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June 2005

Global Health
Graduates Network

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A Global Health Community

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Next edition September 2005.

Welcome to our second newsletter. We launched in March, with a jam-packed meeting of new and old faces with a shared interest in global health. Many thanks to Prof John Yudkin, Drs Bhanu and Matt Williams, Nick Emmel and David Osrin who gave their own perspectives on careers, education and research in international health, sharing their adventures with a dedicated audience (it was a Saturday night).

We enjoyed it so much that we are planning another *Global Health Directions* event for the autumn with a variety of speakers and workshops. It will focus on the key areas: Careers, Education and Research and Advocacy aiming to be interesting, informal, and accessible for even the busiest of people. Full details will be sent out to the mailing list soon and posted to the site.

Spirit of Debate with a Coffee?

In the meantime, there is the launch of the Alma Mata London global health discussion forum on September 28th. Jane Hassell, the organiser, says, "As clinical students we really miss the opportunity to explore international health issues and, though few of our hospital colleagues have had the privilege to study I.H, many are keen to know more." These informal sessions will give you the chance to meet, learn more and join the debate, over a coffee. Richard Horton, the editor of the *Lancet*, is kicking off the first café debate – it promises to be a good evening!

Networking

Since the launch the network has been rapidly expanding. The hundredth member registered in May (no prizes we're afraid) and there are several hundred others using the site each month. We've been busy linking up with NGOs including Medecins Sans Frontieres and Oxfam, universities and international research institutions and health forums and we hope this is reflected in the range of features, links and profiles at www.almamata.net.

Global Health Directions Survey

New additions to the site include sections on short courses and internships, a database of global health organisations and an education resources section and journal library.

We have also been conducting a survey of members' future career plans which is online at <http://www.almamata.net/globalhealthdirections.html>. There are big changes afoot to the medical careers system, as discussed in this edition and our spring newsletter, and the question is how global health work can fit into new training routes. Please take the time to complete this if you can, to provide your comments and opinions. Thanks to those who have already sent us their surveys.

We would urge you all to register to make the most of the marvellous features of the site. Registered members currently receive 20% discount on Oxford University Press titles, full access to the site's contents, personalised web space and a messaging service to contact other members. Open access means exactly that: members can publish news, events, interviews to the site and keep a web blog.

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Building on the Foundations

Current activities and promising developments for a career in Global Health

In the last newsletter, we outlined the current proposals of 'Modernising Medical Careers (MMC)', and speculated on what this could mean for a career in global health. Gaz Lewis continues his assessment with the current plans of the Royal Colleges the post foundation years and the options for working abroad in specialist training years.

Modernising Medical Careers

In February this year, the BMA produced "The Shape of Specialist Training Aspirations for Seamless Progression"¹. It gives in-depth analysis and recommendations for MMC after the foundation years (see last newsletter's article), and what should be implemented to ensure this new structure achieves its goals. Principally, the aim of MMC is to stop or minimise the number of doctors 'hanging around' while waiting for a place in higher specialist training or changing specialities late, and starting all over again, because they couldn't find a post in their chosen speciality. But although the BMA report gives some good recommendations of what should be done, it does not set out its implementation.

Where are we in implementing post-graduate training beyond the foundation years?

The Post-Graduate Medical Education & Training Board (PMETB) is an independent body, created in 2003 to be responsible for "the standards and quality assurance of all postgraduate education, training and assessment in medicine and dentistry in the UK"². It replaces the Specialist Training Authority (STA) and the Joint Committee on Postgraduate Training for General Practice (JCPTGP). The aim of its creation was to bring postgraduate training under one roof post MMC reform. However, the organisation isn't due to take over its responsibilities until September 30th this year. It states on its website that from July 2005 to July 2006 it will "consult with stakeholders on the future shape and direction of postgraduate medical education and training in the UK and will develop a plan from that"³.

Given that PMETB is not up and running yet, it is unsurprising that the Royal Colleges are biding their time on what will happen in the post-foundation years. Several colleges have expressed concern about a 'run-through' grade replacing the basic specialist training and advanced specialist training that takes part during the current SHO and SpR years respectively. The principle behind this grade is to streamline the years required in training, making them more efficient. It seems that the introduction of the European Working Time Directive (EWTD) is one of the main concerns regarding this.

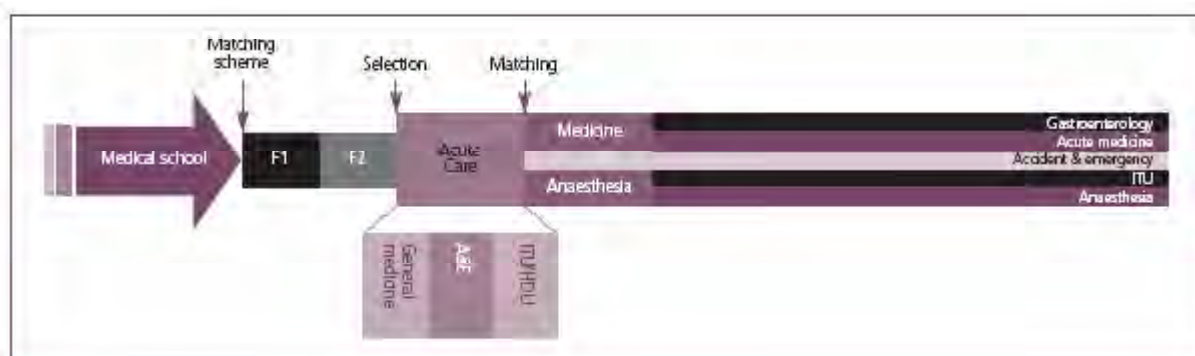
There are doubts expressed on several college websites, be it in official statements or minutes from various meetings, about whether the quality of training will be maintained, let alone advanced when there are a fewer number of years, and fewer potential hours within those years. These concerns have been echoed by the junior doctor's conference, which stated "it is irresponsible to propose the shortening of training until the impact of the reduction of hours imposed by the EWTD has been properly evaluated"⁴. As a purely speculative point, some forms of education within the scheme could be counted as outside of working hours, but it remains to be seen if any other more amenable solution could be found.

Aside from these concerns, all the Royal Colleges can really do is sit and wait for the PMETB to arrive. This is not to say they are unprepared for its arrival. It appears quite clear that discussions are going on within them about what reforms are needed and how

Figure 1: Example of a career structure for direct path training¹



Figure 2: Example of a career structure for broad-based training¹



they should come about.

Working in Global Health

So now I come to working in International Health within the new structure. The new curricula for F1 and F2 have recently been published. The aim at the end of these curricula is for graduates to have a generic set of skills applicable to a modern medical career. According to the NHS information page on MMC, F1 will be "similar to the current PRHO year, although there will be greater educational coordination between placements"⁶. F2 years will build on the skills acquired in F1 and also have a greater focus on acute care, while also giving the opportunity for work in both primary care and mental health.

On the face of these statements it would appear that placements in public health are not high on the agenda – unless they come under the scope of primary care. However, it is possible at present to do an SHO rotation in public health. While it would be in the spirit of these reforms to offer some sort of global health training, in practice this may prove difficult to organise in the early years of F1 and F2 while the programmes find their feet. However, as I have observed previously, once a graduate is past the foundation programme, there should be an equal if not enhanced opportunity for spending some time in a global health placement straight away, as the structures, in the form of flexible training schemes and specialist public health training, are already there. It is to be hoped that after the foundation years have settled in there could be similar things in them.

So what do the Royal Colleges currently have to say and how well do they aid finding information on flexible training and working abroad? Flexible training is a well-established part of medical training now, and information regarding it is well catered for and talked about on all college web sites. However, a flexible training contact is something that must be sorted out with your local deanery or trust. It is also important to note that flexible training as a junior doctor is more difficult to negotiate, namely because of the expense of these types of contracts to employ by trusts⁷.

The information on international work is more varied, with all having information for doctors from overseas wishing to work in the UK, but not the other way round. Some have specific sections about working overseas and most have either international committees or networking bodies. In particular, the Royal College of General Practitioners and the Faculty of Public Health have very strong commitment to international work for their members.

It is pointed out by nearly all colleges that working abroad can even be counted as a training year, although at the moment it appears that this needs to be arranged rather than their being any specific training programme which includes a period spent abroad. All sites are encouraging on foreign work, but there is a clear emphasis on considering if you would learn the skills required for work in the

UK with whichever placement you had in mind. Obviously this depends on whether or not you would be gunning to include foreign work as part of your medical training or whether you fancied a change of scenery.

So overall, there is a lot of uncertainty still surrounding the advent of post-graduate education beyond the Foundation years. The Royal Colleges have no specific plans and the final structure of their individual specialities training is unlikely to be put in place until they finish consulting with the PMETB in July 2006. However, current information and facilities for working abroad are catered for to varying degrees by all colleges and this along with flexible training are encouraged for those who wish to do so. It is entirely possible for these facilities to be put to use in creating training posts in either the proposed broad, specialities or systems based training schemes that include some time working in the international arena. Whether or not such a thing will be possible in the Foundation years remains to be seen. The increased involvement of the colleges in junior years, particularly F2 as their specialities are incorporated more into it, means this may be possible, although the availability of flexible training may be more difficult due to a lack of funding for this type of job structure at junior level.

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See the website soon for extra tables looking at the Royal Colleges' plans post Foundation Programme and what they have to say about working abroad...

NHS Links

Connections between British and overseas healthcare providers have existed for centuries. Now there is new impetus to formalise these to make these exchanges easier. Aska Leslie examines these while John Sloan describes how international health links were established in Leeds Teaching Hospital NHS Trust.

Exchanges between hospitals and primary care organisations in the UK and those in the developing world have tended to be short-term and overly reliant on the enthusiasm of individual health professionals to maintain them. A more structured approach in the form of NHS Links, an organisation that was set up in collaboration with the Tropical and Health Education Trust (THET), is therefore encouraging. The network of NHS and THET professionals aim to improve the effectiveness of health links and to make such links more mainstream within the NHS.

Already, Leeds Teaching Hospital NHS Trust has established the Overseas Partnering and Training Initiative (OPT IN) which seeks to build permanent links in developing countries. The Trust views these projects as an opportunity to offer unique training opportunities for their staff. OPT IN is integrated into the Trust – for example, staff taking part in OPT IN can do so through their formal leave policy.

These links allow individuals to gain an awareness of global health issues and exchange skills and knowledge. An example of where this has occurred is Ghana, which faces severe nursing shortages. The Nursing Directorate at North Bristol Hospital NHS Trust is now sharing expertise with the Bolgatanga Nurse Training School in order to help them develop teaching methods and provide them with training resources and reference literature. Similarly, King's College Hospital has built links to help rebuild health services in post-conflict Ethiopia.

NHS Links has received backing from the Chief Executive for the NHS (England), Sir Nigel Crisp:

“Links allow NHS staff to contribute to the improvement of healthcare worldwide, whilst continuing to serve their own communities. Links motivate staff, enlarge their experiences sharpen their skills . . .”

Support from the UK Department of Health and Department for International Development will allow a national framework to be developed to ensure the quality and longevity of these links.

The national database of Links activities (which will include all link activities taking place in UK NHS Trusts) that THET is compiling at the moment will give opportunities for Links to network by UK region, country of operation and specialty and provide contacts for new Links, thus promoting best practice.

As Dr John Wright, Consultant in Clinical Epidemiology points out:

“For too long the NHS has ignored the growing global inequalities in health. NHS Links is a network of health professionals that aims to move international health issues from the margins to the mainstream.”

With the UK holding both the G8 Chair and EU Presidency this year, it seems an ideal time for the NHS and the government to address global health inequalities through the mainstreaming of partnerships between Trusts and their counterparts in less developed countries.

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THET is holding their Annual Links meeting on Tuesday 21st June (10am-5pm). UK collaborators and overseas colleagues will have the opportunity to share lessons and experiences, and establish new links.

For more information visit www.thet.org or e-mail: Susana Edjang Mangue, Links/Project Coordinator susana@thet.org



The world population now exceeds 6 billion, but more than 1 billion people live in extreme poverty. The UK government has stated that "eliminating such extreme poverty is the greatest moral challenge the world now faces". This is highlighted by the fact that each year more than 10 million children under the age of 5 die, the vast majority from the less developed world. That was one every 3

seconds. The causes of death were not complex; respiratory infection, diarrhoea and malaria alone make up over 50%. Many people want the chance to make a difference.

This was the reason OPT IN (Overseas Partnering and Training Initiative) came into existence. It started in Leeds in late 2000 and has grown to become an umbrella charity which fosters a number of capacity building projects in the less developed world. OPT IN takes advice from THET, the Tropical Health and Education Trust. THET has years of experience in developing links with hospitals, medical schools and other health care institutions in poorer tropical countries helping them to achieve their goals.

OPT IN uses the skill and motivation of staff, combines this with statutory leave and charitable funds for travel, and delivers projects which are designed to make a permanent difference. As such, it does not deplete the NHS at all, and it is clear that it is a major motivator for many of the staff who have been involved. These number over 30 from medical, nursing, allied health professionals, technical and library staff to date. Paradoxically, though we aim to benefit those overseas, we feel that the staff within the NHS stand to gain much more in the process.

There have been a number of visits from link sites to the UK, such as Dr Hoque, Orthopaedic Surgeon from Bangladesh, and Dr Kalantri from Sevegram, India. In addition, Dr Singh visited from Guyana for Surgical Skills training, sponsored by Jimmy Savile. In December 2004, Monica Watuvamu from Uganda attended the British Medical Ultrasound Society (BMUS) Annual conference in December.

Links

We have taken the approach of dividing our links into two; Core Links, which imply a commitment for at least 3 years, and Incidental Links, which may last only for the duration of the project. In the main these are conducted by short secondments to identified centres with whom we have long-term good relationship.

At present we focus on the following core links. Some have been in existence for a number of years and will continue, though others are expected to come to a natural conclusion;

| Examples of OPT-IN's Projects | |
|--|--|
| Link | Work |
| Centre for the Rehabilitation of the Paralysed Bangladesh | Spinal Surgery, Research Methodology and Therapies |
| Kamuli & Kumi Hospitals and Mildmay Centre Kampala, Uganda | Post-Surgical Nursing Training |
| Good Shepherd Hospital Siteki, Swaziland | Chronic Disease Programme for Epilepsy |

A number of medical students and junior medical staff have approached OPT IN for Overseas placements, and we have given advice and assistance as appropriate. Other charities have also approached OPT IN for assistance which has been provided where possible.

Besides the core links, we have packages that readily export, based on our existing skills, and we wish to develop these further in the coming two years, namely basic surgical skills and basic research methodology.

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Circles of Life

There are many ways in which to find yourself working in and researching international health. Tom Poyser interviews Professor Peter Winstanley about this research interests, and finds out how everyone has their part to play.

During medical school it seems we all have to do modules that are horrible acronyms. At Liverpool they call them SSM's (Special Study Modules). During one of these SSM's I was introduced to Professor Peter Winstanley. He taught a small group of us about pharmacology using malaria as a paradigm disease. He taught us that there is much more to dealing with tropical diseases than giving out small pills. Issues concerning culture, society and poverty are every bit as important as matters like bioavailability, active ingredients and metabolic products. Each has its place and must be considered if all the other pieces are to fall into place.

He was also extremely friendly, an involved and interested doctor and a man who hated bureaucracy and didn't mind being blunt about it.

So I decided to take an afternoon off from worrying about my own research project at Leeds, where I am intercalating, and go back to Liverpool to speak with him about some of the things that I thought he might have opinions about.

Professor Winstanley works for the University of Liverpool¹ and directs the Wellcome Trust Tropical Centre². The Wellcome Trust is a charitable organisation set up by Henry Wellcome in 1936, who was a philanthropist with a particular interest in bio-medical research in the tropics. As a trust fund it has always been independent of Wellcome PLC, the pharmaceutical company³⁻⁴. Furthermore in the early 1990's the Wellcome Trust sold a large proportion of its shares in Wellcome PLC and spread them across the stock market. This means that the Wellcome Trust has considerable financial resources. The Trust is managed by scientists of international repute.

The Prof started his interest in malariology by working towards academic positions, reading for a Doctorate in 'The Clinical Pharmacology of Amodiaquine' and eventually securing a position as a Professor of Pharmacology at Liverpool. He feels that this has helped his vision of International Health, as he has been able to apply the 'rigour of the bench' to all his work. Working from 'the micro to the macro' has provided him with clarity about international health developments, but he appreciates the role that other disciplines have in providing health care in developing countries.

I asked him about conflicts of interest. Personally he has never had a conflict between his various funders, but does acknowledge that every researcher cannot be entirely altruistic. He admits to obvious academic interests in what he is doing, needing to achieve academic goals whilst providing affordable drugs to those in need. He maintains that as long as you 'know yourself' it is better to be aware of your motivations because it allows you to critically analyse your own work.

He has had conflicts - in a more general sense - however, due to the politics involved in the contentious area of providing drugs to those suffering from malaria. For example, the new antifolate antimalarial drug Lapdap™ (chlorproguanil-dapsone) developed by Professor Winstanley and Dr Bill Watkins at



Photo: Swiss Info

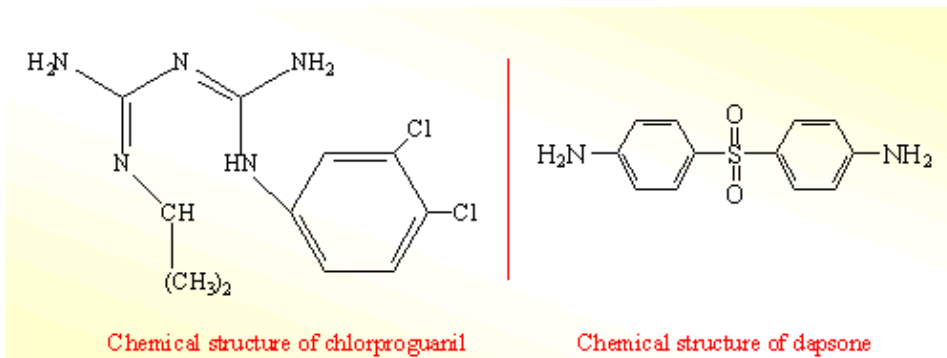
Liverpool University in close partnership with others, has now started phase four trials⁵⁻⁷. Winstanley is frustrated by the political 'wrangling' that has surrounded the launch of this drug and wants good evidence to support policies, not bureaucracy. This is especially irritating as the 'big Pharma' backers of Lapdap™ have agreed to provide the drug on a 'not for profit' basis to the 20 African countries who have registered it⁸.

We spoke about the recent developments in the drug patent laws that are taking place in

India⁹. He did think that 'poor people should have access to good drugs, profit isn't an issue.' The issue that Professor Winstanley was particularly interested in, however, was not one of cost but quality. He felt that 'big Pharma' spent huge sums of money monitoring not just the active ingredients but the contaminants and the stability of the breakdown products. This helps the pharmaceutical companies decide on the safe shelf life of the products. If smaller generic manufacturers did not apply the same thorough testing to all their products, then people could be exposed to dangerous contaminants (Winstanley stressed that the majority of generic manufacturers do adhere to high quality standards).

Another point that was raised is that pharmaceutical companies form part of our global economy and that, without their dependability for profit making, the economy would suffer.

The current system was in the Prof's eyes probably as good as possible. Although pharmaceutical companies are bound to be mainly interested in making profits and protecting their share prices, they have considerable motivations for being 'good corporate citizens'. These motivations include enhancing their corporate image.



Rings to Roll Back Malaria?

Picture:
Wellcome Institute

His suggestions for improving the system were that more institutions like the *Medicines for Malaria Venture*¹⁰ could help, and also the concept of 'risk sharing' by companies, through public/private partnerships, to reduce the vast cost of bringing drugs to the market.

In speaking again to Professor Winstanley after a period of studying International Health, I was in a position to engage him on a great many more subjects but, once again, he has provided me with a fresh perspective and much food for thought.

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Finally, the coming months are a busy time in global health, with the G8 summit in Scotland and the launch of Institute for International Health at University College London. We'll be keeping you up to date with the new developments over the summer, as we continue to expand the Alma Mata network.

If you have any comments, questions or would like to be involved with writing for the site and newsletter, we would love to hear from you. Contact us at:
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No-Brainer?

The movement of health professionals from resource-poor countries to Europe and North America has once again hit the headlines. To compliment the report recently issued by Medact (see news item on page 120), Charlotte Chamberlain writes about the background and potential solutions to the "Brain Drain".

In the recent UK General Election, parties vied for polling superiority on numerous platforms from health and education to immigration. The issue of the 'brain drain' is topical to all these manifesto themes. The flood of migrant health professionals, from developing countries to developed countries questions the balance of an individuals' right of freedom of movement and labour against the rights and necessity of a population to have access to health services.

Objection

Currently, there is an inverse care relationship¹ where those countries most in need of health services are the most understaffed. "Protection for developed countries at the expense of the developing world must come to an end. It is both immoral and hypocritical..." Mr. Howard² expressed this Tory view recently, highlighting the growing imbalance in the developing-developed world relationship.

Rising dissatisfaction with the unequal symbiosis between poor and rich led Dr Igodogho, deputy director of ActionAid International Nigerian

Programme, to speak openly about the devastating effect the brain drain was having on health services in Africa. He points out, of his graduating class of 137, only 47 are left in Nigeria; the remainder dispersed to richer nations around the globe.³ UNISON general secretary, Dave Prentis, has emphatically pointed out that "it is morally wrong to take nurses and doctors from countries where their services are desperately needed".⁴

So how do we balance the right to travel and work abroad, with the needs of a population to attain basic human rights, including a right to health?

How does the migration work?

In order to understand how to satisfy the needs surrounding health professional circulation it is important to quantify the causes. Many documents rely on the 'push' and 'pull' classification of health migration. Push factors include the desire to

abandon poorly resourced, poorly remunerated and often dangerous working conditions of many developing world health services. Pull factors include the attractive prospects presented by the developed world, such as greater job prospects, higher wages, and the lure of active recruitment and advertisement. The flow, in other words, is essentially from poor to rich. This translates to a significant rural to urban migration, public sector to private sector shift and a developing world to developed world exodus. A Lowell and Findlay ILO paper estimates that 80% of Zimbabwe medical graduates have emigrated since the country's independence in 1980.⁵ South Africa loses 300 nurses a month overseas.⁶

Implications

Higher nurse staffing levels improve health outcomes.⁷ A recent estimate suggests "sub-Saharan Africa is approximately 700,000 doctors and 700,000 nurses short of the staffing requirements necessary to meet the Millennium Development Goals".¹ And yet, labour from the most underserved areas of the world continues to emigrate, in order to fill shortfalls in developed

world health care services. The drain is immoral and unsustainable, resulting in poorer health in the developing world, which has vast consequences for the developed world.

In Countries, such as Mozambique, where the ratio of doctors per head of population is 1/30 000, or in Malawi, where the figure is 1/100 000, health workers are trapped in a vicious cycle. The reduced workforce is required to cope with ever higher work loads. When this is put into the context of HIV/AIDS, as illustrated in Malawi where 40% of the average annual output of nurses from training die prematurely, in all likelihood all due to the HIV/AIDS epidemic, remaining health workers' are overburdened and afraid.⁸

A Save the Children and Medact Joint publication, labels the brain drain "An unjust subsidy", highlighting the cost of training health graduates,



© Illuworld

Obligations

The state is responsible under international treaty obligations to make health care available, accessible, acceptable and of good quality. (CESCR General Comment 14 based on art 12 IESCR)

However, international treaty articles pertaining to the freedom of movement (borne out in article 12 of ICCPR as well as article 13 UDHR) define another perspective on health migration rights.

In order to respect, protect and fulfill the rights of the individual *and* of the communities affected by health worker migration a balance needs to be achieved on an international basis.

their lost productivity and the lost health benefits to their native population as part of the price to underserved source nations. Why is this continuing?

Plugging The Drain



Willets and Martineau have identified 15 codes of practice targeting ethical international recruitment. Since the introduction of the first ethical guidelines⁹, the outflow from South Africa has more than quadrupled. The DoH advises

against recruitment from a list of vulnerable nations, yet in 2002/2003 one in four new nurse registrants were from this list¹⁰.

The current DoH code of practice permits individuals to pursue careers abroad. The ethical codes in place are not all encompassing, leaving many private agencies free to continue to recruit from poor health source countries. Eric Goemaere, the MSF head of mission in South Africa voices his frustration that 'despite the UK's Code of Conduct on International Recruitment private agencies continue to recruit viciously throughout South Africa'⁸.

We now know that the code of practice in ethical recruitment pioneered by England and the UK has been unsuccessful. Further aggravating the ethical minefield of international recruitment the Guardian recently uncovered that Foundation hospitals are to be exempt from rules limiting the poaching of overseas 'nurses and other medical staff'. A draft code of practice alleged to be seen by the Guardian, says foundation trusts will be treated like private hospitals and merely "invited" to adopt ethical recruitment policies, without any sanction if they choose to ignore them¹¹.

Potential Solutions

Here are some potential solutions to the "be-heading" of health services. However, no single intervention is a cure and multiple strategies will be needed to reduce the exodus.

- 1) Strengthen health systems in countries of origin to reduce the factors impelling evacuation from impoverished, overburdened health systems.
- 2) Restitution: compensation for the costs incurred in training and loss of work hours to source countries.
- 3) Better human resource planning in destination countries. Rather than train numbers that require international recruitment top-ups, train sufficient numbers to meet health requirements at home as a minimum.
- 4) Managed Migration. Advocate exchange programmes.
- 5) Encourage ethical recruitment by destination countries.
- 6) Bonding. Required service to home countries in order to recoup some of the costs of training

7) Auxiliary worker training, thereby relying on non-exportable health employees to act as a reliable health care buttress.

8) Increase the policy role of International Organisations, such as the WHO and the World Health Assembly.

Conclusion:

The Foundation of any solution to the health care exodus must be to head the words of Mr. Johnson the BMA chief executive, who has recommended the government commit itself to becoming self-sufficient in doctors and nurses within the next decade. "If one considers the absolutely catastrophic effect that the current polices are having on the developing world, it seems quite immoral to consider any other course of action." Overall, it is estimated that by 2008, the UK will need 25,000 more doctors and 250,000 more nurses than it did in 1997.^{6"} Isn't it time to stop the poorest countries subsidizing the rich?

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Treatment Action Campaign

The provision of antiretroviral drugs to three million people by the end of this year is a key target for the international health community. Treatment Action Campaign were a key part in driving the need for antiretroviral medication and health system improvement in South Africa. Aska Leslie looks at the work of the organisation in depth.

"A first element, a foundational element, is real leadership and real activism in every country . . . Activism is vitally important to the response because it is the most potent force to get political leaders to overcome their unwillingness to act promptly on AIDS . . ."

These are the words of Dr Peter Piot, Executive Director of UNAIDS, in a speech at the London School of Economics earlier this year. He was highlighting the importance of activism as a response to the AIDS epidemic; that interplay between activism and responsible governance was key.

Nowhere is this more evident than South Africa, which, whilst being slow politically to address the issue of HIV/AIDS, has a strong grass-roots movement in the form of Treatment Action Campaign (TAC), an organisation founded by Zackie Achmat, a former anti-Apartheid activist.

Activities

TAC campaigns for affordable treatment for all people with HIV/AIDS. It also raises public awareness about AIDS treatments through protests, presentations to Parliament, and by working with labour, community and religious groups. A large part of their work is built around their "Treatment Literacy Campaign" to educate South Africans about HIV/AIDS and the lack of availability of treatment for so many in developing countries. 120 trained treatment literacy practitioners in Gauteng, Kwazulu-Natal, Eastern Cape and Western Cape



Campaigning In Action, © David La Page

provinces teach at clinics, hospitals, schools, workplaces and community institutions. Subjects covered include the science, prevention, treatment and care of HIV, nutrition for people with HIV, social grants, the health-care system and political issues

relevant to TAC's work. In addition, TAC runs a Treatment Project providing holistic treatment on a small scale to people living with AIDS.

Friends of TAC (FoTAC), TAC's UK-based supporting organisation, seeks to raise awareness of and educate the UK public with regard to HIV/AIDS in South and Southern Africa and to lobby governments and opinion formers for support on specific campaigns and issues around HIV/AIDS. The core issues they are campaigning for are:

- the crisis in deficit of health care workers in South Africa which - a significant barrier to the implementation of all treatment programmes and support
- drug company pricing structures - advocacy is required to ensure drug companies keep prices down
- inter-agency harmonisation and global treatment standard for the treatment of children with HIV/AIDS
- poverty and unemployment in South Africa - challenging the South African government's policies on these issues

Although FoTAC have been campaigning and raising funds for some time now, they are holding their official launch in October. Part of the launch will involve an event held in Trafalgar Square for students, school pupils and others to promote the educational role of FoTAC.

It is vital for us to support organisations such as these - as health professionals and as members of the global community. I would like to end with a quote from TAC which captures the government and global inequalities driving the epidemic in South Africa.

"Around the globe more than 3000 people die daily in poor countries of AIDS-related illnesses. We die while drug companies post huge profits. We die because our governments are in denial of the seriousness of the HIV epidemic. We die because rich countries invest substantially more in war than in public goods. We die because we cannot buy life-saving medicines. Unlike our neighbours in the rich countries we die because we cannot afford to buy life."

For further information on TAC please see their website: www.tac.org.za. Or FoTAC: www.friendsoftac.org.uk.

Aska Leslie
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 Postgraduate Education

Postgraduate Courses

An MSc in Epidemiology

Name:

Jaime Miranda
j.miranda@ucl.ac.uk



Photo: LSTHM

Country of origin:

Peru

University / College / Training Scheme:

Wellcome Trust Research Training Fellowship at London School of Hygiene and Tropical Medicine

Why did you choose to study this course?

I want to contribute to my country with research of good quality and relevance. This will then influence local policies. Also, I think that medical research is a great space for long-term north-south collaborations.

What prior qualifications/experience did you need?

Some interest in the field, some publications, the support of supervisors, but most importantly a relevant idea to develop.

Which topics are covered by the course?

The core MSc involves research and statistical methods. There is also opportunity to take other broader topics in Public Health and learn new tools. For example, I am taking mental health and predicting disease in time and space (learning GPS and remote sensing and its application to health issues).

Is there any project / overseas work?

You have to do a summer project in a two-month period and then write-up a project report. Yes, you can go abroad if your topic/area of interest is abroad. But usually time and feasibility of your study may be a barrier. Again, it depends of the project.

Which are the best aspects of your current training?

Although I do not see myself analysing data for the rest of my life, I found these skills very useful to understand and digest the most appropriate and relevant information for my country. When, in the future, someone recommends something based on research, I would be able to analyse the data and see if it's applicable to my country. That is the main advantage, to see the applicability of health research (and in the long run, health policy) combined with my work in a developing country

What are your future career plans?

Go back to Peru and work based there. In the medium term, the research I am doing will be used for a PhD degree. I like collaborating with foreign colleagues and also international health (the first time I use this word in this interview!), so I hope I can contribute to the debate from Peru.

Would you recommend this course to others?

Definitely. It teaches us about the feasibility, practicality and relevance of health information.

Medsin Update



GLOBAL HEALTH • LOCAL ISSUE
medsin

The Medsin calendar is always full, even when most students are finding life a bit quieter – the last three months have been no exception!

students to train in valuable skills like leadership and project management, externally facilitated by the trainer for the Red Cross and Ikea! There was plenty of opportunity for the new trainers to practice their new skills at the Global Health conference hosted by Peninsula medical school in April. The conference focused on the impact of the environment on health, as well as the impact of natural disasters on our work as healthcare professionals alongside other agencies.

March kicked off with a 22-strong UK delegation to the International Federation of Medical Student Associations' (IFMSA) 54th March Meeting in Antalya, Turkey. Medsin-UK wanted to push the idea of Fair Trade and the Make Poverty History campaign to medical student societies in other countries, many of which are not as politically active as us. Incredibly, we sold over 500 white bands to the attending delegates, and more than 26 other nations left aiming to enhance or initiate the Global Campaign for Action Against Poverty in their home country.

The end of May saw the Spring General Assembly in Manchester which included a really enlightening vision setting exercise. It was great to have such wide representation and we hope the weekend will shape the future of Medsin. We also elected our new National Committee.

For more information on these or any other Medsin activities, see www.medsin.org.

The end of March saw Medsin hold a "training new trainers" weekend in London, designed to empower

Natalie Sibbald
 Medsin National Secretary
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Medact Latest



Compensation for African health systems?

In February, Medact launched two new papers on responding to the brain drain of health workers from African countries, looking at the UK government's response, possibilities for compensation and a human rights approach to health professional migration. Links to the papers are below. They have triggered further national debate on the issue, most recently in the *Independent* newspaper.

The paper by Ghanaian author Kwadwo Mensah and colleagues Maureen Mackintosh and Leroi Henry questioned the effectiveness of the government's Code of Practice on "ethical recruitment" which seeks to prevent NHS employers (and, more recently, private sector recruitment firms) from recruiting from a large number of developing countries experiencing staff shortages. However, the research showed that in Ghana at least the Code was ineffective in preventing the outflow of health workers to the UK and may be seen as discriminatory by migrants from these countries who want to work in the UK.

The researchers argued that labour market integration in health care was proceeding fast, led by the expansion of recruitment firms, high demand from the UK and US for more health workers, and the availability of information about jobs in the developed world, which has been made much easier by the internet. In this situation it was harder for preventive codes of practice to work, and strengthening them – for example to prevent applications by individuals to work in the NHS – would discriminate against the rights to freedom of movement of health workers.

The paper argued that there are other ways in which the extent of the UK NHS' reliance on poor countries could be acknowledged. In effect very poor countries like Ghana, are spending money on training staff who are then leaving to work in countries many times richer. The researchers calculated that the availability of Ghanaian doctors and nurses alone had saved the UK NHS £103 million in training costs. It is time for the UK government to recognise this "perverse subsidy" from very poor to rich and to pay compensation to poorer countries which could be used to rebuild health care systems, and thereby improve incentives to stay.

There is a particular need to fund higher wages, better working conditions and further training opportunities for doctors and nurses. Better management of health workers was also important. The research found that although the Ghanaian government had been making efforts in these directions by funding incentive schemes for health workers, these needed to improved and expanded.

The paper suggested that financial compensation should also involve greater collaboration between the UK and poor country health systems – existing partnership schemes to share staff and equipment between parts of the NHS and low-income countries should be built on.

Compensation should not be provided to all countries who send health workers to the UK – the subsidy from Ghana and other low-income countries is particularly unjust because they are so poor and face staff shortages which are unimaginably severe. Other types of solutions are needed for richer developing countries or nations such as the Philippines and India which are actively training health workers for export.

Links

The Medact papers are available at http://www.medact.org/article_health.php?articleID=337

See the *Independent's* reporting at <http://news.independent.co.uk/world/africa/story.jsp?story=641735>

Global Health Watch – launch on 20 July

Medact, together with the People's Health Movement and the Global Equity Gauge Alliance is about to launch the *Global Health Watch 2005-2006* – an alternative World Health Report – covering key issues such as globalization, health systems, medicines, conflict, education and water, and monitoring the performance of the global health institutions such as WHO and UNICEF.

The *Watch* will be launched in Ecuador at the People's Health Assembly in Cuenca and simultaneously in London, Amsterdam and Berlin on 20 July. Anyone wishing to attend the London event, which is co-sponsored by the Lancet and being held at the Royal Society of Arts should email patriciamorton@medact.org.

Links

You can download a copy of the report from the GHW website from 20 July onwards www.ghwatch.org; It will also be available on CD from info@medact.org. The *Watch* will be published by Zed Books later in the year.

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