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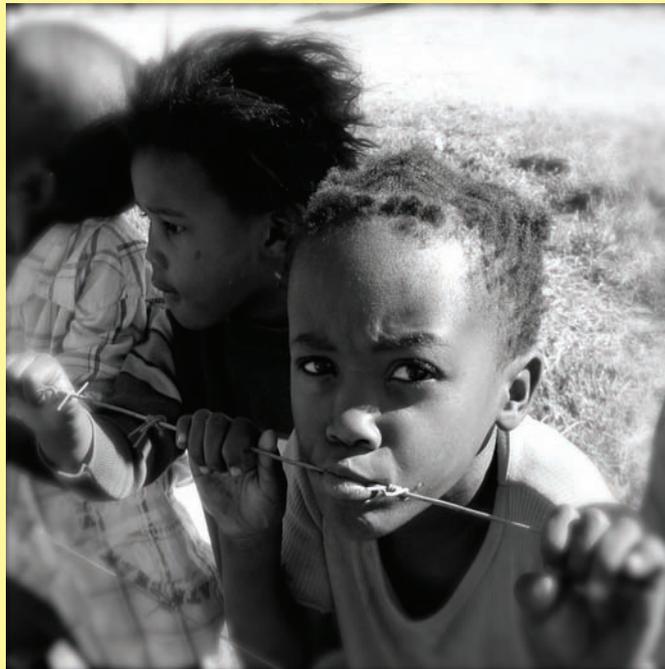
Global Health
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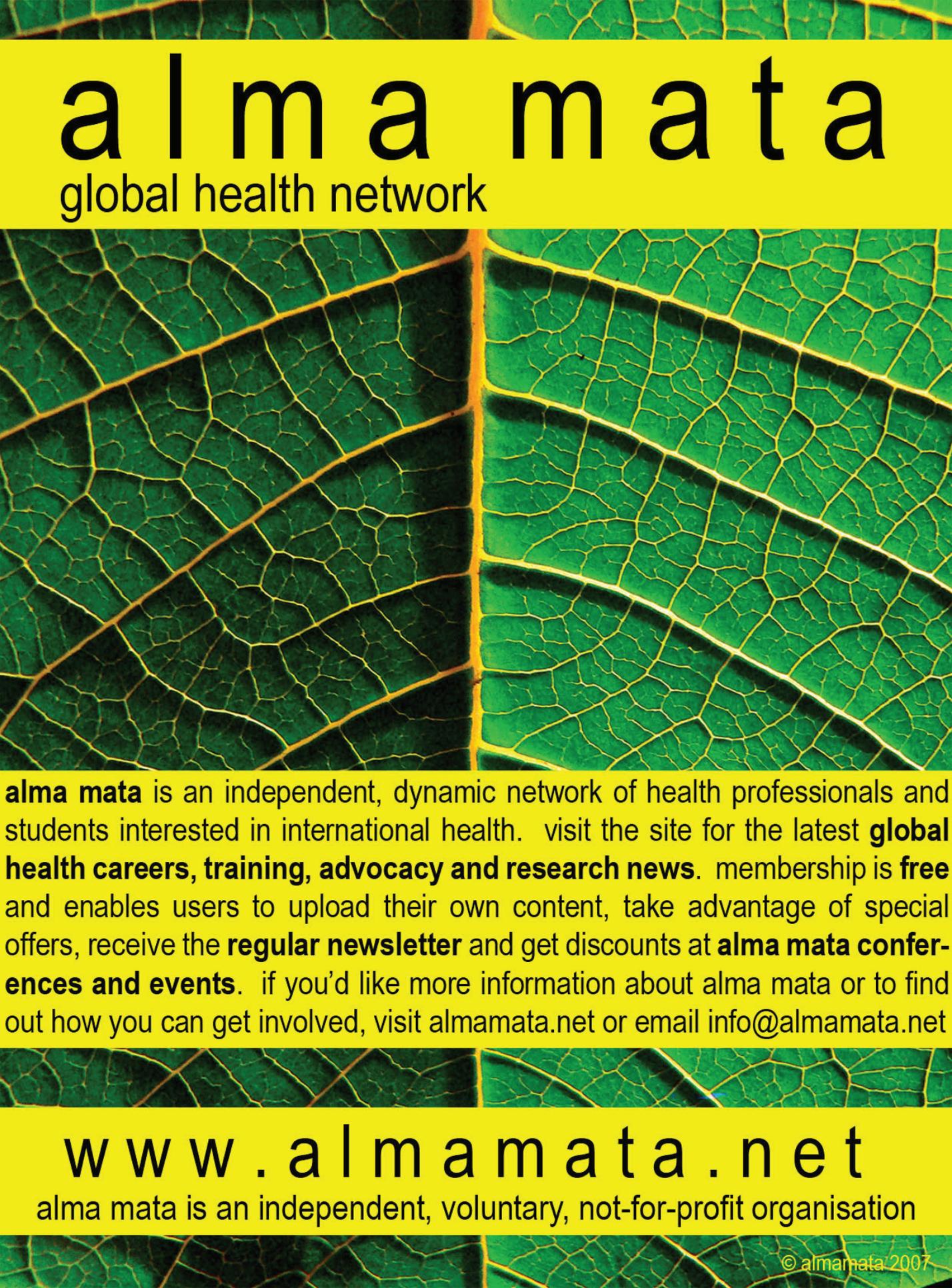
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global health network

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Welcome!

This is the first edition of the Alma Mata journal of Global Health, abbreviated to 'AMjGH'. For those unfamiliar with the work of Alma Mata, you only have to look overleaf to discover the aims and aspirations of the group. In the four years since its inception, the progress and evolution of Alma Mata has been such that the production of a regular publication felt like a natural 'next step'.

So what are the aims of this journal? What do we hope to achieve by publishing it? The strengths and achievements of Alma Mata include its successes at bringing together like-minded health professionals, sharing resources and ideas with the ultimate goal of improving global health. Until now, the website (www.almamata.net) has been the organisation's main forum, with three conferences and a careers day further enhancing our activities. But since Johannes Gutenberg developed his printing press in the 15th century, print has been the medium with which the greatest amount of information has been disseminated. Evidently, the advent of the internet has improved this, providing a more affordable means with which to communicate ideas and information. So what advantage, or even purpose, do journals now hold?

A journal was and remains a collection, a short cut, to information - be it news, re-

search, jobs or conference listings. With this journal, we aim to use the website and its readers to determine what is published. The articles and features with the most hits, i.e. the most popular aspects of the website, will be included in the latest edition and will guide the content of the features and articles commissioned. This, as far as Alma Mata is aware, is the first time such a method has been employed in the production of an academic journal. It effectively involves the website's users in the production of the journal, thus adding a degree of flexibility and a much greater number of individuals to the editorial process.

Additionally, we recognise that a large amount of global health research and information - effective 'content' - is inaccessible. Every year, over one hundred medical students graduate from Intercalated International Health BScs in London, Leeds, Bristol, Birmingham and Edinburgh. There are countless post graduate courses relating to global health, both in the UK and overseas. This begs the question: what happens to the potentially useful and informative academic work and research generated by these courses? A minority of it finds its way into peer-reviewed journals; but inevitably, the vast majority stays on a university server or a personal hard-disk drive, never to see the light of day beyond the pupil and its assessor.

Editorial

Through this journal, we want to bring this work into the open - to bring useful insights, essays and research into the public domain. For this to happen, the original concept of the Alma Mata website needs to be reignited. There are now over one thousand Alma Mata members - a substantial number of individuals interested in global health. We hope that the production of a journal will enthuse and encourage these individuals to contribute new content. Maintaining the website's status as a source of information to those wishing to pursue the improvement of global health has been one of Alma Mata's primary goals since its inception.

Perhaps the most salient of Alma Mata's current activities is lobbying for and participating in the development of internationally focused training for NHS staff. But we grew from the International Health BScs, and so we begin with selected pieces by students who have undertaken the degree. Peter Baker and Ashley Sharp give their respective answers to fundamental questions surrounding economics and global health, while Lucie Collinson writes the first of her series on the role of the International Community in humanitarian crises.

The Alma Mata website has always had interviews and accounts of work in the global health field. With recognition of this, we feature accounts from two very different global health experiences. Kiran Jobanputra talks about his work with MSF in Somalia, while Peter Bamford describes his experience working at the Kolinska Institute in Sweden.

Finally, we feature a piece from the working group and profile those currently active

within it in various areas. Along with writing pieces such as these, the working group is currently involved with improving post-graduate opportunities for those health professionals who wish to work abroad during their careers. This has been one of our biggest areas of activity in recent years and we hope that this journal will join it.

Gareth Lewis
Dave Baguley
Danni Kirwan

Co-editors

The Editorial Panel wish to thank all contributing authors and peer-reviewers for their contributions towards this first edition of the Alma Mata Journal of Global Health.

Wellcome Trust fellowships for clinicians

The Wellcome Trust offers a range of fellowship awards for clinicians at each stage of their careers.



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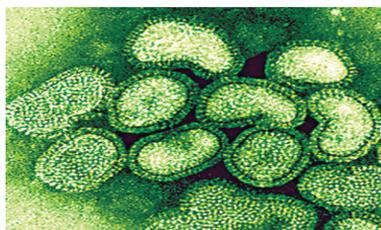


Each issue, we will bring readers global health news covering recent studies, release of reports, disease outbreaks and conflict and disaster coverage in each issue. All news articles are sourced from our website in the month leading up to each edition's release.

Swine influenza outbreak continues to spread

As of 26th May, the WHO has confirmed 11,168 cases of Influenza A (H1N1) spread over 42 countries. But over five weeks since a declared category 5 status was given to the outbreak, the International Community have been relieved to find that mortality from the virus is not as severe as once feared. In total, eighty-six deaths, or 0.77% of all cases, have been attributed to swine influenza since the

outbreak began. Seventy-five of these were in Mexico in the early stages of the outbreak.



H1N1 Under the microscope

Latest WHO advice does not include travel restrictions other than for those who have already been infected. It is

also reassuring the public that pork consumption is safe.

However, a research team at Imperial College London (ICL) has predicted that up to one in three individuals could be affected by the virus, and that it will 'go global' within 6-9 months. The quickfire analysis of Mexico's outbreak suggests that it may be as virulent and dangerous as the 1957 outbreak, but not as serious as the 1918 'Spanish Flu' pandemic that killed between an estimated 50-100 million people.

The team, led by Professor Neil Ferguson, state that until the advent of the normal 'flu season' over autumn and winter, we will be unable to assess the full impact of the virus. While Influenza normally affects 1 in 10 during this period, we should expect a "really major epidemic" this year.

This warning echoes that of the UK's Chief Medical Officer Liam Donaldson, who last week warned that the nature of influenza means that we cannot draw conclusions on its virulence this early - "We may see an apparent peak in the incidents over the next month or so.... but it could be that we'll see a resurgence of the virus in the autumn and winter when the normal flu season starts"

Their warnings stem from the rapid change in character that influenza viruses can undertake. During the 1918 epidemic, the initial wave of infections were mild, whereas later waves proved devastating to large numbers of the world's population.

The risk of the virus co-infecting a swine with H5N1 and producing a swine/avian flu hybrid is also a real one. It is this situation that the global community managing the pandemic are hoping to avoid.

For latest information, visit the WHO's

swine influenza page at:
<http://www.who.int/csr/disease/swineflu/en/index.html>

Merlin report highlights need for greater investment to cut maternal mortality

On 5th May, to coincide with the international day of the midwife, the charity Merlin have released 'all mothers matter' as part of their 'hands up for health workers' campaign (www.handsupforhealthworkers.org)

The report highlights several statistics that evidence suggests need to be addressed in order to meet the 5th Millennium development goal on maternal survival. 75% of maternal deaths are preventable with the presence of a skilled health worker and emergency obstetric care, a-



Merlin's Report Logo

-nd more than 50% of maternal deaths occur in fragile states (defined as countries where the government cannot or will not deliver core functions to the majority of its people). With these in mind, it draws the conclusion

that 50% of all health funding must be channeled into health systems and 25% to strengthen health worker capacity in maternal care if the 5th MDG is to be met. Finally, it "calls for urgent reallocation of funding to pay for health workers needed to ensure pregnant women living in countries in crisis are not simply left to die."

Broader vision informs Obama's plans for US Global Health policy.

Last week, US President Barack Obama asked congress for \$63 billion over 6 years to re-shape former President Bush's AIDS policy. While the 'Presidents emergency plans for AIDS relief' (Pepfar) was praised as one of President Bush's most significant achievements, President Obama is seeking to broaden the program to focus beyond AIDS. A White House statement, released on Tuesday 5th May, read "We cannot simply confront individual preventable illnesses

in isolation."

It also detailed how the funds would be distributed over a 6 year period, with \$51 billion going towards AIDS, TB and Malaria and \$12 billion for other global health priorities. In 2010, \$7.4 billion will be in-

News

vested by the US government on tackling HIV/AIDS, TB and Malaria, an increase of \$366 million on this year.

However some quarters are accusing President Obama of broken promises. Dr Paul Zeitz of the Global AIDS alliance, a US-based advocacy group, said "To me, this is a betrayal of trust...they are expanding the mandate, but not expanding the pie." In his election proposals, president Obama proposed annual increases of \$1 billion, rather than the \$366 million scheduled for 2010. However, the White House has made clear that the \$51 billion commitment will go ahead, but over the aforementioned six years instead of five. This, it claims, explains the lower than expected increase scheduled for 2010.

This story was sourced from the Global Health Council. For more information visit <http://www.globalhealth.org/news/article/11074>

WHO and UNEP Roll-back DDT use in Malaria Control

A joint announcement on behalf of the World Health Organisation (WHO) and United Nations Environmental Project (UNEP), in cooperation with the Global Environmental Facility, has paved the way

for a ban on twelve organic persistent pollutants, including the infamous Dichloro-Diphenyl-Trichloroethane (DDT). DDT was outlawed throughout the world after research suggested increased risk of cancers and other diseases, combined with massive ecological effects catalogued in the book 'Silent Spring.' Despite this, DDT use has continued in many Malaria-endemic areas, where its risks are outweighed by the benefits of

(IVM). The success of the trial means these alternatives to DDT can be used in combination with interventions adapted to local circumstances to improve Malaria control, and ultimately help achieve the MDG surrounding the disease.

for more info on this initiative visit: http://www.who.int/mediacentre/news/releases/2009/malaria_ddt_20090506/en/index.html



Bill Gates announces a TB partnership with the Chinese Government

(source <http://www.gatesfoundation.org/press-room/Pages/overview.aspx>)

vector-control it brings.

The announcement last week detailed the success of a five-year trial in Mexico and Central America of pesticide-free techniques and management regimes for controlling malaria. These reduced incidence of Malaria by 60%. The project was one of many carried out as part of the WHO's Integrated Vector Management Strategy

Lancet study details Gates' Global Health Influence

A study published this month in the Lancet has assessed the grants given out by the Bill and Melinda Gates Foundation. It found that, in total, \$8.949 Billion was given out in the ten year period from 1998-2007, with over a third (36.5%) going

towards research and development of vaccines, microbicides and drugs and nearly a quarter (24.1%) going towards health-care delivery.

While commending this huge investment, the paper and accompanying comment emphasises the need for the accountability of this huge private donor. One of the key findings was the large amounts of funding given to key 'Global Health Partners', including the WHO, the World Bank and GAVI. Over a third of funding was donated to not-for-profit (NFP) or Non-

governmental organizations (NGO) other than these. With this kind of influence over the flow of funding for Global Health problems, the authors feel it is necessary for some kind of public accountability

An accompanying comment notes that the organisation's goal of reducing the burden of maternal and child health by half in the next twenty years is being hampered by a lack of evidence-based priorities. Research into the implementation of current interventions, along with diseases that cause

a large proportion of child mortality such as pneumonia and diarrhoea, are relatively under-funded in relation to their importance in reducing mortality. It is suggested that a shift to these neglected diseases and delivery-based research will strengthen the impact the organization has already made.

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Can and should markets provide our healthcare? A view from economics and politics.

Peter Baker

In much of the developed world, experiments are underway to bring elements of the market into healthcare. In the UK this has produced considerable debate regarding increasing patient choice and health service responsiveness. It is worth, at this point, taking a step back and considering what is wanted from a health service, and whether a health care market can and should provide this.

Figure 1 shows as countries get richer they tend to avoid leaving health care to the market [1]. The 1993 World Development Report found that 60% of health care spending world wide is spent by governments [2]. Why is this? Why is health not left to the market like other goods? The World Development Report discerned two possible economic reasons for the public dominance of health care provision. The first surrounds health care as a “public good” which, as will be shown, economic theory predicts the

market will under-provide. The second proposes that certain unique properties of health care may cause the market to fail in efficiently producing health care. This article views these as valid concerns, but finds more strength in critiquing the equity of the market, which stems from the intensely moral and political nature of health care delivery.

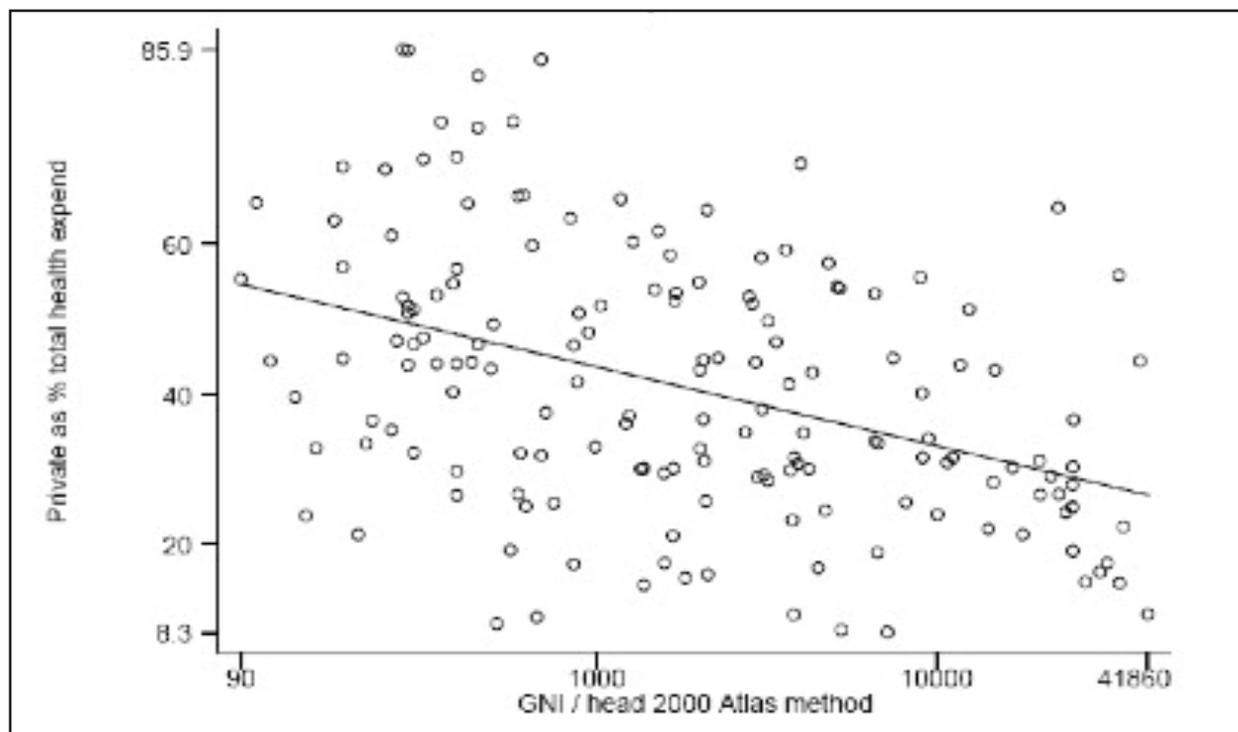
Can we market healthcare? Lessons from economics.

One argument against a health care market is that health is a “public good”. Public goods are commodities that all can enjoy. Economically, public goods are defined as non-excludable and non-rival [3]. No one can be excluded from using them, and when one does so, they are not used up, thus others can enjoy them as well. It is argued that because public goods cannot be parcelled up and sold privately to only those that pay for them, they are effectively non-marketable goods.

Samuelson noted a further result; a person’s utility is not dependent on the amount in society generally [4]. The classic case is national defence. No individual uses this privately, but we all gain utility in proportion to the total security. Health care is limited, is used up when accessed, and from which it is possible to exclude people.

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Figure 1: Falling private expenditure on health as countries get wealthier. 2000 WHO and World Bank data. [11]

It is rival and excludable, and thus on the surface it is not a public good [5]. Crucially then, it is marketable.

Holtermann [6] argues that the traditional public good-private good dichotomy is too simplistic. Many commodities have characteristics of both public and private goods. This can be shown in three ways. To begin, certain commodities have public good sides to them. Immunizations provides a private good, which enters an individual's utility function (Hurley [7]). But immunizations also create herd immunity, creating a safer society. This enters everyone's utility function in non-rival and non-excludable ways. Perhaps then, health security as a whole is a public good. Woodward and Smith [8] have similarly described global disease surveillance as a global public good.

Next, Holtermann [6] considers the whole

health care system to be a mixed good, with utilization of health care a private good and availability of health services a public good because it makes everyone feel secure. This implies that just having an accessible high quality health service makes the public happier, regardless of whether it is used. Cuyler [9] argues that a final public good dimension derives from altruism and concern for equity. Because it is valued by all, all gain from ensuring the poor get treated. This enters everyone's utility function in a public good manner. Therefore herd immunity, health care availability, and health equity are all unmarketable. Since no one can be charged for them, markets will tend to under-provide them.

Private charity may be able to make up for the market's under-provision, but faces problems of free-riding [10]. Everyone gains when someone gives to charity, but people in general gain even if they personally do not. Thus an economic in-

Article

centive exists to “free-ride” on others’ charity. As game-theory predicts, the result is under-provision of public goods [9]. If it is accepted that health care is part public part private good in nature, the market can thus be expected to undersupply health care proportionate to the level of public good nature in the system, even with private charity added.

Four further challenges to the health care market exist [11]. Arrow [12] argued that uncertainty in medicine is the key cause of market failure. This creates uncertainty in the price and product, resulting in inefficiencies. For example, imagine a patient arriving in an ambulance with chest pain. He may just need cheap antacids and reassurance for indigestion, or he may need major heart surgery and long term medical help. The doctor may not even know until investigation and treatment are started.

The second problem is information asymmetry, which allows the highly informed provider to manipulate the vulnerable sick consumer for profit. A third challenge to the perfect market surrounds the economies of scale needed to provide good health care. This may result in a natural oligopoly forming, with a few huge health corporations controlling all health care, thus aggravating the poor bargaining position of the ill patient [5]. The final problem lies in the positive externalities of healthcare goods like immunisations, which improve others health but can’t be charged for, and will thus be socially underprovided by the market.

Due to the public good elements, the uncertainty, the information asymmetry, the economies of scale and the externalities all inherent in healthcare, healthcare markets will be sub-optimal. Despite these strong arguments, Cuyler [9] cautions that this doesn’t necessarily mean government provision will be superior.

Should we market healthcare? The political view.

There are more fundamental reasons why healthcare shouldn’t be left to the market. Health is part of a group of societal goals regarded to be of special moral importance. Health is considered a human right [13], a fundamental element of human freedom [14] and human security [15]. People even spend their way into dire poverty in order to be healthy [16]. The main purpose of health care systems is to maintain and improve health, which means maintaining an individual’s opportunity to function in society [17]. Their life, citizenship and dignity are all at stake. Its importance demands a stronger consideration of equity than in other industries. Can markets meet this social justice element?

There are always competing claims for limited healthcare resources. In deciding between claims social justice asks the question: on what basis do we make these decisions? And equally important, who makes this decision?

Daniels calls these the fairness and legitimacy problems [17]. Fairness questions include: Do we treat according to need or ability to pay? Do we prioritise the old or the young? Do we treat the most ill or those patients most likely to benefit? Daniels argues that we currently do not have societal consensus on these hard issues of distributive justice, and we potentially never will. Instead we must create a legitimate health care system able to discern generally agreed rules for equitable health care. In Daniel’s view this is not a matter for experts, or the market’s preference for the biggest wallet, but for society to discuss and negotiate its core values. Social deliberation of values and democratic decision making produces the fairest and most legitimate process possible for rationing health care equitably. The market by contrast is not able to

democratically negotiate these societal values, nor do so legitimately.

Conclusion

Market failures and the semi-public good nature of health care reduce market efficiency. This makes it harder to justify leaving health-care to the market, but doesn't rule it out. The real challenge to the market, however, comes from healthcare's special moral status. Making equitable decisions on health care distributions requires a legitimate social institution that only a deliberative democratic process can provide.

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Is Wealth Health Creating?

Ashley Sharp

Is wealth health creating? At first glance, the answer to this question seems fairly obvious. It is understood that the life expectancy in rich countries is greater than in poorer ones. Wealthy governments can afford to provide healthcare services, good sanitation, health education, and infrastructure. Similarly, wealthy individuals within countries can afford to buy adequate food, secure housing, and purchase private healthcare if required.

It is also recognised that wealth is not the only determinate of health. National issues such as political unrest, war, poor governmental policy, lack of public spending on dependent populations will all have an effect on national health. What follows is a discussion of some of the evidence relating to the relationship between wealth and health, both on a macro (national) scale and a micro (individual/household) scale. As will be seen, economic analyses have produced interesting and sometimes surprising results.

Global trends

The first example is a graphical representation

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of countries' Gross Domestic Product (GDP) per capita (per head) versus life expectancy. This is shown by the Preston Curve (figure 1), where the size of each circle is proportional to the population of that country.

Unsurprisingly, there is a strong positive correlation between increasing wealth and life expectancy. There is also a significant spread of values around the line of best fit with some countries straying far from the 'average', notably South Africa and Equatorial Guinea, suggesting that the determinates of health are very broad. Hypothetically, if wealth was the single limiting factor determining the health achievable by a country, the circles would settle on the best fit curve and follow it as wealth increased.

In reality, this is not the case. The whole curve has shifted as global trends have seen a generalised increase in income and life expectancy (www.gapminder.org). What is also apparent is that the line of best fit has a much steeper gradient at lower levels of wealth. For example, the difference in GDP between China and Nigeria is relatively small, but this affords them a large increase in life expectancy. This compares to the vast gap in wealth between China and USA, which is associated with relatively modest gains in longevity.

Causality

Having demonstrated a positive correlation between wealth and health, the next step is to determine the direction of causality. Is wealth the cause of better health, or is it in fact the other way around? A healthier population has obvi-

ous economic benefits - a more productive work force and a high possibility that they will require less time off work for illness. The members of such a population may also be more inclined to invest in the future through savings and financial investments.

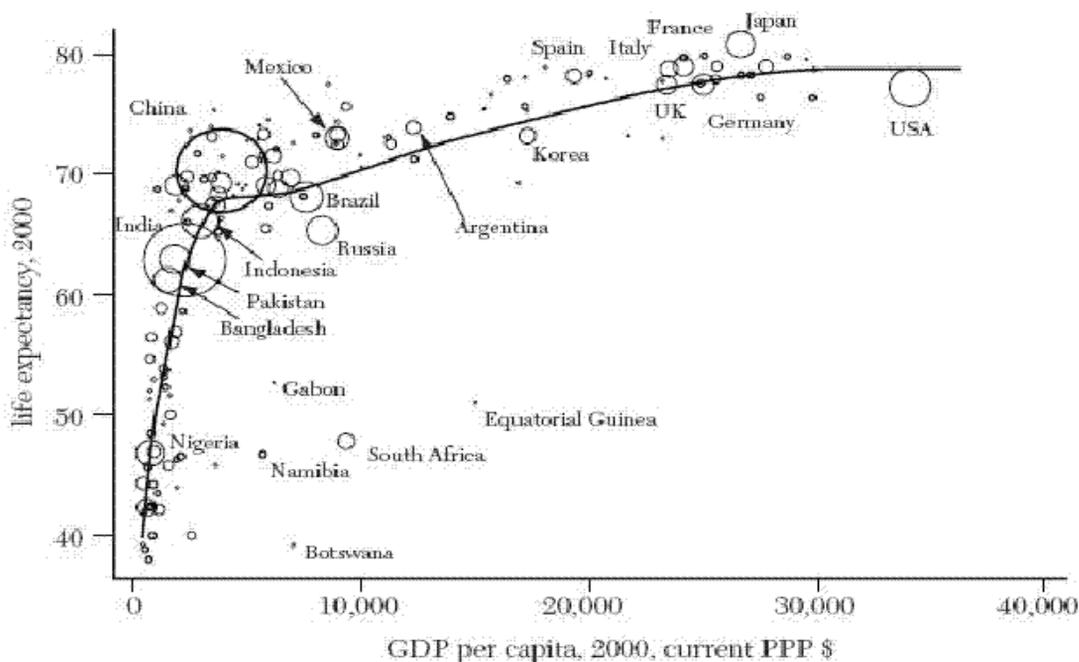
Interestingly, a self-perpetuating stage has been observed during a country's development. Improvements in health, particularly child survival, create a temporary increase in the proportion of the population that is of working age, a so-called 'demographic dividend'. This happens because there is a time lag between the reduction of infant mortality rate and a corresponding reduction of fertility rate. As this happens, income per capita can rise dramatically, provided the workers can be absorbed into productive employment [1].

The question regarding the direction of causality may seem rather abstract - in the real world,

both processes are happening at the same time. There are instances where wealth leads to better health, and vice versa. The aim here however, as with any sociological question, is to make a generalisation. What is the 'net' direction of causality when all pathways are taken into account? To do this it is first necessary to consider the third direction of causality, namely that some confounding factor could be the cause of both wealth and health. At country level, these include good governance and a favourable climate or high levels of education.

The challenge in economic analysis, is how to measure the effect of one direction of causality, while at the same time minimising the effect of the other two. One technique which has been used often in research is to take Infant Mortality as the indicator of health. By doing so the effect of reverse causality (i.e. health to wealth) is limited, as infants do not contribute to a country's wealth. To control for third variables such as

Figure 1: the Preston curve in 2000 (reproduced from Deaton 2006)



Article

education, it is possible to use national statistics on primary school attendance or literacy rates, where available, and adjust the results accordingly. Also, so called Instrumental Variables: factors that are determinants of income but are unrelated to health or other variables can be used.

One such approach was used by Pritchett and Summers. They looked at cross country, time series data on infant and child mortality and GDP per capita to try and identify overall direction of causality within the health wealth relationship [2]. Education was controlled, and several instrumental variables were used, shown in **panel 1**. All these variables had been previously found to be related to GDP growth.

It was found that the overall direction of causality was from wealth to health and concluded that raising per capita incomes will be an important part of any country's health strategy. Other

PANEL 1: Instrumental variable used by Pritchett and Summers [2]

- Terms of trade changes
- Ratio of investment to GDP
- Black market premium for foreign exchange
- Price level distortion

factors that could produce reductions in infant mortality were not claimed to be less important, nor that income growth would always lead to improved health, for example if changes in the distribution of income occurred simultaneously. However, Pritchett and Summers decided that holding factors unrelated to income constant, a rise in income will tend to produce improved health. They went on to state that over

a half a million child deaths in the developing world in 1990 alone can be attributed to the poor economic performance of the 1980s.

Anand and Ravillion [3] tried to determine the main mechanisms through which this works and found it to be mainly through the impact on incomes - specifically of the poor (poverty removal) and public expenditure. They found that the positive correlation vanishes when one controls for incidence of poverty and public spending on health. A later study by Filmer and Pritchett found evidence to the contrary, that showed little or no benefit of government spending on health [4]. The two studies used different country samples, which partly explains the different results - the impact of public spending on health will vary widely. This debate remains unresolved.

Likewise, there is still no consensus about the overwhelming direction of causality in 'macro' studies. Deaton shows if absolute decline in infant mortality is focused on instead of relative decline (as Pritchett and Summers did), the relationship with changes in GDP per capita vanishes [5]. He argues that low levels of mortality are associated with successful economic growth and suggests common 'third factors' to be the most important.

Anomalies

Returning to the original issue of the correlation between wealth and health, the Preston Curve (Figure 1) demonstrates an overall positive correlation, though anomalous points exist. What follows is a selection of examples, which probe into countries' histories, and examine the trends that exist between wealth and health over time.

Amartya Sen, the Nobel Economist, looked at trends in Great Britain between 1900 and 1960 and found that the decade by decade rate of in-

crease in life expectancy was inversely related to the rate of growth in GDP per capita [6]. That is, the decades in which life expectancy increased most were those which saw the lowest growth in the economy.

These were also the decades of the two World Wars. It must be remembered that these figures did not reflect mortality due to Wars themselves, as the life expectancy figures were based on the age specific death rates at the point of observation at the end of each decade. It should also be emphasised that this study compared the rate of increase in longevity and GDP over each decade. The life expectancy did increase overall, but those decades that saw the greatest improvement were the worst decades in terms of GDP.

So why did life expectancy increase so much faster between the beginning and the end of the war decades? It can't be ruled out that this was due to a delayed effect of the previous decades' growth in GDP. However, Sen suggests the reason lies in improvements in public delivery of food through rationing systems, and improvements in health services (creation of the NHS), which occurred during the war decades. Reportedly, while the total food supply went down, the incidence of under nutrition actually declined. In a more recent example, Drèze and Sen looked at rates of growth of GDP and rates of reduction in infant mortality rates in China and India; they found a similar inverse relationship [7]. In China virtually all the improvement in child health occurred before their economic reforms and there has been little improvement since. Similarly, in India, the rate of decline in infant mortality was slower in the 1990s, when growth was higher, following economic reforms.

Drèze and Sen reflect on the circumstances in which wealth leads to health, and distinguish between two broad types of processes that lead

to rapid mortality reduction: 'growth mediated' and 'support-led'.

Growth mediated mortality reduction works through rapid economic growth. This requires that the growth process be wide based and participatory, and that the wealth generated be used to expand the social services such as health care and education. This is exemplified by Korea, which saw a 500% increase in GDP and an 80% fall in infant mortality between 1960 and 1990. Brazil on the other hand are an example of rapid economic growth not producing such an increase in life expectancy - its GDP increased by 190% while infant mortality fell just 30% (below average) over the same period. The support-led approach to mortality reduction does not wait for economic growth, and with political commitment produces results through investments in the social sector. The low cost of labour in developing economies means the same service costs less than in richer economies, as health care and education are very labour intensive. This was seen, for example in Sri Lanka, which enjoyed a 72% decrease in infant mortality rate with a modest 51% growth [2]

Ruhm looked at the United States between 1972 and 1991, and found another interesting wealth-health correlation [8] He discovered that temporary economic downturns were associated with health improvements. Specifically, state unemployment rates were negatively correlated with total mortality, and eight out of ten specific causes of mortality (suicide was an exception). The largest fluctuation was in young adults due to an increase in motor vehicle accidents. Mortality from cardiovascular disease, liver ailments and flu/pneumonia showed substantial fluctuation, explainable by changes in obesity, smoking, diet and exercise.

Dehejia and Lleras-Muney extended this, to look at child health in the US [9] They looked at

Article

national data from the Natality Files from 1975 onward and found that babies conceived in times of high unemployment have a reduced incidence of low and very low birth weight, fewer congenital malformations and a reduced rate of post-neonatal mortality. They found that this pattern was not just due to changes in behaviour during recessions (which appeared to improve among pregnant women) but also due to a selection effect, meaning there are differences in the fertility decisions of mothers and differences in type of mothers that conceive during recessions.

Trends within nations

The studies discussed so far have taken the 'macro' view of the wealth health relationship, with countrywide measurements, but what about individual and household, 'micro' view? What are the features of the wealth health correlation on a more individual basis within the populations of countries? Wagstaff analysed data on infant and child mortality rates versus household income in several developing countries and found higher mortality in households with lower total expenditure [10]. Moser, Leon and Gwatkin showed within 22 low and lower middle income countries, a negative correlation between infant and child mortality and socio-economic position as measured by an index of household wealth based on ownership of household assets, housing characteristics, drinking water source, toilet facilities and the availability of electricity [11].

A wealth health correlation exists in rich countries too, despite widespread access to food, housing and healthcare. Case et al [12] looked in detail at the health of American children and adolescents and the relationship to household income. It was found that the same wealth-health relationship exists in this age group and increases as children grow older. It concludes that the health inequalities which exist between adults

of different socio-economic position have their roots in childhood.

Some interesting mechanisms are given to explain the correlation: children's health could be affected by the health of their parents (which would also affect family income). Example of this included an inherited susceptibility to certain diseases, a less healthy uterine environment or lower quality of care due to illness. Furthermore, parental health - particularly the mothers - was found to be correlated with child health, suggesting some of these factors are at play. The genetic element, whereby poor health is directly transmitted in part through susceptibility to diseases, was found to be unlikely by looking at the income effect on adopted children. Parental behaviours which are correlated with income may well have an influence, such as smoking, family eating habits, and many others, such as insisting a child wears a seatbelt and overseeing of the child's meals. They found inclusion of such behaviours to be of some importance and suggest future work will focus more on such factors that they could not examine.

Much of the relationship can be accounted for by the arrival and impact of chronic conditions which have worse consequences for children from poorer households both in terms of health and education. They suggest that the impact of parents' income on child health may explain part of the inter-generational transmission of socio-economic status. These individuals tend to enter adulthood in poorer health and have worse school attendance due to illness, both of which then affect future income.

Conclusion

There is much evidence of a positive correlation between wealth and health, both across countries, within countries over time with economic growth and between individual households. To

accurately answer the question ‘is wealth health creating’, it is necessary to tease out causality from mere association. As has been shown, this is a very difficult problem. One final question to be asked is, what is the value of studies such as the ones discussed here, in terms of their ability to inform policy? For the more broad based studies which seek to make global generalisations, it is arguably small. On the other hand, the Preston Curve shows the great gains in health achievable at relatively little cost. This supports the United Nations’ call for rich countries to increase their development aid to 0.7% of GDP (some countries have surpassed this figure). Also, the evidence that rapid growth does not necessarily produce rapid health gains, and that the converse may in fact be true, provides an important opposition to policy makers who value increasing GDP as the only priority for development. It may be generally true that wealth is health creating, but the support-led approach to mortality reduction, is surely favourable over pursuing economic growth [7].

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FEATURE

In the first of three articles, *Lucie Collinson* investigates the International Community and its role in humanitarian crises. In this issue, the mechanisms currently in place for the protection of both refugees and internally-displaced persons are critiqued.

Refugee and internally displaced people (IDPs) crises are rising up the global political agenda. The increasing prevalence of natural disasters and civil conflict has elevated forced migration into a global phenomenon. This is creating new pressures at both state and local levels that lack the capacity to manage these demands.

This article will evaluate the existing protection mechanisms for refugees and IDPs. It will focus on humanitarian crises born of conflict rather than natural disasters, and on the protection mechanisms that have the primary aim of protecting the basic human rights of individuals – in particular the right to health. These include the international legal framework theoretically safeguarding refugees and IDPs from physical and psychological trauma; international agencies and non-governmental organisations

(NGOs); and host governments.

What is a refugee and who protects them?

Refugees, as defined by the 1951 Refugee Convention, are people who have a well-founded fear of persecution and cannot return to their home countries or regions for fear of placing their lives in jeopardy. IDPs are people who take flight within the national borders of their home countries and are thus forced to seek safety from their own governments [1]. Every day both refugees and IDPs from many different corners of the world are forced from the safety of their homes. Direct threats to personal security and other forms of violence oblige individuals, families and entire communities to gather their belongings and begin a journey to uncertain destinations.

The key actors in providing protection mechanisms for refugees and IDPs today are the United Nations High Commissioner for Refugees (UNHCR), the International Committee of the Red Cross (ICRC) and the United Nations Children's Fund (UNICEF) [2]. The UNHCR, created by the UN General Assembly in 1950, is the only international organisation charged with legal protection of refugees [3]. IDPs, on the other

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hand, have no formal protection: the UN Guiding Principles for Internal Displacement written by the UNHCR stresses that the primary responsibility for the protection and assistance of IDPs must lie with national governments. In practice, however, the UNHCR does take responsibility for IDPs wherever feasible.

Differing Roles

The UNHCR's protective role for refugees operates more through advocacy than producing a definitive action. It anchors international debates about human rights and international responsibility in the delivery of humanitarian assistance. It is vested with considerable moral authority and legitimacy but lacks political weight. It is restricted in its actions by the practices of states and is not permitted to intervene politically against human rights violations. The UNHCR therefore relies on other actors to manage problems created by refugee movements, and this creates some delicate political dynamics.

The UNHCR must balance its founding purpose and responsibilities, to manage the consequences for domestic instability, interstate tensions and national security of refugee displacement, with sensitivity to the sovereign prerogatives and conflicting interests of different states. If it does not take account of these realities on the ground, or alienates host states, it risks becoming a producer of empty rhetoric, undermining effective solutions for refugees. However, while the UNHCR is a useful focal point for the reasons described above, it is unable to provide comprehensive protection for refugees and IDPs.

The ICRC and UNICEF provide humanitarian protection and relief for victims of war and armed violence - as exemplified by their actions in Kenya recently. The ICRC's mandate under international law, to take impartial action on behalf of

prisoners, the wounded and sick, and civilians affected by conflict including prisoners of war, ceases when conflict ends [4]. Despite UNICEF and the ICRC having no legal standing in the protection of refugees and IDPs from conflict they have the ability to place the protection of refugees and IDPs on the humanitarian agendas of governments. The ICRC and UNICEF are capable of advocating humanitarian values however are limited in providing sufficient protection for refugees and IDPs in the field.

International agencies and NGOs provide life saving assistance and protection to refugees in the form of humanitarian assistance such as emergency shelter and food, health care, refugee camp coordination and management, IDP registration systems, evacuation of people in extreme danger and promoting international cooperation on migration issues. A current example is Columbia today where Médecins Sans Frontières are providing basic health care services in the absence of any other [5].

In order to improve coordination among United Nations (UN) agencies it was agreed in 2005 to establish responsibilities by sector to lead organisations in humanitarian assistance and develop clusters of relevant partners. Despite the good intentions of this joint programming, and information- and knowledge-sharing on technical and policy issues, the cluster approach has been criticised for being a UN concept imposed from above on the aid community. NGOs in Somalia admitted to feeling they were being pushed to intervene in insecure areas [6]. However it has been argued that the majority of the problems encountered since implementation of the cluster system in the field derive from a misunderstanding of the key operational nature of clusters [7].

Despite providing emergency humanitarian assistance, raising awareness in the international

community and advocating nationally for better health care, international organisations and NGOs are powerless to protect refugees and IDPs from conflict itself. At times they may be responsible for exacerbating forced migration through being unwittingly manipulated by local politicians in host countries. The Zimbabwean government, for example, has become particularly adept at directing foreign aid towards rewarding and strengthening government supporters, whilst systematically excluding the supporters of opposition groups [8].

Legal Protection?

The international legal framework which governs the protection of displaced populations is composed of three interrelated sets of rules: International Humanitarian Law (IHL), International Human Rights Law (IHRL) and International Refugee Law (IRL). IHL regulates the protection of persons in areas of armed conflict; IHRL imposes standards that governments to which must abide in their treatment of persons both in peacetime and in war; and IRL exclusively protects refugees.

The common objective of these legal regimes is to protect human life, health and dignity. There is, however, an enormous gap between the rights that the above laws “guarantee” to refugees and the realities they face. International conventions on the laws of war are largely ignored by the perpetrators of atrocities. Women and children are rarely able to make use of these protection mechanisms. Refugee law, as it is conventionally interpreted, is an inadequate shield for those people whose fears of persecution arise out of forms of protest or ill-treatment not considered to be political, or deserving of international protection.

The inadequacy of current approaches to protecting refugees and IDPs in areas of civil or international conflict is demonstrated by the

instability brought about by refugee and IDP crises. The escalating plight of refugees and IDPs that still exists today underlines the need to re-evaluate both traditional and current practices and the role of international organisations, in particular the UNHCR.

Efforts by domestic NGOs to assist refugees and IDPs provide the most potential at the national level. The international community needs to exercise greater assertiveness and creativity in order to gain access to refugees and IDPs to improve their existing protection mechanisms. Its recalcitrance in this regard may lie in post-colonial guilt and a reluctance to interfere politically or militarily to relieve the suffering of refugees and IDPs for fear of being labelled ‘imperialist’. Yet many of these problems of displacement find their roots in colonial activities: ‘Old Europe’ carved up Africa with arbitrary lines across the map, creating new countries that ignored centuries old tribal and religious groupings. The consequence has been continuous and growing tribal and religious civil conflict, producing more refugees and IDPs every year. Perhaps it is the responsibility of New Europe, therefore, to commit more effort to resolving this problem.

International organisations and NGOs are equipped and experienced to supply the necessary humanitarian relief for refugees and IDPs. However, states often lack the resources or the will to assist in this provision of care and protection. The protection of refugees and IDPs is the first and foremost duty of the state. When states are unable or unwilling to comply with their obligations under international law, humanitarian and human rights organisations become crucial in providing protection. These mechanisms are insufficient, however, to create binding legal protection for refugees and IDPs, and lack the capacity to stop conflicts from escalating. States therefore remain the key actors in the process.

Government responses to crises of forced mi-

gration are known to be notoriously inadequate in terms of protecting refugees and IDPs. This is often due to a lack of resources, but in some circumstances the forced displacement of people forms part of systems of power and is pursued strategically, as is seen currently in the Sudan. Thus, as the international community witnesses the daily flagrant abuse and violation of its own laws in areas of conflict and violence, the conclusion that the ultimate protection of refugees and IDPs resides in the political will of individual governments, is a sobering one for refugees and IDPs the world over.

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New Global Health Directions for All Health Professionals

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Alma Mata Working Group

Introduction

Significant changes in the way international health and development is approached and funded has seen the release of a host of major reports and policy documents[1-8]. Within these thousands of pages of evidence, policy and guidelines, lies the promise of a solution to a pressing puzzle; how can we, as developed world health workers, practically and effectively contribute to developing world healthcare?

These publications offer a welcome opportunity to develop a new evidence-based framework for cohesive and cooperative action towards improved global health. They also highlight challenges, both old and new -- how these are faced will dictate the success or failure of many of our collective efforts to improve global health over the coming decades. Focus is provided to those new to international health, and renewed direction for those distracted from the global health agenda.

The sheer volume of information included can, however, be off-putting. A distilled version of their contents, accompanied by a careful analysis of common themes and key guidance, stands to benefit the time-pressured health professional. This article aims to present an accessible summary review of these publications and their recommendations. It concludes with a realistic model for practical action that the glob-

ally aware health professional can easily apply.

21st Century Problems and Solutions

The over-arching theme connecting these reports is that of globalisation and its profound and novel effects on the health of populations. Within this, three consistent strands run through the entire corpus, reflecting the most pressing areas in which opportunities for progress can be seized or lost. They are grassroots involvement and the role of the individual, health worker migration and foreign policy.

Realising Your Potential

Highlighting the potential that individual developed world health professionals have to improve health in developing countries is central to many of these publications[1-3,6].

Consensus across the reports advocates strong institutional support to provide these health professionals with the guidance and material help they need to contribute to the best of their ability. In the UK, this support has become eroded in recent years through;

- *The introduction of the MMC run-through framework and its lack of flexibility.[8]*
- *Under-recognition of the value of doc-*

tors working abroad, both to developing world health system and NHS patients.[3,4,8,9]

- A lack of funding and will at deanery level for employment positions in global health, research or educational exchange programmes, such as those facilitated by NHS Links or for research.[3,4,8,10]

Undergraduate education and interest in global health has grown significantly in recent years, but postgraduate options remain limited for those in specialist training [1,4,10-12]. The funding necessary to create these posts could be sourced from the DoH and DfID, especially with the recent focus on development in the latest comprehensive spending review [13].

these opportunities. Promising schemes run by NHS Scotland [14] and the London Deanery [15] are already underway.

There must be a defined, well-organised, accessible structure for global health work opportunities within each aspect of postgraduate training. A global health curriculum should be developed to set standards of training in the area, be it as a public health sub-specialty or in general specialist training exams. These would provide elements of a 'one-stop shop', described and recommended by Lord Crisp[10,11]. With these elements in place, approaches can be made to local deaneries, Royal Colleges and PMETB/GMC, and local variations and specifics can be worked out based on these solid foundations.



Figure 1: Ways in which individuals can take action to improve global health

Where funding is not forthcoming, alternative sources can and have been sought [11]. With the current groundswell of enthusiasm for these positions, lobbying and guidance needs to come from all levels, no more so than from the institutions who have set precedents in creating

Migration Matters

Health worker migration from the public to private-sector, rural to urban settings, and from the North to the South, has long been acknowledged to have a net negative effect upon the health of the world's poor [2,3].

Despite this, more work is needed to quantify the full extent of health worker flows [16].

Knowledge and expertise for human resource management is often lacking in source countries. Technical and financial assistance is required to develop broad human resource retention strategies and effective domestic governance to improve working conditions, provide targeted incentives to retain staff and

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trainees and to address cultural pressures to work abroad [3].

Collaborative links between institutions, professional associations, trade unions, and individuals in the developed and developing worlds are increasingly important [17]. Through these partnerships, research, experiences, information, and best practise can be shared in a mutually beneficial way. Targets for lobbying should include the removal of disincentives for health professionals in the developed world to take part in such work; factors such as continuity of pension payments while overseas and lack of accreditation for training. Training and funding packages should be conceived with the goal of building capacity in mind [1,16].

The governments of recipient countries must be lobbied to develop more effective codes of practise for the ethical recruitment of health professionals from overseas. Recipient country health workforce needs to be better organised and strengthened to remove the necessity to employ from abroad, whilst aggressive marketing strategies in developing countries must be ended once and for all [18].

WHOse Foreign Policy?

Developed world foreign policy has great potential to directly and indirectly affect health in developing countries. Consideration of the vast interplay of factors such as trade, health protection and human resources is integral to challenging the broader determinants of today's borderless disease trends and is thus essential when devising an equitable foreign policy for sustainable development. The Oslo Declaration and, more recently, the 2007 World Health Report both identify key policy areas for international health security, underlining the growing awareness of developed world governments that poor health and security threats such as political instability, war and terrorism frequently

share socioeconomic, environmental or social causes.

Crisp concluded that currently the most effective way for NHS staff to contribute to global health is through providing emergency health care in conflict situations, natural disasters, and infectious disease outbreaks [1]. However, the multitude of governments, organisations, and people providing support to developing countries are operating with considerable overlap and with poor inter-agency communication. Crisp discussed the need to develop, co-ordinate, and sustain a clearer framework for collaboration and used the example of an international database to match volunteers with relevant organisations.

In the UK, there are unified calls for the NHS, DoH, and DfID to develop an NHS structure linking health and development [1,4]. An inter-Ministerial group† has been convened to research strengthening health system capacity in developing countries, and Donaldson has proposed a strategic framework to facilitate inter-departmental co-operation within the British government [19]. This is indicative of the wider expressed need for an effective cross sector global policy and governance incorporating mechanisms for the coordination of multiple stakeholders to achieve the MDGs.

But who is best positioned to provide global governance over health? The creation of new, powerful actors in global health, such as the Bill and Melinda Gates Foundation and the Global Fund, have diluted the WHO's authority. With the WHO too poor to fulfil its mandate alone, strategic partnerships with private providers, borne of necessity, have allowed the private sector more control over health priorities. It is argued that this may promote increased competition and accountability and ultimately lead to stronger and more effective global health institutions.

Summing up

Global health is now mainstream. In Britain, medical schools have produced hundreds of graduates with additional qualifications in international health and Medsin UK have ensured its place on most curriculae. Health professionals take time out to study Masters and Diploma programmes. The presence of global health at the top of the political agenda from 2005 shows that government recognises that moves to address drastic international health and development inequalities can win votes.

There has been a clear shift of emphasis towards the role of the individual. More than ever before, individual health professionals have the means, and with it the responsibility, to increase awareness and action through teaching colleagues and themselves about global issues, informed lobbying of the government and international actors, forming and supporting global health pressure groups, volunteering and research. Now is the time to get stuck in.

† Consisting of input from the Department of Health, the Department for Education and Skills, HM Treasury, the Foreign and Commonwealth Office, the Home Office, DFID, The Northern Ireland Office, the Scottish Executive and the Welsh Assembly

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This article was written in January 2008. As a result, it does not take into account the financial implications of the global banking crisis when discussing funding for global health projects. It has been one of the most read on the Alma Mata website and was linked to the South African Ministry for Health's website in March 2009.

Global Experiences



Dr. Kiran Jobanputra was working with MSF in Somalia from October 2007 to February 2008, and here shares his daily experience as a medical doctor working for an humanitarian organisation.

As you fly in to Somalia, you are struck initially by how normal everything appears. Gently dipping hills, great expanses of scorched red soil, and a total absence of movement – a very African environment. Likewise your first contact with Somali people – beaming young men, with Kalashnikovs swung over their shoulders like

Mandolins, queuing up to shake your hand and ask you whether you support Man U or Celtic. This infamous land is populated by gentle young guys, who happen to have big guns.

On the way to the compound you notice for the first time that one of your guards has stuffed

cotton wool into the barrel of his gun, whilst another has a cigarette pointing out of the end of his. At this point the equally young driver puts on a CD of Britpop, full-blast, and you have no choice but to settle back into your seat as the Land cruiser speeds along the dirt track, Kalash at each window, with the song 'Umbrella' competing with the delighted screams of the children that sail past you.

Within hours you face your first customer, a scenario that will quickly become familiar to you – a 20 year old 'circumcised' woman, presenting in obstructed labour of three days duration, now febrile (and of course anaemic) with the foetus probably dead and the family refusing C-Section. Elsewhere in the hospital 4 patients are arguing about a failed Qat deal (Qat, also known as Mira, is a mild stimulant drug imported from Kenya, chewed by much of the Somali population); the 4 friends now lie in adjacent beds, recovering from the bullet wounds they inflicted on each other after the deal fell through.



Somalia is undoubtedly a challenging country to work in. Since the fall of the Siad Barre regime in 1991, the government disintegrated and the country reverted to anarchy, with powerful 'warlords' from various clans taking control of each region and exacting payments from citizens for protection and use of infrastructure [1]. The country was briefly united in 2006 by the Union of Islamic Courts, but they were ousted by Ethiopian-backed Somali forces in 2007, which has resulted in over 1 million Somalis fleeing their homes [2]. War and the consequent displacement of people, combined with a harsh climate and the failure of the last 3 harvests has

resulted in enormous levels of malnutrition, with 3.5 million at risk of malnutrition this year [3]. There is no functioning health service, and 1 in 10 women die in childbirth whilst more than 1 in 5 children die before the age of 5 [4]. Violence and insecurity is now the only reality that most young Somalis know; the United Nations has accused both armies of killing and raping

children, as well as the recruitment and use of children in armed conflict [5]. The lack of any education, health, or public services means that Somalia faces immense humanitarian needs that the efforts of the few NGOs who are still working there cannot begin to meet.

MSF has worked in Somalia since 1991, and is currently providing basic and secondary health care, treatment for neglected diseases, and emergency surgery in 11 regions of the country [4]. At our hospital in Bay region, the staff treat

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250 outpatients per day, in a hospital with 100 inpatient beds, a 250 patient TB programme (110 resident on site), a 30 bed therapeutic feeding centre, and a Maternal and Child Health programme conducting deliveries per month. Our role is to manage and develop the service, carrying out surveillance and quality assurance, delivering clinical care but more importantly

iar situation of being the blind man leading the not-so-blind.

The outpatient department presents me with the anticipated array of patients with pathologies so grotesquely advanced that they would surprise the writers of Baileys Surgical Textbook. As this is the only hospital in Bay region, patients travel up to 200km by donkey to reach us, and mortality, of course, is high. Some days it seems as if everyone I touch expires within hours; yet on other days I am stunned at how magnificently undernourished Somali children respond to food and antibiotics. Today a mother brings her slim but healthy looking daughter into the consulting room, and before I can ask her the problem, she places a jar full of foot-long elasticity Ascaris worms on the table. The consultant (as we call the staff members who have received basic training in consulting) who called me in to advise seems surprised when I have to lean on the table to steady myself.



Picture 2: The Special Care Baby Unit : this baby was born at 32 weeks (1.3kg) by precipitate delivery from a critically ill mother. The staff fed and warmed him meticulously, and both went home 6 weeks later.

training and transferring skills. The foreign staff consist of 1 midwife, 2 Nurses, 2 Doctors (including myself), and we work together with 100 Somali staff, almost all of whom have not studied. This seems quite intimidating at first; however, I quickly realise that, whilst the staff are lacking in professional qualifications, they can cut off an arm in seconds (for therapeutic reasons, of course). They have seen more Cholera and more Measles than I ever will. I am in the famil-

Over the weeks I begin to warm to my Somali colleagues – our evenings are spent exchanging tales of our cultures. Moh'm Noor, a young Guard and key player in Dinsor's (remarkably) still active football team, asks me if it true that we have no camels in Europe, and if so what animals the Nomadic people keep. I tell him that they keep horses, because I feel it would shake his world view too much to tell him in one go not only that we have no camels, but also no nomads.

Traditionally most Somalis are nomadic; terri-

tory and power are delineated along clan lines, such that even today clan dynamics trump all other religious and political forces. The Polish journalist Kapucinski describes this phenomenon in his book *The Shadow of the Sun* [6].

When two strangers meet, they start by asking "Who are you?" "I am Soba", the first one begins, from the family of Ahmad Abdullah, which belongs to the Mussa Arraye group, which is from the clan of Hasean Said, which is part of the larger Isaaq clan" etc. After this recitation, the second stranger gives the particulars of his lineage, his roots. The exchange lasts a long time and is immensely important, because both individuals are trying to determine whether something unites them or divides them, whether they should embrace or attack each other with knives.



made of sticks, and I wonder whether it would just attract attention to myself if I run for the OT,

Clan considerations influence all areas of social activity. Occasionally I find a patient lying abandoned and unconscious in the hospital yard, because no one from his clan is on duty that day. Yet at other times the staff are impressively generous to those of other clans or tribes – a nurse approaches me one day to say that he has started a fund, which all staff contribute to from their salary, to raise some money for the poorest patients (of Bantu origin) to buy clothes for their children. All they want from me is to look after the money.

Today we are in the hospital trying to treat 11 war wounded . Two more died on transit, and 3 of the 11 are in critical condition. I am trying to resuscitate a soldier with an apparent brachial artery bleed when I hear shooting and screaming from outside the room. The shelter I am in is

Picture 3: Two close friends settle a dispute

which is made of concrete. Along with two Somali staff and the French nurse who are treating other casualties, I decide to keep my head down and get on with what I am doing. After 30 tense minutes things quieten down, and we step outside to find life continuing as normal.

A few days later we learn that three of our colleagues at another hospital have been killed in an (apparently) targeted attack on MSF, and that we will be evacuating the next day. It is hard to explain one's feelings at a time like this. The intensity of the environment acts like a stopper in a barrel, holding in all the stress and emotion and allowing you to keep functioning; this event pulls the stopper, and you are left feeling hollow. I feel bad about not being able to express sadness for the families of our colleagues,

yet at the moment all I can feel is guilty and frustrated that we are leaving, and concerned about the fate of my patients and colleagues that are left behind.

When I ask him about the future of Somalia, my Somali colleague says quite plainly, "There is no future for Somalia. I used to have hope for that, but I have lost it". True enough, at the age of 28 he is one of the few young men on our staff not to be walking around with a bullet or two inside him. A recent study by MSF showed that mothers bringing children to an outpatient department in Mogadishu had experienced a mean of 5 violent events in the past 2 months, and that rates of PTSD approached 70% in this 'well' population [7].

In Somalia chronic conflict and the absence of any state institutions (particularly education and security) give rise to a society overshadowed by relentless violence, resulting in almost total unemployment, crushing poverty and widespread psycho-social stress. The flow of resources is controlled by the 'warlords', leading to extreme disparities and exacerbating the plight of the poor. The harsh climate and repeated harvest failures mean that Somalia is on the brink of famine, and these various factors combine to produce extreme levels of malnutrition and chronic ill health, and war and the mass displacement of people is likely to put Somalia at risk of an HIV epidemic. These elements appear to be congregating to create the perfect storm (from a public health perspective), which unfortunately is exacerbated by the ongoing contraction of the 'humanitarian space'.

In recent months, peace discussions in Djibouti have injected a little hope into debates about Somalia. Nevertheless, there continues to be a strong case for humanitarian and public health involvement. There are very few qualified professionals living in Somalia, so the skills required to build and implement public health policy, as well to train and deliver care on the ground,

must initially come from outside the country. We were working only in the field, and what we did felt worthwhile - in the last few months we built a new Therapeutic Feeding Centre and Out patient department, delivered 48 hours of formal teaching (and many more hours of bedside teaching) and almost succeeded in teaching the clinical officer how to perform Caesarean Section. Work of this sort has tremendous impact for those we reach, and possibly communicates to the population that Somalia is not entirely forgotten. But bringing Somalia back from the brink will require extensive structural, economic and public health stabilisation, which could be greatly facilitated by ongoing engagement by the international community.

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Working In Sweden

Peter Bamford

In the summer of 2007 I took the unusual step of deciding to work in Sweden. My only previous experiences of working abroad were two short elective periods in Ghana and Jamaica, neither of which involved working in a foreign language!

Prior to my emigration I exchanged correspondence with a number of hospitals in the Stockholm area and discovered that the major stumbling block to starting work would be the language barrier. Although most Swedish people speak excellent English, it was apparent that most institutions only consider applicants with a reasonable standard of conversational Swedish. There are some exceptions to this rule; for instance in northern Sweden, where it is traditionally hard to attract applicants. In this area, Swedish courses are frequently offered as a sweetener to foreign doctors in exchange for a given period of service.

After arriving in Sweden without any formal language training, I spent the first month finding my feet and researching local language schools, the best of which was Stockholm's Folkuniversitetet. Their programs comprise of monthly

courses that start at any level between beginner and advanced. If numbers permit, they also run medical Swedish courses.

Their classes are relatively intense and cover relevant subjects at a brisk pace, and although expensive are excellent for highly motivated students. Additionally the classes I attended were relatively small which meant personal learning objectives could be realised at the same time as studying the standard curriculum. An alternative to Folkuniversitetet is the government run SFI courses (Swedish for Immigrants), which although free, do not cater for people needing to learn Swedish quickly. Classes are large and because of the massive range of abilities within each group it is difficult to progress quickly. Overall, it took me approximately six months of university teaching and private study before I was in a position where I was ready to start work.

Starting work

There are a number of bureaucratic obstacles which must be negotiated before working in Sweden. Firstly, prior to entering the country an application must be made to the Swedish embassy in London. In order to work a citizen must obtain a residency permit and a personal number, affording the holder access to health-

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care and education for their family, as well as the freedom to live and work within the country. Once this process is completed, a request for registration to practice medicine must be

sent to the Swedish Medical Association (Socialstyrelsen), this requires the applicant to submit a copy of their current GMC certificate and a complete the appropriate application form. The whole process takes around 2-3 weeks and if applying as a citizen from an EU country there are rarely difficulties.



Figure 1: Panoramic of the Karolinska University Hospital

The Swedish Health System

The structure and management of Swedish health care has many similarities to the UK system. Sweden is run as a National Health Service with the provision of funds coming from governmental income taxes, with an additional levy

of up to £200 dependent upon whether an individual accesses medical services during a given fiscal year. Services are divided much like the UK into primary care, local hospitals and tertiary referral centres. Although unlike the UK the level of communication between these centres is excellent due to all records being held electronically.

The main differences relate particularly to the grading of doctors and the wage structure. Sweden simplifies training grades into three levels; AT doctor/underläkare (Foundation/ST1/ST2), ST Läkare (ST3-7) and överläkare (Consultant), and after applying at a suitable level, a doctor has the right to negotiate a salary directly with hospital administrators based on their experience and worth to the department.

Applications themselves are relatively informal, and should consist of a CV and a covering letter directed to the appropriate departmental head. The major exception to this system occurs when applying for a foundation program equivalent - these posts are advertised annually in a publication from the Swedish Medical Council.

Learning on the job

I was fortunate enough to be accepted for an underläkare post in Anaesthetics at Karolinska University Hospital in Stockholm. Karolinska is a large teaching hospital which provides both under and post graduate training and is renowned as a centre of excellence for many different specialities. I was warmly welcomed within the department and despite my reasonable grasp of Swedish they paid for extra private tuition in medical Swedish during my first month, something I was extremely grateful for.

For anaesthetic trainees, working practices differ

in certain ways but retain some of the important components which ensure safe clinical practice; this includes the customary three month introductory period during which new skills are learnt and perfected under supervision. After this phase, training programs become increasingly flexible.

Although a core curriculum must be covered by all trainees, each individual has responsibility for organising placements and facilitating the development of a specialist interest within a given speciality. My specific experiences of Sweden revealed further differences in the day to day role of an anaesthetist. Sweden employs anaesthetic nurses who remain present throughout the whole operation. Their clinical skills in simple induction and extubation techniques are almost equivalent to that of anaesthetists, which means a couple of anaesthetists can be responsible for the induction, extubation and emergency management of a number of theatre patients any one time. This system greatly benefits trainees - exposing them to a greater number of emergency and clinical procedures in a shorter time period, a process which helps to build confidence and gain competencies quickly.

Looking back

I can wholeheartedly recommend working in Sweden. Socially everyone I worked with was friendly and this was something I found throughout the country. Everyone was willing to help whether the problem was related to a language or clinical situation. The clinical experience I had was also exceptional. The quality of the supervision and focus of the senior clinicians to actively seek out learning opportunities was fantastic. This is something I feel can be overlooked in the UK, especially in large teaching hospitals where there are more trainees. I was also highly impressed with the standard of the

in-hospital and regional teaching programs. Finally, the last bonus to working in Sweden is the ten week a year holiday allowance, which leaves plenty of time for visiting a chalet in the mountains or taking a boat out around Stockholm's stunning archipelago!!

Following my experiences and adventures in Sweden I have decided to pursue a career in anaesthetics. I am currently working in A&E medicine, prior to commencing an anaesthetic ST in August. That brings me to my last point. Remember that if you are returning to the UK, don't forget how rigid the British system remains and remember to apply the January before you plan to come back. Otherwise, like me you may have to work in A&E for ten months instead of doing what you really wanted to do!

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The



Working Group

Dave Baguley



FY2, Southampton General Hospital
MBChB Leeds, 2007.

"I have been fortunate enough to be involved in Alma Mata since its conception. My continued enthusiasm for the organisation stems from the belief that its role in facilitating the sharing of information is fantastic way to build capacity within the field of Global Health."

Colin Brown

Specialist Registrar in Infectious Disease, St Thomas Hospital, London.

MBChB, Edinburgh 2004

Colin joined the working group in 2008 and has been actively involved in Alma Mata's on-going work with officials to introduce postgraduate pathways for those interested in pursuing global health work throughout their career.

Ankur Gupta

FY2, Leicester Royal Infirmary
MBBS Imperial College London, 2007

Daisy Hamilton-Baile



FY2, Taunton, Somerset
MBChB, Leeds 2007

"I believe in alma mata- what we do, the changes we can make and the help we can give to individuals for an overall improvement in global health."

Vanessa Jessop



Fourth Year Medical Student
University of Edinburgh

Graduate of Law (LLB Hons), IDHA

Throughout Alma Mata's four years, the working group has been the hub of the organisation's activity. They organise the website and its content, make the conferences and careers events possible and work consistently in their spare time through various means of advocacy to inform its members and improve their chances of being able to work in global health throughout their medical career.

Here, we profile the working group, with some insights into what motivates them to be a part of Alma Mata....

Tim Killeen



FY1 Barnet/Chase Farm Hospitals

MBChB, Leeds 2008

I'm keen to look at ways that doctors training for careers not traditionally associated with global health -- such as surgery and anaesthetics -- can stay interested in the field and help fight health inequalities. Alma Mata gives us a voice to promote North / South research collaboration.....as well as providing great motivation to keep going post-qualification

Danni Kirwan



FY2 Ealing Hospital

MBChB, Leeds 2007

"Regular meetings with others with similar interests helps maintain personal focus and motivation, and

keep up to date with developments and events in global health. Alma Mata has become a great resource and strong lobby of junior doctors who wish to keep global health on the agenda."

Catherine Kirby

FY2 St Peter's Hospital, Surrey.

MBChB, Leeds 2007.

"I chose to be in the working group as I wanted to be part of a dynamic global health group of like-minded individuals and engage in events and advocacy

Gareth Lewis



Postgraduate Student,
Institute of Child Health, UCL

MBChB Leeds, 2006

"The best way for health professionals in developed nations to contribute to global health is spend some of their career to working in those countries. I joined Alma Mata to help as many people as possible achieve that"

Profile

Fred Martineau



ST2 Paediatrics, Royal London Hospital

MBChB, Bristol 2005

Currently on OOPE in Nepal

Fred has been one of the most, if not the most important part of the working group over the last two years, coordinating the 2007 conference and 2008 careers day, along with contributing to three published pieces and numerous other projects within the organisation.

Brian Nicholson



FY1 Leeds General Infirmary

MBChB Leeds 2008

“Since its inception in late 2004, Alma Mata has achieved far more than I then imagined possible. Now, with such a dedicated working group and strong members base, I am proud to remain part of our forever strengthening voice for global health. With each new contributor comes fresh ideas and exciting possibilities.”

Tim Rittman

**King's College Hospital
ST2 general medicine**

Nottingham MBChB

“The world is getting smaller and the medical profession has a responsibility to make sure everyone has the opportunity to the best health care the world has to offer”

Davina Sharma



**ST2 Core medical training
Barts and the London NHS trust**

MBChB, Glasgow. 2005

“I always knew a group of people existed somewhere like this, and I knew that when I finally tracked them down I wanted to be part of it. It turns out the group was Alma Mata and I feel honoured to contribute in any way I can. “

Emily Spry



ST2 GP Trainee, Barnet.

MBBS London, 2005

“I have always been passionate about global health and staying active in the Alma Mata network has helped me to keep that interest going through my training”

Maddy Wright



FY2 Leicester Royal Infirmary,

MBChB, Leicester 2007

“I got involved in Alma Mata Working group because I wanted to meet and share with other people interested in Global Health.....to be a part of an organisation with a voice to change global health training, career opportunities and to make information regarding Global Health more accessible”

Past Contributors....

Daniel Beck, Claire Farrow, Sarah Finer, Sam Hilton, Rebecca Hope, Andrew Khodabukus, Aska Leslie, Mori Mansouri and Ameesh Patel

The working group would like to thank Professor John Yudkin for his continued support and enthusiasm, and all members of the peer-review panel.

If you are a current Alma Mata member, or new to the network and wish to become involved in the Working Group, please contact us at

workinggroup@almamata.net



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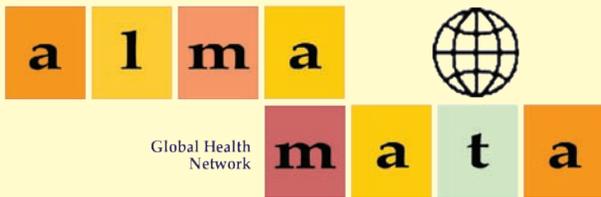
If you are not ready to go to the field you can still get involved by volunteering in our London clinic, signing up to MDM HEALTHlink network, joining our campaigns or by taking part in one of our fundraising challenges.

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