Global Health on The Move – Dissecting Health Interventions Through a Social Medicine Immersion Course

Alobo Jackie, Aol Pamella, Ocitti Morris, Katungi Ambrose, Kakungulu Eddie, Kiiza Peter, Bakyawa Irene Bagala, Atim Julian, Michael Westerhaus and Amy Finnegan

Abstract

Applying a set of innovative pedagogical approaches to the study of social medicine, the course Beyond the Biologic Basis of Disease: The Social and Economic Causation of Illness aims to train medical students to critically understand the linkages between social and clinical medicine. Through class discussion, field visits, and films, the students and course faculty work to analyze a variety of global health interventions with an analytical framework that classifies interventions into models of *charity, development*, or *social justice.* Through description of course pedagogy and content, presentation of the framework used to analyze interventions, and incorporation of student reflection, this paper provides an example of rigorous social medicine education employing theory, discussion, and hands-on activities to train future practitioners. We argue that incorporating such training for global health practitioners is indispensable in the quest to maximize partnership and the promotion of equity in global health interventions.

Alobo Jackie, Medical Student. Gulu University Faculty of Medicine.
Aol Pamella, Medical Student. Gulu University Faculty of Medicine.
Ocitti Morris, Medical Student. Gulu University Faculty of Medicine.
Katungi Ambrose, Medical Student. Gulu University Faculty of Medicine.
Kakungulu Eddie, Medical Student. Gulu University Faculty of Medicine.
Kiiza Peter, Medical Student. Gulu University Faculty of Medicine.
Bakyawa Irene Bagala, Medical Student. Gulu University Faculty of Medicine.
Atim Julian MB.Ch.B., MPH, Uganda Health Marketing Group.
Michael Westerhaus MD, MA, Brigham and Women's Hospital, Division of Global Health Equity.
Amy Finnegan MALD, MA, Boston College, Department of Sociology.

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Course overview

Most global health practitioners agree that it is critical to pay attention to social factors such as poverty, gender inequality, and violence when understanding patient illness or population health in a resource-poor setting (Anderson, Smith & Sidel, 2005; Farmer, 2005). Yet, global health pedagogies often have little or no focus on how and whether global health interventions adequately and appropriately address these factors. It is uncritically assumed that as long as you are attentive to the issues that a social determinants of health lens reveals, then you'll necessarily implement projects that improve the lives of the poor. The origins of social medicine, however, call us to look not only at the social determinants of disease but also towards the mechanisms to address these determinants; in particular, the political programs of social reform that are designed to improve health conditions (Porter, 2006).

In a social medicine immersion course held in Gulu, Uganda, entitled Beyond the Biologic Basis of Disease: The Social and Economic Causation of Illness, in which we all participated, we spent a significant portion of the month-long course learning how health practitioners attempt to address the social determinants of disease. We explored this theme through patient case discussions, bedside clinical teaching, didactic lectures by a host of speakers, group discussions and interactive activities, films, and field visits, which encouraged us to think through different models of global health intervention. This paper seeks to share the experience of our course, with a particular emphasis on our efforts to foster critical analysis of global health interventions in resource-poor settings.

Image 1. Social Medicine Course Participants 2010. Photo taken by Brian Blank.

Beyond the Biologic Basis of Disease brought together twenty-one medical students from around the world – twelve from Uganda, eight from the United States, and one from Holland – in January and February of 2010 (Image 1). Non-Ugandan students learned of the course through advertising on global health blogs, list-servs, and journals. Ugandan students became aware of the course through publicity by the Gulu University chapter of Students for Equality in Health (SEHC), a student-run organization dedicated to advancing health equity through advocacy efforts. All students submitted applications designed to evaluate their interest and experience with social medicine and their potential for growth with the course curriculum. Based on review of these applications, the course instructors selected a final group of students with diverse class, gender, and ethnic backgrounds with wide-ranging previous experience in global health and social medicine. All participants were in their clinical years of medical education (third- and fourth-year students). The course was an elective course for all students with the majority of non-Ugandan students receiving credit for course participation from their home medical schools.

The course incorporated both full-time, and parttime instructors. The full-time course instructors and organizers included: Julian Atim, a Ugandan physician with a master's in public health from Harvard; Michael Westerhaus a U.S resident physician in the global health equity track at Brigham and Women's Hospital; and Amy Finnegan, a sociology PhD student at Boston College with experience in social movements and social medicine. In addition to the full-time course instructors, part-time course instructors from diverse backgrounds included members of the Gulu University Faculty of Medicine, individuals involved in non-governmental organizations (NGOs) implementing social medicine and global health, and leaders from governmental bodies and institutions.

Through the aforementioned set of pedagogical methods, the course merged the teaching of clinical and social medicine to provide a unique immersion into global health in an African context. We utilize critical education as a tool for preparing students to be practitioners of social medicine. The course was designed with the following objectives in mind:

To provide a structured global health immersion experience for medical students with dedicated supervision and teaching in clinical medicine and social medicine.

To study issues related to global health in a resource-poor setting with an emphasis on local and global contexts.

To foster critical analysis of global health interventions in resource-poor settings.

To facilitate the development of a clinical approach to disease and illness using a biosocial model, through structured supervision and teaching

To build understanding of and skills associated with physician advocacy

To promote international solidarity and partnership in generating solutions to global health challenges facing societies throughout the world

During the course, these objectives were achieved through teaching methods aimed at conscientization, or "consciousness raising" (Freire, 1970, p. 101). While always attempting to link the clinical conditions with the social medicine topics, morning sessions were devoted to clinical medicine and afternoons were dedicated to explicit engagement with social topics. (Image 2)

Image 2. In-class presentation and discussion on war and health facilitated by Julian Atim. Photo taken by Brian Blank.

Mornings typically began with ward rounds and case discussions on topics such as malaria, tuberculosis, tetanus, malnutrition, HIV/AIDS, mental health, schistosomiasis, acute respiratory infections, measles, and rheumatic heart disease. The afternoon social medicine curriculum was divided into the following five units:

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

Together the course content and methodologies aimed to provide students with a dynamic, challenging, and interactive environment in which to face the local and global context of illness causation beyond biology. Beyond providing familiarity with a core set of clinical tropical medicine and social medicine topics necessary for understanding social determinants of disease in resource-poor settings, the course design also sought to introduce students to how to address such health problems through the interrogation of various models of global health intervention. After reviewing the analytical structure used in our class for conceptualizing interventions, this paper will highlight the ways in which classroom experiences, field visits, and films gave us the opportunity to carefully and critically examine global health interventions through the lens of social medicine.

A framework for analyzing global health interventions

Global health interventions today take numerous forms, mobilize actors in local and global settings, and involve complex funding, programmatic, and logistical components. The form and logic of these interventions depend upon how the roots of disease and illness are defined. For example, conceptualization of pediatric malaria as a failure of caretakers to properly use mosquito nets results in educational interventions aimed at correcting problematic behavior. Conceptualization of the same problem as caused by poverty, economic inequities and gender inequality results in political and social interventions that promote socioeconomic and gender equity. As end products of the particular worldviews, values, and educational training of involved individuals and organizations, interventions always have political and moral positions that shape the solutions offered (Stewart, Kearsley, Keusch & Kleinman, 2010; Feierman, Kleinman, Kearsley, Farmer & Das, 2010).

Table: **Models of Global Health Interventions**

Model of Intervention	Benefits	Critiques	Examples
Charity	Meets immediate survival needs Leftover, unused medical equipment and medications put to use Donors see beyond themselves	Implicit assumption that poverty and inequality will always exist Little acknowledgement of the root causes of suffering False generosity	Child sponsorship programs to pay for school fees and healthcare Humanitarian responses to war and natural disasters Medical equipment donation programs
Development	Advancement towards certain socioeconomic indicators Focuses on longer-term solutions and frameworks	Locates poverty and inequality as an inherent problem of the poor Rare critique and/or action to change the social and economic structures that perpetuate suffering Assumes need for linear progress modeled after Western concepts of modernization Focus on overall health trends hides interclass differences within countries	Educational projects to teach the poor about proper sanitation and hygiene Privatization of health sector to encourage capitalist market forces to shape healthcare delivery Understanding problems through knowledge, attitude, and practice (KAP) surveys of the poor
Social Justice	Attempts to address underlying causes of suffering Deep analysis of historical, social, and linkage of local and global context to understand health outcomes Equal respect for the dignity of all individuals	Vague plan of action and inadequate pragmatic action Overly romanticized Unsustainable because of burn out and unrealistic goals	Efforts to preserve/ improve access to generic medications Social movements pressing for health equity, such as the People's Health Movement (2000) Participatory Action Research (Cornwall and Jewkes 1995)

In order to rigorously study global health interventions as part of a social medicine curriculum, it is useful to ground such analysis in a broader framework. Drawing on the teachings of liberation theology (Pixley & Boff, 1989; Gutierrez, 1973), anthropologist-physician Paul Farmer (1995) has identified three categories of response to the heavy burdens of disease amongst the poor – charity, development, and social justice. While offering a concrete response to pressing humanitarian needs, interventions based on charity typically "presuppose that there will always be those who have and those who have not" and consist of "false charity" because the underlying causes of inequality are not addressed (Farmer, 1995). Development interventions seek progress by implementing programs aimed at achieving a set of often-laudable goals measured by socioeconomic indicators. However, those with power and the purse strings typically determine the specific goals and advancement is regarded as a "natural process" dependent on changing the knowledge, attitudes, and practices of the poor (Farmer 1995). The knowledge, attitudes, and practices of the wealthy and powerful are rarely examined or confronted. Finally, interventions based upon principles of social justice usually operate from an understanding that "the world [is] deeply flawed" and "see the conditions of the poor not only as unacceptable, but as the result of structural violence that is human-made" (Farmer, 1995). Thus, such interventions typically work to change oppressive policies and work for the redistribution of resources. Social justice models can falter because of poorly thought-out plans of action, the immobilizing trappings of romanticization, and strong resistance by those in power. See Table for a comprehensive summary of these various models.

In the second week of Beyond the Biologic Basis of Disease, we utilize this paradigmatic structure to form a basis of critical analysis of health interventions; in particular, those that we engage during field visits as well as those that we read about and

discuss during class time. After we become familiar with a specific intervention, we dedicate class time to collectively analyze the efforts and utilize Farmer's model to frame that discussion. It is important to note that most interventions often integrate aspects of all the models. It is rare for an intervention to be strictly limited to one model; however, a dominant logic based upon one model usually drives the intervention. In addition, differences between these models are most successfully illuminated through rigorous examination of the rationale and logic driving an intervention rather than identification of an intervention's concrete actions because similar actions, such as distributing medications to the poor, can result from different models. The rationale employed does, however, have a profound impact on how the problem is understood, who/what is viewed as the root cause of the problem, and how the concrete action is ultimately accomplished. In the case of distribution of medications, a charity model might result in providing expired, unused drugs from U.S. hospitals for the poor, while a social justice model might result in securing a sustainable, low-cost supply of generic medications for the poor.

Within this analytical framework, our course pedagogy emphasizes the importance of trainings physicians to dually work as advocates for their patients as well as support patients in becoming agents of their own health. Thus, in considering health interventions, the course pushes students to engage questions the merge analysis of interventions with a critical examination of their own role as health care workers. These include: What is my personal motivation for global health work? How could I best serve as a patient advocate in this particular intervention? What are the potential unintended consequences of my participation as a patient advocate? Does this intervention provide opportunities for patients to act as agents of their own health? How might my participation either limit or create space for patients to work as agents of their own health? In the final analysis does this intervention only help patients survive at the bottom of an oppressive system or does it provide them with the tools to reshape systems that promote equitable distribution of resources, power, and health? Through reflection and conversation on these topics, the course attempts to translate the theory of conscientization into a practical consideration and skill as students discern their future roles as physician-advocates.

Viewing global health interventions through a social medicine lens

Utilizing a "problem-posing" pedagogy (Freire, 1970) to encourage critical analysis and dialogue, three types of engagement with global health interventions were integrated into our course — classroom-based guest speakers and discussions, field visits, and films. We now describe a sample of these activities and incorporate student reflections in order to tangibly illustrate our innovative model of teaching.

Classroom-based guest speakers and discussions

In order for students to gain exposure to a diversity of practitioners involved in global health interventions, guest speakers from numerous organizations were invited to facilitate class discussion. Amongst these were individuals from Human Rights Focus (HURIFO), a grassroots Ugandan organization utilizing legal mechanisms to protect human rights in northern Uganda; a public health officer involved in designing and implementing health programs in Amuru District; and an individual representing both the People's Health Movement (PHM), a network of global advocacy organizations, and Partners in Health (PIH), an international NGO working to provide community-based healthcare. In all cases, students were asked to make use of the framework presented above to analyze interventions.

During the visit by HURIFO, Patrick,[*] an outreach worker for the organization, led a round-table discussion about their efforts to protect human rights through campaigns related to gender, war crimes, good governance, legal support for victims of human rights abuses, and training individuals in the community to serve as human rights promoters. Through interactive dialogue, students gained exposure to the concrete ways in which HURIFO strives to reach its overall goal: "To create an enabling environment for protecting, improving, and promoting human rights in Uganda in particular and the world in general" (HURIFO, 2011). Patrick also shared the organization's funding philosophy, which strives to ensure that funding sources are as unbiased as possible; for example, the organization refuses to accept USAID funding because of potential conflict of interest.

Upon reflection, students generally agreed that HURIFO best represented a social justice model. Students noted that HURIFO's work takes into account the local realities of recent war, directly challenges government structures and actions, and

[*] In order to protect confidentiality, all names have been altered.

works for equal respect for all individuals. Students also sensed that HURIFO might avoid the social justice trappings of rhetoric without action. One Ugandan female student reflected:

> *[Human rights] treaties need to be implemented through creating awareness and empowering people to demand for their rights where they are being denied. Governments also have a big role in respecting, protecting and fulfilling rights of [their] citizens by providing peace and security and strong legislations in the judiciary that aim at the above. Because without harmony of citizens and national security, public health may be compromised whereby communicable diseases may be difficult to prevent or contain for instance when there is war and displacement of populations.*

HURIFO's commitment to social change inspired this student to take action in her own life:

> *One very important lesson I learned from this course was that I do not have to first finish medical school, become a doctor or be rich so as to offer help to my community, because all I need is advocacy skills and an organized group like Students for Equity in Healthcare. With these I can spare time, for advocacy work through talking about social rights that affect health like the rights to peace and security, to avoid communicable diseases that could spread easily in refugee camps, rights to good roads to reduce road traffic accidents and improve access to health units, right to clean and safe water to prevent water-borne diseases…*

The Amuru public health officer's visit gave students the opportunity to interact with a government official deeply involved in efforts to deliver health care amidst extremely challenging circumstances. He first provided an overview of Amuru district, a rural area with only one physician per 50,000 people, pit latrine coverage of 60%, a poverty rate of 68%, and an infant mortality rate of 172/1000 live births (Amuru District, 2008). He then shared the opportunities and frustrations of trying to improve care delivery in Amuru in the face of severe staff shortages, lack of facilities, inadequate support by the central government, and the delicate balance of working with international NGOs driven by their own agendas.

Student response to the public health officer's presentation encompassed numerous perspectives. Some were excited to meet an individual from the public sector working for authentic social change. Others, reflecting common perceptions that Ugandans have of their government, felt that his words were simply rhetoric. One male Ugandan student expressed:

> *The Ministry of Health, a government body mandated to formulate policies, quality assurance, conduct health research, monitoring and evaluation of the overall performance of the health sector, has worked tirelessly to put forward policies and health interventions but implementation remains bizarre… The health officer puts it clear that the resources are available but in his discussion, there were no suggestions put forward to address the socioeconomic challenges that have affected the health sector.*

In general, students felt that the work of the Ugandan government in health did not neatly fit within one predominant model of health intervention. Rather, they saw the Ugandan public sector as simultaneously involved in charity, development, and social justice.

Lastly, a representative of both PHM and PIH visited the class. Over the course of two days, he introduced students to PHM, a grassroots global network of individuals and organizations committed to building equitable health systems and overcoming the destabilizing forces of economic globalization (People's Health Charter, 2000). He also shared the model of community-based healthcare which PIH utilized to address HIV/AIDS, TB, malaria, and primary care in places such as Haiti, Rwanda, and Lesotho (Partners in Health, 2006). The PIH model relies heavily on paid community health workers who provide home visits and play a central role in delivering health care in resource-poor settings. In response, a Ugandan female student excitedly reflected:

> *The people who are sent out as global health workers should at least get some basic training about the culture of the people they are going to work with and how to interact with the community. Otherwise, how we dress, act and interact with the community has a big impact on the acceptability and support of the project. The key to a success of a project is to involve the community from the start of the project and make sure they participate in every single step of the project.*

Other students generally shared her view that community-based efforts and cultural sensitivity as essential components of effective care delivery to the poor. Students felt that PHM and the PIH approach represented social justice models of global health interventions with some elements of charity and development.

Image 3. Interaction with patients at Bobi Health Center as part of NUMAT field visit. Photo taken by Brian Blank.

Field visits

Field visits were an essential component of the course that allowed students the opportunity to move from a theoretical descriptive examination of global interventions to a hands-on, observational, and participatory engagement. Specific sites were chosen based on perceived differences in the philosophy and logic driving their activities. The sites visited were The AIDS Support Organization (TASO), a grassroots NGO working throughout Uganda to deliver HIV prevention and treatment services; the Northern Uganda Malaria, AIDS, and TB (NUMAT) project, a USAID-funded, five-year project to address high prevalence diseases in the community (Image 3); and Amuru Peripheral Health Center, a rural community-health center run by a larger non-profit Catholic mission hospital.

During all three visits, students participated in clinical activities and community outreach efforts as noted by one student:

> *Our study involved us getting down to some of the health centers to interact with the workers on ground and the population served. Interaction was also with health staff from the different NGOs involved in development and sustainability of these health centers. Sessions were held to provide health services and information including health education, school outreach and patient treatment. The interactions were further used to socially bring the service providers and the beneficiaries closer in soccer matches, song and dance which was both entertaining and educa[tional].*

Student field visits were followed by group discussions meant to promote critical analysis of each global health intervention specific to experiences from the field visits. Students found aspects of charity, development, and social justice present in each model and had difficulty determining which model predominated. The only exception was the NUMAT project, which they felt clearly represented the development model. While most interventions witnessed in class promoted the social justice principle of equitable access to healthcare for the poor, none attempted to address the underlying structural causes of suffering; thus, students suggested that perhaps all of interventions visited most embody a development model. The field visits were highly regarded by the students as a critical part of the course as it gave them the opportunity to take theory studied in class and apply it to local realities. In that process, they discovered that when global health interventions are applied in the real world they are complex, difficult to categorize, dynamic, and at times contradictory.

Films

Films were used to complement the classroom and field visit interrogations of global health interventions. Films included in the course included *Uganda Rising, War Dance, A Closer Walk, Invisible Children, This Magnificent African Cake, State of Denial*, and short documentaries describing PIH and Médecins Sans Frontières (MSF). Students found the films to be an entertaining and engaging way to further deepen their understanding of global health interventions. One Ugandan male student explained:

> *[Films were] such a good setting that it gave us the opportunity to see how different interventions were being applied in different communities using different approaches in resource limited settings to holistically manage the morbidity and mortality of disease burden as being fuelled by social causes. At the end of each movie then, the students and facilitators would discuss the films and ask the opinions from the students and what they learnt and how possible it was for them to apply the lessons learnt from the film to our own home country setting.*

Discussions focused on the content of the film, the style of representation utilized by the filmmakers, and the application of the interventions framework to topic matter of the film. For example, *State of Denial* focuses on the efforts of the Treatment Action Campaign (TAC) in South Africa to improve access to antiretrovirals. TAC utilized a historical understanding of the local and global context to argue for structural changes in access to medications; for the students, TAC provided an example of a social justice organization. On the other hand, a National Geographic documentary about the work of MSF featured a European health worker traveling to diagnosis and treat people in a remote area of the Democratic Republic of the Congo. The worker referred to the area as "the land of the living dead," an attitude paradigmatic of the charity model (National Geographic, 2003).

In addition to increased exposure to models of intervention, students felt that the films gave them a sense of connection with others struggling for health equity. A couple of Uganda male students shared:

> *It helps equip the students with various skills of advocacy, and ways in which some of these skills can be utilized in our own setting to address the problems affecting our communities.*

> *The intervention models used by some of the organizations like PIH and MSF can be applied in our own communities as the problems are similar… It motivates and inspires us as advocates to push on harder and that it's possible to cause change even if the odds are against you but what you are pursuing is the right cause as seen by the TAC campaigns in South Africa… It helps us identify and link up with other advocates in different countries who share the same vision of striving for the observance of the health rights of the marginalized communities, poor people, and the voiceless by all the stake holders.*

Watching films documenting the efforts of collectives throughout the world gave the students confidence and a sense of solidarity in addressing the health challenges in their own communities.

Impact of course participation on students

Upon course completion, we administered a confidential, written questionnaire to the students in order to evaluate the overall impact of the course. The majority of course participants reported an improvement in the level of knowledge/experience with global health and social medicine. In particular, 83% of Ugandan students moved from minimal to moderate/advanced levels, while 63% of the international students reported that they had improved their levels of knowledge. Most students also reported deepened familiarity with social justice models of health care provision.

Qualitative student responses to the questionnaire indicate that the course provided a transformative and rich learning experience. When asked to identify central learning points, students shared the following:

> *Working with the community requires a lifelong commitment and also involving the community at every single step of the programme.*

> *I have been inspired to call upon my elected officials in the US to make changes for health and human rights both in the US and abroad.*

> *I learned about all the politics behind poverty – the things that cause poverty and the factors that allow poverty to continue.*

> *I've learned that although battling the factors that contribute to poverty and health care inequities is difficult, it is doable.*

These and other comments revealed that the course gave students the tools to identify and confront obstacles to the provision of high-quality healthcare to all.

The impact of the course can also be recognized through observation of student action following the course. As the course closed, students independently developed working groups to address antiretroviral drug stockouts in Uganda, inadequate

medical supply provision to health centers, and food supplementation for malnutrition in rural areas. Further, the class initiated an email listserver to promote communication related to course projects and other social medicine news. A few months after the course, a group of participants attended a People's Health Movement training in Kisumu, Kenya on health activism. Another group of students wrote an article on the course for the Gulu University Medical Journal (Lubega, Kiiza, & Westerhaus, 2010). Finally, two U.S. medical students returned to Gulu to complete clinical rotations and continue work on projects initiated during the course.

Conclusion

Bringing together a diverse group of medical students from different parts of the world to study social medicine under the guidance of an assorted group of teachers created a powerful platform to analyze global health interventions applied in resource poor settings. Social medicine course participants critically scrutinized these interventions as a result of the "consciousness" created by the various teaching methods which included classroom experiences, field visits, and films. While field visits gave students the opportunity to compare theory learned in the classroom with local realities, films offered a broader view of global health interventions worldwide. Juxtaposition of both local and distant models of intervention helped students see that while templated models of intervention exist, the transfer of interventions between distinct localities requires cultural sensitivity as well as target population empowerment and participation in the design of interventions.

As future global health experts, it is imperative that medical students study the irrefutable linkages between social and clinical medicine. Study of these connections is best accomplished during medical training, when foundational acquisition of knowledge and skills occurs. Through this course, students appreciated that the clinical management of a patient never ends with the biological causes of disease. It must also include responses to the political, economic, cultural, and social factors that put individuals at risk of disease. Such appreciation molds future physicians to recognize that poor health results not only from unhealthy behavior but also from weighty external forces, often political and economic in nature. This enables them to prescribe solutions attentive to all of these factors.

Likewise, implementers of global health interventions must assess motives, intended outcomes, and the potential unintended consequences of a particular intervention. They must also understand local and global context, and the connections in between, in order to best meet the health needs of communities. Without such analysis, the outcomes of global health interventions can be unhelpful or even disastrous. With such analysis though, individuals and collectives, such as the students who participated in the social medicine course in Northern Uganda, can lead social change that brings about greater health and equality for all.

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