather than as part of the core of what is taught to graduate students in public health. Sexual and reproductive health and rights courses are usually associated with faculty who have active involvement in or partnerships with advocacy-related groups. Without exception, SRHR issues are not mainstreamed within the core public health training agenda.

The context of SRHR education

A comparative analysis across the different programmes suggests that the reasons for the lack of institutionalisation of sexual and reproductive health issues within public health education are complex and systemic and fall into three broad, interconnected categories: the global health context of public health and SRHR education; the prevailing national context in which institutions are located; and the specific cultures of these institutions. The global context influences national priorities, and both national and global forces, such as access to funding or national laws or mores, influence how and what sexual and reproductive health content is included in the curriculum (or not) in specific institutions. However, for clarity of presentation, we discuss these categories *seriatim* and provide examples within each.

Influence of the global context

The influence of the global health context cannot be overestimated. There is not one single global health agenda, however; rather it is a site of struggle where contradictory trends co-exist. On the one hand, the rebirth of Alma Ata,[18] universal coverage[19] and investing in health systems[20] are championed. On the other hand, vertical programmes targeting single diseases with technological solutions such as vaccines or treatment-only approaches are funded at increasingly high levels. These large, funded programmes dominate the discourse and often undermine efforts to improve health system functioning.[21] In this context, focusing on HIV or maternal health rather than on reproductive health, or gender and health, or health systems and reproductive health, can be expected. It is also likely that if the focus is on technological solutions, then both the social determinants of these health problems and a rights-based approach are less likely to be a focus as well.

The global context thus influences the kind of courses and the focus of the training that is on offer. It also influences students' choices. Students, particularly at the postgraduate level, need to make choices to optimise their career opportunities and increasingly limited funding for SRHR is taken as evidence of lack of relevance of the field. In Belgium, students expressed concern that time spent in the classroom on sexual and reproductive health and rights might not be useful to their potential career trajectory, given waning funding for the field overall and thus fewer job opportunities. In the US, students have shied away from what they perceive to be a "politically correct" curriculum that is not guaranteed to provide them the optimal jobs. Similarly, in the Middle East region, which has yet to institutionalise or recognise a "public health workforce", there are similar concerns for those with an interest in the SRHR field. Health systems in the region remain very biomedical in their approach, and health institutions tend to prefer to hire doctors and nurses to do public health work.[17] Thus, while there are questions about career trajectories for everyone trained in public health, with reduced funding for sexual and reproductive health, students worry more about their job prospects in this field.

Significant numbers of faculty in these institutions play key roles on the global health stage. It can therefore be expected that global health trends that appear to de-emphasize the relevance of SRHR will have an impact on the curriculum and focus of public health programmes, and thus on the training of future public health leaders, who are also likely to trivialise SRHR. This effect has been described as the "revolving door", illustrating the phenomenon where a select group of key players influence not only policy, but the generation and dissemination of knowledge

through their roles in government, global health institutions and academia.[22]

National context: political and ideological forces

Within a national context, political and ideological forces determine both knowledge production and dissemination. Despite the focus on hygiene and administration in how public health is generally taught, public health is by definition political. Effecting changes in population health cannot be done outside the context of government policy, politics and power. In many countries, however, there are restrictions on the levels of political content that academics can introduce to students. This in turn shapes the ways in which sexual and reproductive health can be taught. A review of institutions in South East Asia, for instance, identified Malaysia as one of the countries where academic freedom is often curtailed. The University and University College Act 1971 of Malaysia gives full authority to the government over student enrolments, staff appointments, educational programmes and financing. A 1975 amendment provides the basis for government to forbid academics and students from involvement in any political activities or affiliation to any political party or trade union. Students and academics are also discouraged from expressing their views publicly, from shaping public discourse and from participating in national debates.[23] Furthermore, the Sedition Act, dating back to 1948, is still used to control discourse that highlights inequalities between ethnic groups and marginalised populations, to avoid the risk of inciting disaffection against the government or creating disharmony between groups.[24] These restrictions make it difficult to engage students in areas that are deemed sensitive by the government. Public health education and practice is therefore very traditional, with a focus on disease surveillance and government regulation.

In Brazil, on the other hand, a social justice and rights ethos is central to the development of schools of public health and to the courses that are taught. A politicised agenda has been central to the teaching of women's health, beginning in the late 1970s. This social movement for health rights resulted in the creation of the Collective

MARCUS ROSE / PANOS PICTURES

Demonstration against increase in university tuition fees in England, London, 2010

Health Post-graduate Association (ABRASCO) in 1979. Under ABRASCO, all health activities or studies, ranging from epidemiology to social sciences, which are not related to individual clinical care, are called *saúde coletiva*. Technical subjects such as epidemiology and health programme management were taught as tools to critique social inequities and promote change and are understood to be politicised.[25] ABRASCO's wide-ranging activism helped to create the Comprehensive Women's Health Programme (PAISM) in 1983, and the Unified Health System (SUS) in 1989, which in turn, created a universal right to health care. There has been a Gender Working Group in ABRASCO since 1994, and the influence of the feminist movement is evident not only within the NGO sector but within academia.

Prior to the ICPD in Cairo, sexual and reproductive health issues in Brazil were included in courses dealing specifically with women's health. These issues were mainstreamed into broader public health teaching in the 1990s when sexual and reproductive health and rights programming for the community began to be offered through partnerships between universities and NGOs. Programmes for health providers on gender-based violence played a key role in introducing the gender-related issues of power imbalances and institutional gender violence in the health sector. All this politicisation and activism did not change the reality that over-medicalisation of women's health is the rule, and that abortion, available only in the private sector, is illegal and remains an important cause of morbidity and mortality.[26]

Government support in Brazil is further reflected in access to funding for tertiary institutions for research in sexual and reproductive health and rights issues.[27] There have also been joint initiatives of the National Research Council and the Special Secretariat for Policies for Women. A study on teaching gender in academic health institutions[28] showed that among 23 universities, sexual and reproductive health and rights teaching was included under the broader gender and health framework. The content includes gender theory, history, health programming, mortality and morbidity, and a variety of themes, including sexual and reproductive health and rights, the ICPD and Beijing action programmes, contraception, abortion, sexual diversity, masculinities, sexually transmitted infections and HIV. Some of these programmes also include maternal health; in some it is separate, as maternal health tends to be less overtly politicised, even as it is increasingly over-medicalised.

The political context of post-apartheid South Africa, with its emphasis on equity, has undoubtedly had an influence on providing the context for public health training and on sexual and reproductive health and rights education. Led from schools of public health, it emphasised social change and included a national consultation with thousands of women throughout South Africa, and developed 13 women's health policy proposals that were discussed and approved at the first national women's health policy conference in South Africa in 1994. High expectations and ambitious plans turned into some of the most far-reaching and enabling policy and legislation, including with respect to sexual and reproductive health. Reform at the time enshrined women's rights: the 1996 South African Constitution established the right to access health care services, including reproductive health care. The Bill of Rights (chapter two of the Constitution, Act 108) proclaimed the "right to bodily and psychological integrity, which includes the right to make decisions concerning reproduction". Other legislative change included the passing of the Choice on Termination of Pregnancy Act in February 1997, which saw improved access to abortion services for women, and a dramatic decline in abortion-related morbidity and mortality, and has been extremely successful in advancing women's health and rights more generally.[29]

Staff at universities in South Africa, and in Schools of Public Health in particular, have been key players in many of these initiatives. These schools of public health have since influenced national women's health policy significantly but perhaps less so the development of the curriculum for sexual and reproductive health and rights within schools of public health. This outward focus, essential at the time, did not take into account the need to develop the next generation of public health professionals skilled in the technical and social advocacy skills required.[30]

Institutional context: lack of mainstreaming

At the institutional level, schools of public health in general give inconsistent attention to sexual and reproductive health and rights issues. A consequence of a lack of mainstreaming of these

issues into public health is that course offerings are highly dependent on the personal interests of individual faculty members. While this is not necessarily a problem, it can result in what are considered "boutique" courses that are time limited in their appeal, lack sustainability and have little impact on what is taught in other courses. An example is a programme in women's health in an institution in Australia that offered a course on the experience of surrogacy but little else in the field. Without denigrating the relevance of the topic itself, its broader application for students who would otherwise have no other experience of the issues was limited. More importantly, the reliance on individuals for courses in sexual and reproductive health and rights, without some coherence across the broader public health programme, is a major missed opportunity for longer term influence and integration of the critical political agenda that sexual and reproductive health and rights can bring to public health.

Cross-disciplinary conflict between biomedical perspectives on public health and more social science-oriented perspectives persist in many regions, and play out particularly in the context of what is taught and valued within schools of public health. To date, with the exception perhaps of health economics, relatively few social scientists have been incorporated in schools of public health, based on the authors' collective experience in Africa, Asia, Europe, Latin America and the Middle East. In 2004, Wills and Woodward described the tension within public health training in the UK as an "implicit rivalry between biomedical and social science disciplines expressed as a conflict between the desire to describe thorough collected data and the desire to achieve change for social justice which privileges methods of involvement and partnership working" (p.11).[31]

Institutions also operate within the reality of securing an ongoing funding stream and make decisions to trade off particular content and structure against the requirements of a commercial market. Where there is evidence that a particular type of programme is more likely than another to attract students and funding, there are economic imperatives to make particular choices. Private international higher education institutions in Malaysia, for instance, focus on those courses that promise lucrative salaries for graduates. Programmes such as public health therefore have limited appeal because they do not present worthwhile investments for parents and are therefore not cost-effective for institutions to run. A further example is given by one of the few interdisciplinary public health education programmes in the Middle East, which went through a rigorous process in order to be accredited by the US-based Council on Education in Public Health. Accreditation was highly beneficial to the programme overall, in that it was an acknowledgement that it met international standards. However, another consequence of the accreditation was a much stronger emphasis on competency-based disciplinary training in order to fulfill the competencies stipulated, which came at some expense to the interdisciplinarity central to sexual and reproductive health and rights. Competencies became benchmarked against those of the American schools of public health, and although there is room for flexibility in interpreting these benchmarks, they do not currently include any competencies related to sexual and reproductive health and rights in Masters of Public Health programmes.[32]

Short courses: a lifeline

Given the limitations noted above, across our regions, one of the best opportunities to pursue training in sexual and reproductive health and rights is outside the traditional educational sector. Short courses – some offered by public institutions, others by private organisations and NGOs – provide invaluable opportunities in many settings. In countries like Malaysia, where there is state control of the curriculum in public universities, sexual and reproductive rights issues are largely taught by civil society, international NGOs and those engaged with the larger global health agenda. Ironically, such programmes may be supported by various ministries as short courses but not through public higher education institutions.

A four-week course in a systems approach to reproductive health and rights held in South Africa, for example, led to publication of a WHO training curriculum, that several of the authors were involved in developing.[33,34] The aim of the course is to enable people in positions of responsibility and authority to advocate for changes in policies and service delivery procedures, and to contribute to improvements in national policies in reproductive health. This curriculum was tested in Africa, Asia, Australia and Latin America prior to publication,[35,36] and a recent evaluation has indicated that it has had significant international

impact. "The training initiative has extended well beyond the initial five regional training centres and, remarkably, continues to expand". Training sessions ranging from one to three weeks were held in eight countries in 2007. More recently, established regional training centres in Burkina Faso and Sudan offer the course annually, as does the Ministry of Health in Malaysia. With the support of WHO regional offices, training sessions have been conducted in Afghanistan, China, Kazakhstan, Paraguay and Tajikistan, and the regional training centre in Yunnan, China, has begun to offer regional training of trainers in Lao and Viet Nam. An estimated 1,300 participants have been trained in these WHO-sponsored courses since 1997. Many thousands more have participated in courses and workshops directly derived from this curriculum, including several hundred medical and health personnel in India alone.[36] This course is an important example of a successful global curriculum, yet it represents a missed opportunity as it has not been incorporated into schools of public health.

To prospective students of sexual and reproductive health and rights in the Middle East and North Africa, short courses provide the most accessible and affordable option. A three-week short course in reproductive health, designed for participants from the Arab countries, has been offered in Egypt since 1987. The course includes a strong focus on social determinants of reproductive health in the region, and gender and rights perspectives, as well as a critique of existing information and provision of a general introduction to the main research methods used in sexual and reproductive health. It is taught in English mainly by Egyptians and some regional researchers and activists; it also includes case studies of actual programmes and of research initiatives taking place in the region. Interestingly, this short course in reproductive health no longer has sufficient funding to continue to be offered, but the university has received funding from the Hewlett Foundation to offer a course on social determinants of health which will also address reproductive health (Zeinab Khadr, American University of Cairo, personal communication, June 2010). This illustrates how trends in funding can affect capacity-building efforts in the field.

In Brazil, short courses offered in partnership between academics and NGOs have had an important role in mainstreaming sexual and reproductive health and rights and producing students equipped to deal with these issues. In the mid-1990s the sexuality, gender and health research programme was introduced at the Institute of Social Medicine (IMS/UERJ), and later the inter-institutional training programme on research methodology for gender, sexuality and reproductive health was introduced in Collective Health schools and instituted in several states. Further mainstreaming of these ideas has occurred over the last ten years, resulting in inclusion of gender analysis in epidemiology and related courses.[37]

In general, short courses offer an important opportunity for those engaged in sexual and reproductive health and rights to gain expertise and knowledge, network, discuss regional perspectives and learn about relevant regional and other initiatives. It is also the case that because short courses are targeted primarily at practitioners, there is the potential for immediate application of the knowledge and skills gained. Effectiveness is therefore easier to assess than the SRHR education given in higher education institutions. However, short courses are also far less accessible and less likely to engage the younger generation of students attending schools of public health. Another disadvantage of short courses that are offered outside formal institutions is the difficulty in assessing the quality and accuracy of course content, even when based on tested curricula. Therefore, a direct comparison of the two modes of delivery would be somewhat misplaced.

Other constraints of the short course model are that they often do not lead to formal diplomas or recognised awards, and are vulnerable to the vagaries of donor funding. With waning funding for overall capacity building in sexual and reproductive health and rights more generally, the place of short courses in SRHR and their long-term sustainability in offering the needed training is less than secure.

Discussion and conclusions

There is clearly significant concern about the apparent loss of momentum of a movement to address SRHR.[16] A discussion of whether this is indeed the case or the possible reasons for it are clearly beyond the scope of this paper. The evidence of the need for attention to be paid to sexual and reproductive health and rights has been established since the ICPD and the body of

evidence as to why this is necessary is not shrinking but rather continues to grow. The education of tomorrow's public health leaders is critical, and a strategy is needed to ensure that they understand the range of SRHR issues within their historical and political context. This means that education will continue to need more than a focus on the technical aspects of sexual and reproductive health, but give explicit attention to the political, economic, cultural and social issues that interact in complex ways to entrench disadvantage among large sections of the population.

Our experience of efforts to promote the integration and institutionalisation of contextually-grounded sexual and reproductive health and rights in public health education has identified a number of commonalities. Where sexual and reproductive health has been institutionalised, often this has been the more technical aspects of the field. There is considerable resistance to ground content sufficiently in concerns about social justice and social change. Across the contexts analysed, sexual and reproductive health and rights teaching in schools of public health has been most institutionalized in Brazil, although even there with some limitations. Whether with respect to short or long courses, institutionalisation is critical for long-term sustainability. A study of strategies used by feminist scholars in Brazil involved in Collective Health to incorporate sexual and reproductive health and rights in their teaching activities, shows that formalising and institutionalising a research group increases credibility, attracts students and facilitates fundraising for research, especially in collaboration with other groups, local or international; and that research can serve as a motivation to include sexual and reproductive health and rights in teaching and service-based training activities.[38]

We believe it is time to encourage more comprehensive and multidisciplinary integration of sexual and reproductive health and rights into public health education. There is increasing debate and awareness about the need for a "public health workforce" that has the skills to be more responsive to current global and regional health challenges. Without question, sexual and reproductive health and rights need to be fully integrated into the relevant training. Attention to the social determinants of health and to a rights perspective is central to some of the larger debates around competencies, and explicit attention to sexual and reproductive health could help to give shape to these conversations. Moreover, new global initiatives, such as the recently formed Independent Commission for the Education of Health Professionals for the 21st Century[1,39] are promising to stimulate needed reforms. As yet, however, the pressure for inclusion of sexual and reproductive health and rights into these larger global initiatives has not reached a critical level and across the globe, existing efforts to include sexual and reproductive health and rights in public health training are not sustainable.

Building capacity and skills to operate in and address the political issues raised by sexual and reproductive health and rights is critical. Education and training in the area of sexual and reproductive health must focus not only on technical skills but integrate an understanding of the history, values and politics of this area of work, as well as recognition of the role of advocacy and activism in achieving change and social justice.

Acknowledgements

A previous version of this paper was presented at: Repoliticizing sexual and reproductive health and rights, Langkawi, Malaysia, 3–6 August 2010.[16] *We thank the meeting participants for the extensive feedback and discussion, especially Jo Wainer, who acted as discussant, following which the paper was substantially revised and refined.*

References

1. Bhutta ZA, Chen L, Cohen J, et al. Education of health professionals for the 21st century: a global independent commission. Lancet 2010;375(9721): 1137–38.
2. Shaw D. Sexual and reproductive health: rights and responsibilities. Lancet 2006;368(9551):1941–43.
3. Briozzo L, Faúndes A. The medical profession and the defense and promotion of sexual and reproductive rights. International Journal of Gynecology and Obstetrics 2008;100(3):291–94.
4. Erdman JN, Cook RJ. Women's rights to reproductive and sexual health in a global context. Journal of Obstetrics and Gynaecology Canada 2006;28(11):991–97.
5. Porter D. Health, Civilization and the State: A History of Public Health from Ancient

to Modern Times. 1st ed. London: Routledge; 1999.
6. Fee E, Bu L. Models of public health education: choices for the future? Bulletin of World Health Organization 2007;85(12):977–79.
7. Hotez PJ. Training the next generation of global health scientists: a school of appropriate technology for global health. PLoS Neglected Tropical Diseases 2008;2(8):e279.
8. Fairchild AL, Rosner D, Colgrove J, et al. The EXODUS of public health. What history can tell us about the future. American Journal of Public Health 2010;100(1):54–63.
9. Brown TM, Fee E. Rudolf Carl Virchow: medical scientist, social reformer, role model. American Journal of Public Health 2006;96(12):2104–05.
10. Braine T. Public health schools: six portraits. Bulletin of World Health Organization 2007; 85(12):907–09.
11. Welcome to the UK Public Health Register. At: <www.publichealthregister.org.uk/2011>. Accessed 29 July 2011.
12. Carrin G, Buse KHK, Quah S. Health Systems Policy, Finance and Organization. London: Academic Press; 2009.
13. Quah S, Heggenhougen K, editors. International Encyclopedia of Public Health, Six-Volume Set. Revised. London: Academic Press; 2008.
14. Yin RK. Case study research: design and methods. 4th ed. Los Angeles: Sage Publications; 2009.
15. Strauss AL, Corbin JM. Basics of qualitative research: techniques and procedures for developing grounded theory. Los Angeles: Sage Publications; 1998.
16. Repoliticizing sexual and reproductive health and rights: report of a global meeting, Langkawi, Malaysia, 3–6 August 2010. London: Reproductive Health Matters and Asian-Pacific Resource and Research Centre for Women, 2011. At: <www.rhmjournal.org.uk/publications/meeting reports>.
17. Zurayk H, Giacaman R, Mandil A. Graduate education in public health: towards a multidisciplinary model. In: Jabbour S, Khawaja M, Nuwayhid I, et al, editors. Public Health in the Arab World. Cambridge: Cambridge University Press; forthcoming.
18. World Health Organization. World Health Report 2008 – Primary Health Care: (Now more than ever). Geneva: WHO; 2008. At: <www.who.int/whr/2008/en/index.html>. Accessed 10 August 2011.
19. World Health Organization. The World Health Report 2010 – Health Systems Financing: the path to universal coverage. Geneva: WHO; 2010. At: <www.who.int/whr/2010/en/index.html>. Accessed 10 August 2011.
20. World Health Organization. The World Health Report 2006 – Working Together for Health. Geneva: WHO; 2006. At: <www.who.int/whr/2006/en/index.html>. Accessed 10 August 2011.
21. World Health Organisation Maximizing Positive Synergies Collaborative Group. An assessment of interactions between global health initiatives and country health systems. Lancet 2009;373(9681):2137–69.
22. Lee K, Goodman H. Global policy networks: the propagation of health care financing reform since the 1980s. In: Health Policy in a Globalising World. Cambridge: Cambridge University Press; 2002. p.97–119.
23. Lee M. Restructuring Higher Education in Malaysia. School of Education Studies. 2010. At: <www.cshe.nagoya-u.ac.jp/seminar/kokusai/lee.pdf>.
24. Laws of Malaysia. Act 15. Sedition Act 1948. Incorporating all amendments up to 1 January 2006. Commissioner of Law Revision, 2006. At: <www.agc.gov.my/Akta/Vol.%201/Act%2015.pdf>.
25. Aquino Estela ML. Gênero e saúde: perfil e tendências da produção científica no Brasil. Revista Saúde Pública 2006; Aug;40(spe):121–32.
26. Victora CG, Aquino EM, Leal MC, et al. Maternal and child health in Brazil: progress and challenges. Lancet 2011;377:1863–76.
27. de Oliveira Costa A. O campo de estudos de gênero e suas duas revistas: uma pauta de pesquisa. Revista Estudos Feminista 2008;16(1):131–32.
28. ABRASCO. O Ensino de Gênero nas Instituições de Saúde Coletiva. At: <www.abrasco.org.br/GTs/gtgenero/texts/gt-inst.htm>. Accessed 4 August 2011.
29. Jewkes R, Rees H, Dickson K et al. The impact of age on the epidemiology of incomplete abortions in South Africa after legislative change. British Journal of Obstetrics and Gynaecology 2005;112(3):355–59.
30. Klugman B, Stevens M, Arends K. Developing women's health policy in South Africa from the grassroots. Reproductive Health Matters 1995;3(6):122–31.
31. Wills J, Woodhead D. "The glue that binds...":articulating values in multidisciplinary public health. Critical Public Health 2004;14(1):7–15.
32. Association of Schools of Public Health. MPH Core Competency Model. Final Version 2.3. Released August 2006. At: <www.asph.org/document.cfm?page=851>. Accessed 2 August 2011.
33. Cottingham J, Fonn S, Garcia Moreno C, et al. Transforming Health Systems: Gender and Rights in Reproductive Health, A Training Manual for Health

Managers. Geneva: Department of Reproductive Health & Research, World Health Organization; 2001.
34. Glasier A, Gulmezoglu AM. Putting sexual and reproductive health on the agenda. Lancet 2006;368(9547):1550–51.
35. Afsar HA, Sohani S, Younus M, et al. Integration of sexual and reproductive health in the medical curriculum in Pakistan. Journal of College of Physicians and Surgeons Pakistan 2006;16(1):27–30.
36. Datta B, Misra G. Advocacy for sexual and reproductive health: the challenge in India. Reproductive Health Matters 2000;8(16):24–34.
37. Citelli MT. A pesquisa sobre sexualidade e direitos sexuais no Brasil (1990–2002) uma revisão crítica. *Coleção documentos 2*. Rio de Janeiro: Centro Latino Americano em Sexualidade e Direitos Humanos, IMS/UERJ; 2005.
38. Teixeira SA. Matrizes e matizes das estratégias de inserção dos direitos sexuais e dos direitos reprodutivos engendrados por feministas acadêmicas Brasileiras. Tese de Doutorado. Estudos Interdisciplinares sobre Mulheres, Gênero e Feminismo. Universidade Federal da Bahia; 2010.
39. Frenk J, Chen L, Bhutta ZA et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. Lancet 2010;376(9756): 1923–58.

Résumé

Cet article traite des difficultés rencontrées pour intégrer l'enseignement sur la santé et les droits génésiques dans l'éducation en santé publique. Aux fins de l'article, nous avons décidé que l'éducation sur la santé et les droits génésiques incluait les aspects biomédicaux, mais aussi une compréhension de l'histoire, des valeurs et des politiques en la matière, ancrées dans les politiques sur la parité et la justice sociale, qu'elle abordait la sexualité et était placée dans un contexte élargi de systèmes sanitaires et de santé mondiale. Avec des études de cas sur un échantillon d'écoles de santé publique choisies de manière opportuniste dans nos contextes régionaux, nous examinons la situation de l'éducation sur la santé et les droits génésiques et certains des facteurs qui favorisent ou contrarient la définition et la mise en œuvre de curricula dans ce domaine. En dépit de situations nationales et institutionnelles variées, on observe de nombreux points communs. L'enseignement de la santé et des droits génésiques n'est pas pleinement intégré dans le tronc commun. Les initiatives existantes dépendent de l'intérêt personnel des enseignants ou de cours à court terme, options qui ne sont pas véritablement durables, ni reproductibles. Nous demandons une intégration multidisciplinaire et plus globale de la santé et des droits génésiques dans l'éducation en santé publique. La formation des futurs responsables de la santé publique est fondamentale et nous avons besoin d'une stratégie garantissant qu'ils comprendront l'éventail de santé et droits génésiques correspondant à leurs contextes historiques et politiques et seront prêts à y travailler.

Resumen

En este artículo se destacan los retos implicados en incorporar en la educación sobre salud públicala enseñanza sobre la salud y los derechos sexuales y reproductivos, que incluye no sólo aspectos biomédicos sino también un entendimiento de su historia, valores y política, arraigadaen la política de género y justicia social, abordando la sexualidad, y planteada en el contexto más general de los sistemas de salud y la salud global. Empleando el enfoque de estudio de casos con una muestra de facultades de salud pública seleccionadas de manera oportunista en nuestro contexto regional, examinamos el estado de la enseñanza sobre la salud y los derechos sexuales y reproductivos, así como algunos de los impulsores y obstáculos a la elaboración y entregade currículos sobre la salud y los derechos sexuales y reproductivos. Pese a los diversos contextos nacionales e institucionales, existen muchas similitudes. La enseñanza sobre la salud y los derechos sexuales y reproductivos no está totalmente integrada en el currículo básico. Las iniciativas actuales dependen del interés personal del cuerpo docente o decursos a corto plazo, ninguno de ellos realmente sostenible o duplicable. Hacemos un llamado a una integración multidisciplinaria y más integral de la salud y los derechos sexuales y reproductivos en la educación sobre salud pública. La formación de los líderes del mañana en salud públicaes de importancia fundamental. Se necesita una estrategia para asegurar que entiendan y estén preparados para tratar una variedad de asuntos de salud y derechos sexuales y reproductivos, en sus contextos históricos y políticos.