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March 2006

Global Health
Graduates Network

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Career Planning

careers

Relief Work in
Pakistan 2

research

Latest Research from
www.almamata.net 6

advocacy

Career Planning 7
Students As Active
Global Citizens 7

education

New Courses 8

news

Almamata News 8

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Next edition June 2006.

an online 'virtual' pin-map that members could update, that would be just wonderful.)

Post-graduate courses were high on many people's plans. Masters' in Public Health courses were widely touted, with venues including London, Copenhagen and John Hopkins University. Those running diplomas in Tropical Medicine and Health should also anticipate high demand, especially those in Bangkok and London. Other options were masters at the University of Cape Town at the AIDS

Ten Year Plans

With Alma Mata's membership now 400-strong, it is now possible to use our collective weight as an advocacy tool for pushing global health into the new foundation programmes. As Rebecca Hope and Fred Martineau discussed in their [Crossing Borders](#) series, the new structure presents an opportunity to create exciting and innovative posts within the NHS career structure. But before the global health offensive can be launched, and in the spirit of our open and democratic organisation, members of the working group currently in Foundation Year 1 and those in the final stages of undergraduate study, were invited to complete the phrase "when I grow up I want to be...".

Fifteen fascinating contributions later and we are now in a much stronger position to answer the question of what is a career in global health. This qualitative data trawl is planned as a precursor to a more comprehensive survey of all our members in due course, and allows common themes to be explored at that time. So (I hear you ask) what did they say?

Well, as if it needed saying, they are quite an ambitious bunch! Despite widely different and imaginative plans, patterns emerged and many ideas overlapped.

Experience

Plans for foundation years recognised the current lack of public/global health and academic research posts available. Many acknowledged that the likelihood of landing one of these jobs was remote and instead planned to go for the rotations offering combinations of infectious disease/genitourinary medicine/HIV, acute medicine/A and E, paediatrics, obstetrics and gynaecology, general practice or public health.

Many of the respondents plan to work abroad after gaining necessary clinical experience at home. No official plans exist at the moment to accommodate the growing number of newly trained doctors wishing to work abroad for extended periods, however members reckoned on about four years of UK work before eloping.

Organisations mentioned for overseas work included Medecins du Monde, Merlin, Skillshare, Voluntary Service Overseas, Medecins sans Frontieres and NHS links. If one was to place a pin on a map for each respondent's destination, Asia, South America and Africa would be peppered with Alma Mata members. (If anyone wants or has the technical expertise to set up

continued on page 7

Relief Work in Pakistan

In December 2005, six University of Leeds medical students spent two weeks providing assistance at a hospital in Kashmir, Pakistan which was severely affected by the earthquake of the 8th October that year. Danni Kirwan writes about her experiences there.

On December 28th 2005, a team of six fourth-year medical students from Leeds University went to Bagh in the Kashmir region of Pakistan to provide medical assistance to earthquake survivors. Although we only had two weeks due to educational commitments, and were inexperienced and underqualified, we did have some medical knowledge and monetary resources and were willing to work hard.

Initially, we were unsure as to how much help we would actually be to the population of Bagh district, and received much skepticism from people back in the UK regarding how much we could contribute. As it turned out, we found that what we had heard was indeed true – the main shortage in the earthquake region was neither money nor medicines, but man-power, and we were able to accomplish a great deal more than we expected.

Bagh is 205km from Islamabad and has a population of 400,000(1), living in villages and clusters of houses spread around the mountainous terrain. We spent two weeks volunteering at Bagh DHQ, the main hospital in Bagh district. During the earthquake of the 8th October, which killed approximately 73,000 people(2), half of the hospital collapsed. Fortunately, it did so twenty minutes after the first tremor, so the staff were able to evacuate the building, and amazingly no-one was killed. The rest of the hospital remains standing, but was badly damaged and is no longer safe for use. Sadly, the hospital was just three years old.

The initial response to the earthquake.

A relief plan was set up following the earthquake by the Pakistani military in conjunction with national and international agencies(3). The strategy was composed of three tiers. Firstly, a healthcare network was set up by the army with input from international agencies such as Mercy Malaysia, MSF and military hospital units from the developed world. Secondly, dry rations were delivered to survivors to see them through the winter. Thirdly, over \$100m was put towards shelter, with cash distributed to in excess of 240,000 families to help themselves improve their housing. Reports in the British media(3) claim that this has been accomplished; while we were there, the people knew of these promises but were not expecting the money for another month. Many of the tents which have been distributed so far have also proved to be inadequate(2); I spoke to someone from IOM who said that he had distributed 60 tents over the past week, and not one had survived the snow.

In the immediate aftermath, MSF provided tents which were set up in the shadow of the hospital ruins, and from which hospital services were run. These tents remain there today, and have proven to be effective; they remained standing during the recent snows, and the set-up essentially functions like a normal hospital. NATO were also quick to respond, setting up a well-equipped field hospital just up the hill from Bagh DHQ. Perhaps most striking is the immediate response of Pakistani people to the disaster; many volunteers such as nurses, doctors and students went immediately to the affected areas to do what they could.

Staff back in the Pakistan Institute of Medical Sciences (PIMA), the largest hospital in Islamabad, also felt the tremor. One nurse described seeing the equipment in ICU rattling at 8:55 am, and a ceiling air vent falling in. This caused panic in the hospital, but people settled down and continued with their work. Soon after, however, casualties began to be brought in from the Margalla Tower, fortunately the only building in Islamabad to collapse. Before long, staff were completely inundated with casualties arriving every ten minutes by helicopter from affected areas.

The current situation.

Three months on from the earthquake, Bagh Hospital is stable and running out of the tents provided by MSF, with much equipment salvaged from the wreckage of the hospital. It provides basic services including outpatients, obstetrics and gynaecology, emergency care, pathology and radiology. It has four main wards, male and female medical and surgical, with children accepted onto the female wards, and a three-bed ICU tent. Minor injuries are treated in the ER tent, and there is an OT with facilities for more complex surgery. The hospital is functioning, but cleanliness and infection control remain a challenge.

There is a lack of human resources; the hospital has placed a request to the Ministry of Health

for an extra 20 nurses, 6 medical officers and 4 specialist doctors, and at the time that we left, were hopeful that some at least would be arriving shortly. This shortage is compounded by the absence of many doctors in the afternoons, when they leave to practice privately elsewhere.

There are some facilities which the hospital cannot provide, the most notable being surgery; although there is a surgeon available, there is no anaesthetist. The diagnostic services provided by the hospital are also very limited, with only one portable x-ray machine (the quality of the x-rays is shocking) and haematology limited to just full blood counts, and only when the technician happens to be in the hospital.

These deficits had until our visit been covered by the NATO field hospital, to which all critical and surgical cases have been referred, and which has more sophisticated diagnostic facilities such as endoscopy. However, this hospital was set up to provide medical relief, and not to provide long-term support. It closed on January 10th, just two days after we left Bagh. Although there are other small hospitals in the area, they too have just basic facilities. This leaves Bagh Hospital with no support, and with the full responsibility of the health needs of the population. Any cases which it cannot handle will have to be transferred to PIMA hospital in Islamabad by helicopter, weather permitting.

The tents allow the hospital to function in the short-term, but clearly this is not ideal. Patients have to wait outside the tents to be seen, and moving between areas of the hospitals involves walking outside, which are impractical in a region which experiences extreme weather conditions. Gravel paths are inhospitable to wheelchairs, the latrines are unhygienic and inaccessible to those with mobility problems, and the wards are prone to flooding.

MSF have pledged to provide 79 containers, which when we left were expected to arrive at the end of January, at a cost of €1.5million. These will provide a more suitable hospital environment in the medium term, until the hospital itself is rebuilt. Through provision of containers, MSF intend to give the Pakistani government time to plan and build the hospital properly. Following the total collapse of the military hospital in Bagh, the Pakistani armed forces also plan to re-establish a hospital of their own at some stage.

Although the initial crisis has passed, the effects of the earthquake are still noticeable in the day-to-day functioning of the hospital, with patients returning for suture removals or review of healing bones. And, of course, the immense psychological trauma sustained by so many people is highly evident. Hygiene has also deteriorated in the region since the earthquake, causing an increase in the burden caused by waterborne diseases.



Ruins of the Hospital

Credit: D Kirwan

What we were doing.

Our first main task was to move the ER and Minor Injuries departments from their two small tents into one large tent. We salvaged furniture and supplies from the derelict hospital, and sorted through the contents of the existing tents; much of it was out of date, missing, or inappropriate, so we reduced it to the essentials and supplemented it with what we could find in the pharmacy. Although this did not necessarily engage our medical skills, at least we felt that we were being of use.

While we were moving the ER tent the weather was hot, the boys were in t-shirts and us girls found it difficult to refrain from rolling up our sleeves, but on about our third day, the weather turned. One evening we were surprised to find snowflakes the size of 50p pieces floating thickly past our window, and the next morning we waded to the hospital in our snow suits. The weather had an immense impact on the hospital. We were lucky with our accommodation: our two damp and cracked concrete rooms may have been very cold but at least they kept the weather out. Others were not so lucky. Tents lay flattened under heaps of snow. Compounded by the closure of the surrounding roads, this meant that the next morning there were few patients at the hospital, and even fewer staff. The doctors had families and responsibilities outside their work which took precedence, and their absence left us largely in charge.

We divided ourselves into three pairs. As there was no pharmacist, Andy and Naomi, two members of our team, took charge of first sorting the piles of opened boxes and loose pills into a usable system, and then handing out prescriptions. This was by far the most demanding job, as the patients would crowd outside the tent shoving prescriptions through the windows, all demanding to be seen at once. The prescriptions were scrawled on scraps of paper, and an alternative had to be found if the drug required was unavailable, doses had to be calculated, pills counted out, and all this somehow communicated to the patients.

Another two volunteers, Faisal and Daisy, ran clinics. Fortunately, Faisal spoke Urdu, and there was a translator available for Daisy. They would each see around 30 patients per clinic, and counselled the patients, prescribed treatment and made referrals if needed and possible. The MSF nurses were very helpful as they had a good knowledge of which medications were usually given for common illnesses as well as knowing what was available on site. As there was little in the way of investigations, we had to rely heavily on our clinical skills and oxford handbooks. Often, staff were in the habit of prescribing more than one antibiotic at a time, as there was no pathology lab to identify the causative organism; the staff knew that this was likely to be causing problems with resistance, but felt they had no choice.

The third pair, myself and Helen, worked in the ER and Minor Injuries tent with one of the MSF nurses. We were less busy than the others, but had a steady stream of patients all day, often referred to us by Daisy or Faisal. Fortunately, we had plenty of support from MSF, and never had any presentations that were beyond our capabilities. Our activities involved dressing wounds and abscesses, suturing injuries, and managing dog bites, asthma attacks, children in respiratory failure, road traffic accidents, fractures and burns.

We all had a very varied experience, and learnt a lot of medicine in a short period of time. Pakistan probably taught some of us as much pharmacology as three and a half years of medical school. Moreover, we felt that we had been useful, and this was reflected in the attitudes of the staff towards us. During the last few days we had more invitations for meals than we could fit in. We were very sad to have to refuse the requests of the hospital for us to extend our stay, despite their offers to telephone and write to Leeds University and formally obtain permission for our continued absence.

Challenges.

There were some aspects of our work in Bagh that we found very challenging. We had some patients who had potentially curable conditions, who had to be treated palliatively due to unavailability of resources. We had one young woman who was in excruciating pain with what we thought was kidney stones; we could do nothing but admit her, administer analgesia, and discharge her back to her village.



Hospital Support Tents

We also perceived, within a very short time, that there was a lack of interest from the local doctors working in the hospital. We found this surprising, as we had all expected the staff to be working very hard. The Medical Superintendent agreed that morale was very low among the staff, admitting that they themselves are still suffering from depression and other psychological problems following the earthquake, which of course affected all, staff and patients alike. A lot of resources have been put into treating the mental health problems of the survivors, not least the WHO's Mental Health Relief Unit set up alongside the hospital. However, I felt, and it has been reported elsewhere(3), that high expectations of international and national relief efforts have led to a failure for people to recover from the shock of the earthquake and for their lives to begin to return to normal. The international community has made big promises which have given hope and a focus for the survivors, and which have subsequently been broken; this has led people and families to spend their time waiting for handouts rather than rebuilding their lives.



Credit: D Kirwan

Tragically, all of the patient records stored within the hospital were lost during the earthquake. This loss has affected the morale of staff such that they do not see the point in making any effort with keeping present notes. The hospital also suffers a shortage of stationery, with prescriptions written on scraps of paper and patient notes scribbled down margins and over the top of printed text. As a result, patient notes are currently appalling. The hospital management has recognised this problem, and the hospital superintendent told us of plans to re-establish a reporting system within the hospital. The hospital, in conjunction with MSF Belgium, are presently researching the systems employed by different countries to decide which kind of reporting system it would be appropriate to set up in the hospital. This is a positive step and will greatly help to improve the hospital. However, it will take a long time to implement, and in the mean time the current patients would benefit from a more concerted effort to document their treatment. Furthermore, the lack of records renders the accuracy of the WHO's weekly mortality and morbidity reports questionable(4).

The geography of the region makes it difficult for many people to access healthcare, and this has been exacerbated by first the earthquake and then the bad weather. MSF has some health clinics in more inaccessible areas, and we spent a couple of days running clinics in rural villages; however, many people still remain stranded in mountainous villages with no access to healthcare, and this remains a major challenge(5,6).

Final comments

Towards the end of our time at Bagh, the staffing levels returned to normal as the roads were cleared. We were fortunate in our timing; somehow, we managed to be in the hospital at a crucial time when there was a deficit in staffing levels. We were then able to leave knowing that there were sufficient doctors at the hospital, and our absence would not mean that patients would remain unseen.

All six of us felt certain on leaving Bagh that our trip had been worthwhile. As well as having thoroughly enjoyed ourselves, we felt confident that we made a positive contribution. Many of the patients we saw and treated would not otherwise have been seen by anyone. We also made a small sustainable difference through our work setting up the ER tent and organising the pharmacy.

Equally importantly, we gained a wealth of knowledge and experience. We all intend to spend some time working in the developing world at some point in our careers, and everything that we learnt, that changed our attitudes, and broadened our minds during our time in Pakistan has prepared and equipped us to be more useful in any future work that we may undertake.

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Research Round Up

Vitamin D deficiency linked to tuberculosis

Research that shows how a lack of vitamin D can increase people's susceptibility to tuberculosis (TB) could explain why people in Africa and other parts of the developing world are particularly prone to the disease.

The findings, published by *Science*, suggest that vitamin D supplements could be used to fight the disease. The study shows that a successful immune response to TB depends on the conversion of vitamin D into a hormone that white blood cells use to kill the invading bacteria.

Co-author John Adams: "People with low levels of vitamin D are more likely to succumb to TB. This could be corrected simply by using supplements to return their vitamin D levels to normal."

But Robert Wilkinson, a TB specialist at the University of Cape Town, South Africa, says more research, including human trials, is needed before we can be certain of the effect that supplying vitamin supplements on a large-scale would have on the disease.

Full Story: <http://www.almamata.net/news/?q=node/6804>

'Infinite' supply of arsenic in Bangladeshi water

In a paper posted online by Proceedings of the National Academy of Sciences, the team says their results suggest the poison is released from sediments deposited by flooding.

"What this means is you have an essentially infinite source of

arsenic that can be liberated up near the surface," explains Matthew Polizzotto, one of the team at Stanford University, United States.

Arsenic poses a health risk to 57 million people in Bangladesh who drink well water laced with it at levels above those which the World Health Organization says are safe. Exposure can cause cancers and disorders of the nervous system.

The chemical occurs naturally in the country's soil and underlying sediments, but researchers have yet to understand exactly how it passes from the soil into the water.

Charles Harvey, a researcher at the Massachusetts Institute of Technology, United States, who also contributed to the study, says the findings highlight the need to conduct basic research into the water cycle in Bangladesh.

Unfortunately, says Harvey, neither development organisations nor researchers — the two groups looking at arsenic contamination in Bangladesh — have both the expertise and funding to do this.

Development organisations are busy searching for immediate solutions such as alternative clean water sources, while scientists only receive funding for original work — for example, sequencing the genome of the bacteria that liberates the arsenic.

"We can't get funding to do the real basic hydrological work that will really help answer this question," says Harvey.

Full Story: <http://www.almamata.net/news/?q=node/765>

Social Cohesion, Institutions, and Growth

Policy and institutional quality are to a large extent endogenous. While the truth of this statement is familiar to most development scholars, the implications of it have drawn relatively little empirical attention.

Understanding more about this relationship matters, because "poor institutional quality" and "failure to implement better policies" are so frequently identified as the causes of growth collapses, endemic poverty, and civil conflict.

Specifically, we argue that one of the primary reasons why even good politicians in countries all over the world, but especially in low-income countries, often enact bad policies is that they experience significant social constraints on their efforts to bring about reform.

These constraints are shaped by the degree of 'social cohesion' within their country. We show that social cohesion determines the quality of institutions, which in turn has important impacts on whether and how pro-growth policies are devised and implemented.

A country's social cohesion is essential for generating the confidence and patience needed to implement reforms: citizens have to trust the government that the short-term losses inevitably arising from reform will be more than offset by long-term gains. ..."

Adapted From Article.

Full Story: <http://www.almamata.net/news/?q=node/6816>

continued from page 1 For those who imagined they would be based primarily in the UK, the most popular ultimate career was general practice, although several people expressed a desire to be a 'GP with special interests'. One early idea, was the concept of a GP practice formed by our members and other like-minded folk, that encouraged a six month sabbatical abroad every two years that would allow members the opportunity to continue the projects undertaken earlier in their careers while still having a valuable and fulfilling role within the UK health system. Judging by the enthusiastic reception to this idea, this is one Utopian dream I wouldn't bet against.

Many people described an ideal career containing frequent or prolonged periods working abroad. For a minority, the possibility of living permanently overseas was still open. Many envisaged their contribution to global health in the form of side projects in education, research and advocacy, and for one, the dream entailed a vegetarian, community café, possibly based within a general practice, promoting healthy living and community activities, with links to projects in the developing world.

If you have any specific thoughts concerning foundation programmes in International Health, or if you are interested in trying to set one up in your deanery, please visit the new forum thread [here](#). More information and support will be available on the website soon.

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DEA Seminar: Students as Active Global Citizens

Representatives from key student led organizations met at DEA HQ to initiate action towards a common best practice to engage students with global development issues.

The first of its kind, this seminar follows discussions born out of last years DEA Conference "Graduates as Global Citizens" which, whilst involving institutional advocates for the student body, didn't actively involve students.

Key themes important for engagement were generated during the discussion as the experience of those present was shared through workshop and open debate. All agreed action is needed.

Student involvement was considered an issue of accessibility, suggesting a need to publicize, "dumb down", and de-stigmatize development so removing stereotypical or over specialist notions of developmental advocates. Such actions would aim to empower students providing the knowledge to critically appraise developmental issues so engaging the unengaged. Greater communication between existing student initiatives and student groups, improved recognition and accreditation for extra curricular activities such as voluntary work, and the development of a more participatory curriculum for students and academic personnel were all considered key in any attempt to de-fragment existing action. Successful collaboration between activities identifying common principles and goals would generate power through commonality driving forward the group's agenda.

The delegates agreed that an effective way to move forward is through the sharing of successful examples of initiatives from their respective areas of action.

Representatives attended from Development in Action, Alma Mata Global Health Network, The Development Education Association, Students Partnerships Worldwide, Engineers without Borders, People and Planet, Student Action for Refugees and Essex University Student Union.

All parties left with motivation to generate discussion within their groups before the next meeting to be held in April which hopes to involve independent students to generate a wider working perspective.

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For more information on DEA visit: www.dea.org.uk



MSc programmes in International Health Policy

The Centre for International Public Health Policy at the University of Edinburgh

is setting up two new MSc programmes in international health, starting in September 2006:

MSc public health policy (global health)
MSc public health policy (public private partnerships).

Drawing on the research of Prof Allyson Pollock and her colleagues, the programmes analyse the national and international challenge of markets within contemporary public health policy.

For more information: www.health.ed.ac.uk/CIPHP/postgraduate



Masters in Global Health

This Masters programme, building on and replacing our previous successful Masters in International/Community Health. programme.

Core modules are: Researching Global Health, Determinants of Health. Economics and Financing of Health, Policy & Systems: Global & Country Level Perspectives, Key Skills in Global Health.

Optional Modules will include: Tropical Medicine, Nutrition & Global Health, Reproductive Health & HIV/AIDS, Human Dynamics of Development Co-operation Culture, Empowerment & Health.

For more information: http://www.tcd.ie/Health_Sciences/medicine/Mastersgh.php

news



Medact

Medact will be holding its annual conference on Saturday 22nd April commemorating the twentieth anniversary of the explosion at the Chernobyl nuclear reactor.

"20th Anniversary of Chernobyl - The True Health & Environmental Legacy" will bring together experts from across the world to discuss the incident, its aftermath and what still needs to be done.

For more information: www.medact.org

MedSIN

MedSIN members recently attended an international meeting in Chile spreading the global health word with hundreds of delegates from 80 countries. A little closer to home; the annual global health conference took place on 25th and 26th March examining "Poverty and Health in the New Millennium.

For more information: www.medsin.org

Global Health Directions

Many thanks to those who made our Global Health Directions event at Leeds in December such a success. Over 200 delegates met to share experience and discuss the international health issues of the day. Keep an eye out on the website for the conference report which will be published soon and more events.

Cross Professional Partnerships

One of our targets this year is to diversify the membership of Alma Mata to include more health care professionals, allied professions such as biochemists and other health system workers such as engineers. Please forward this newsletter or a link to the site to anyone who you think would be interested in Alma Mata.

Join The Team

We are always keen for more people to join the Alma Mata team under the areas of Research, Advocacy, News, Education and Careers. To find out more get in touch with us at:

www.almamata.net --> contact us
info@almmata.net