

the **elective** pack

The medical student's guide to **essential**
international health
and **development**



International Health and
Medical Education Centre

The Elective Pack

The medical student's guide to essential international health and development

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Production **Heba Al-Naseri**

contents

Foreword	2
Thinking about Electives	3
The World Today...	5
The Global Playing Field	11
Trade, Debt and Structural Adjustment	17
Infectious Disease in Developing Countries	25
HIV/AIDS: the Modern Plague?	29
Bitter Pills: Access to Essential Medicines	33
Nutrition and Water: Food Mountains and Blue Gold	37
Fractured Families	43
Conflict and Health	47
Ethical Electives	51
Essentials for Elective Travel: Know Before You Go	55
Links, Websites and Further Reading	61
Glossary	62

List of figures and tables

Figure 1: North-South divide: GDP per capita from 1820–1998	7
Figure 2: Net worth of the world's richest 200 people 1994–1998	14
Table 1: Where do we spend these resources?	6
Table 2: Top corporations and GDP of countries	20
Table 3: Common infectious diseases in developing countries	26
Table 4: Big pharma and big profits	34
Table 5: From idea to patient: the drug development chain	34

foreword

The elective period is the part of the medical course that is most eagerly anticipated by most students. It's a chance to do something interesting, in an interesting environment, and to combine that with exciting travel plans. At the Royal Free and University College Medical School, and elsewhere too, the vast majority of elective students go abroad, and most of these to a developing country. Most students in most medical schools are provided with pre-elective advice regarding immunisations, HIV prophylaxis and antimalarials, and are told what to do in case of needlestick injury. But it is less frequently the case that there is any decent preparation for the broader experience of a medical elective.

Many of you will have been to a developing country before, perhaps during your gap year. But now you will be working directly with people who are ill, often as a consequence of diseases which you may never have seen. You will have highs and lows, exhilaration and downheartedness. And above all, I suspect, you will have lots of questions.

This Elective Pack has been designed to provide some degree of orientation and to answer some of those questions. Rebecca Hope, the author, is a clinical student at the University of Leeds, and two years ago studied at the International Health and Medical Education Centre at UCL for her intercalated BSc in International Health. The combination of an understanding of clinical medicine (and clinical medical students) with an insight into the dynamics of health care, poverty and development has made her an ideal person to produce such a pack.

The pack is designed to ask a lot of questions and to provide a few answers. It is also intended to act as a resource for the person who has more questions to ask. This is the first edition of the elective pack, so we would very much appreciate your feedback – good or bad.

Have a good elective!

Professor John S Yudkin

Professor of Medicine

Director, International Health and Medical Education Centre

University College London

so you're going on elective?

What comes to mind? Making a shining entrance into the international world of medicine, or a stomach-churning fear that this may involve all kinds of responsibilities far beyond your lowly studentness here in the UK? You may be a seasoned traveller or it may be your first trip alone overseas.

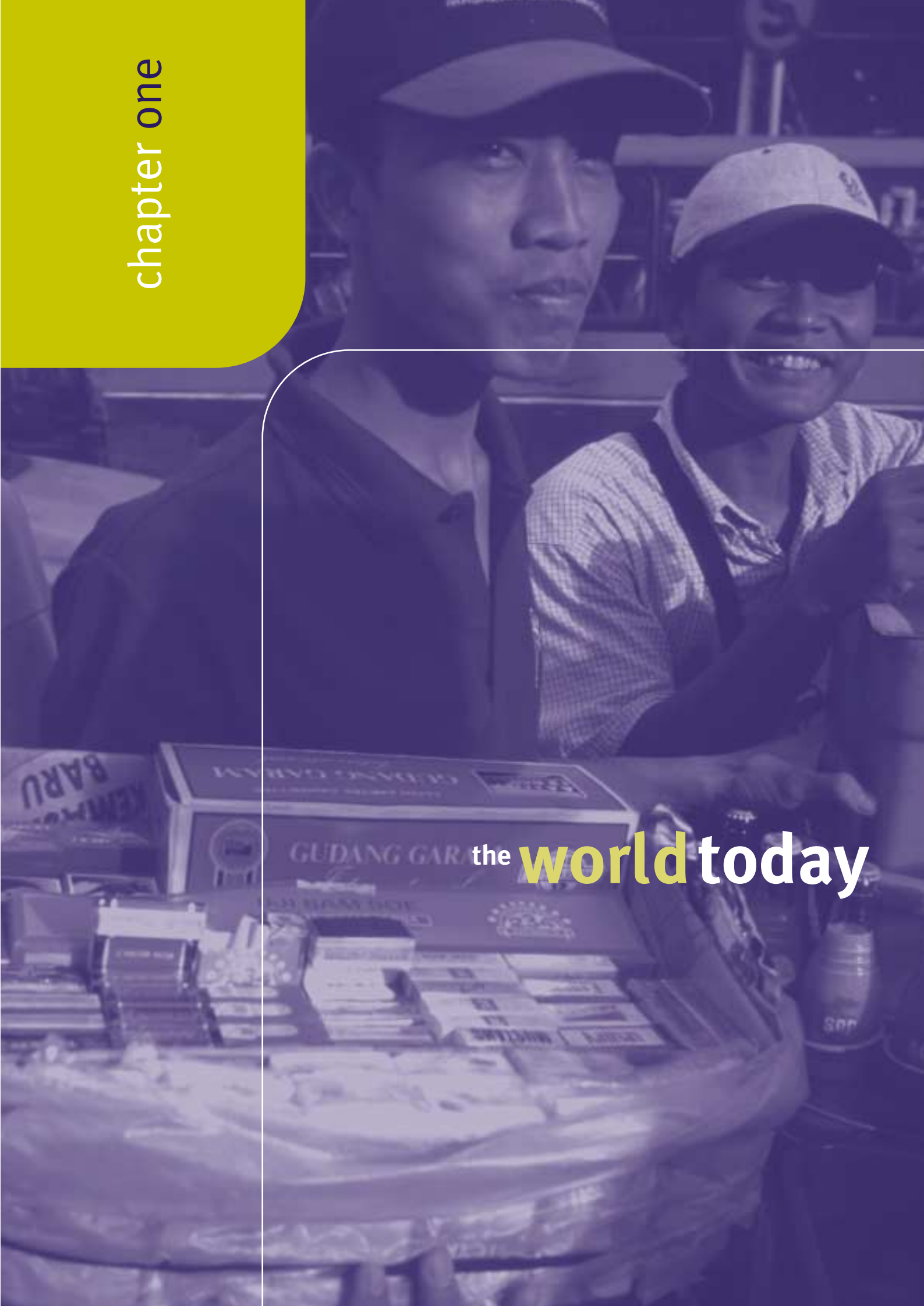
Your elective will be many things. Yes, in some parts shiny, in some parts scary, enlightening, eye-opening, fabulous, hair-raising; we could continue all day. One thing is certain though: if you venture to the developing world, you will return with startlingly different ideas about the way the world works.

Thousands of medical students travel from the UK each year on electives. Many will go to developing countries. Yet many leave for their electives ill-prepared for what they will encounter. This guide aims to help you get to grips with some of the issues you probably feel you should know about but don't. You will find it impossible to separate your experiences on elective from the bigger picture. You will find ills that medicine cannot cure.

Hopefully this guide will help you understand some of the reasons behind the situations you will encounter: patients weakened by poverty as much as by disease, medical students striking against corruption, patients with leukaemia fighting pharmaceutical companies, strange smells, a thousand languages, smiles and stares, and the amazing courage and dedication of health workers worldwide.

As a future doctor you share a common purpose with your colleagues in the rest of the world. Fortunate enough to be trained on a small, rainy island in the northern hemisphere, the choice is ours where we will go next. We are lucky. But we are not alone in the world. This is your elective. Learn, understand, try to help. Be excited, be very excited indeed...

chapter one



the **world** today

the world today

In planning where you are going on your elective, what are you thinking of? Balmy heat, white beaches, deserts, mountains, blue skies, green forests and clear seas may of course feature highly on your wish list. Place your pin on the map. Alongside scenes of stunning and unfamiliar beauty you may witness abject poverty, deprivation and diseases that have been consigned to the past in the UK.

'I entered single room shacks built from corrugated iron and plastic sheeting in which whole families lived. No sewage or waste removal systems existed and a single pump supplied water... The scabies ointments began to seem meaningless in an area where three or four children shared a single bed. Advice on hygiene and hand washing to prevent genitourinary infections was valueless in an environment where children picked through rubbish piles to find a meal. Here, among the poorest of the city's poor, money, not medicine, was the crucial health determinant.'

Andrew Moscrop, Elective in Bangladesh

Show me the money

So where is all the money? Does it make the health of the world go round?

When talking about hard cash, it is convenient to divide the world into what is known as the global North and South. The vast majority of the world's resources are concentrated in the hands of 15% of the world's population: those who live in the global North – North America, Europe, Oceania and Japan (Kawachi and Kennedy, 2002).

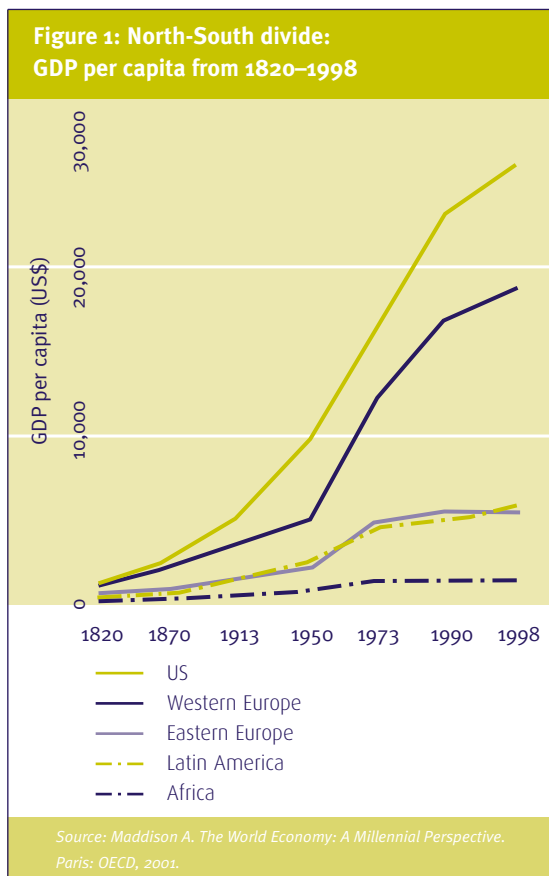
Table 1: Where do we spend these resources? (US\$ per year)

Military spending in the world	780 billion
Alcoholic drinks in Europe	105 billion
Cigarettes in Europe	50 billion
Business entertainment in Japan	35 billion
Pet foods in Europe and the US	17 billion
Basic health and nutrition for all	13 billion
Perfumes in Europe and the US	12 billion
Reproductive health for all women	12 billion
Ice cream in Europe	11 billion
Water and sanitation for all	9 billion
Cosmetics in the US	8 billion
Basic education for all	6 billion

Source: UNDP, 1999

- The world's richest 1% have as much income as the poorest 57%
- While incomes continue to rise in the world overall, sub-Saharan Africa has seen rising poverty and falling life expectancies

While in the developed world, consumption continues to rise, three-fifths of the world's people subsist on 6% of the world's income, less than \$2 per person per day (Kawachi and Kennedy, 2002).



This graph shows how, while incomes in the richest regions continue to climb, GDP per capita is stagnating in other regions. This is leading to wider disparities between people of the world. The rich and the poor exist in different daily realities.

But surely things are getting better?

The World Bank has reported that the proportion of the world's population living in absolute poverty has decreased from 29% in 1990 to 23% in 1998 (World Bank, 2002). But what is absolute poverty? Absolute poverty is defined by some as those earning less than a dollar a day. One dollar per day – a ludicrously low amount to fulfil all your needs: food, shelter, health, clothes, schooling your children, planning your future. But even in terms of this very low \$1 per day figure, the number of people in absolute poverty in sub-Saharan Africa rose from 242 million to 300 million

between 1990 and 1999, while those living on less than \$2 per day rose in number from 388 million to 484 million during the same period. (World Bank, 2002)

There are also some criticisms that can be made of the income measure of poverty. Firstly, many people in developing countries are subsistence farmers and do not earn an income, making it impossible to measure their poverty in income terms. Secondly, it excludes publicly provided goods and services. A better method of measuring poverty is to look at what people really need and whether they are able to meet these needs. The 'basic needs' measure looks at the literacy rate, health indicators such as infant mortality, and access to clean water and nutritious food. Measuring poverty in economic terms, it can be argued, suggests that money is the real goal for the human race, rather than our well-being.

However, using either method, it's clear that the gap between the richest and the poorest is getting bigger. Nowhere has this been more evident than in sub-Saharan Africa.

Life expectancy and wealth

Children born in sub-Saharan Africa are 20 times more likely to die before their fifth birthday than a child born in the developed world. To make this clear, imagine your current firm of perhaps ten students. Two of you would have died before starting school, but for where you were born (UNICEF, 2001). As we become adults, the picture is just as startling. While incomes continue to rise overall in the world, in sub-Saharan Africa and Central and Eastern Europe, incomes per capita have fallen and are lower now than they were ten years ago. Likewise, in these regions past improvements in life expectancy have been reversed. Fifty-four countries are poorer now than in 1990 (UNDP, 2003). In 21 countries more people are going hungry now than ten years ago (UNDP, 2003). A child born in 2000 in sub-Saharan Africa can expect to live to 49, whereas in the richest countries, life expectancy is, on average, 77 years.

However, the picture is not all doom and gloom. As shown above, incomes are rising in most regions of the world. The world's most populous countries, China and India, have seen rapid economic growth since the 1970s and 1980s. Under-five mortality rates have fallen in every region of the world; more people than ever have access to clean drinking water and more children are attending primary school. (UNDP, 2002).

What's it got to do with us?

The number of people who live on \$1 a day is predicted to rise from 307 million to 420 million by 2015. International trade relations and policies keep the poorest trapped in a cycle of poverty, according to a 2002 UNCTAD report (UNCTAD, 2002). As we will explain in this guide, debt keeps poor countries trapped in poverty, forced to spend more on debt servicing than on health and education. Poverty breeds unrest and conflict. In this information age, people are more aware of who are the 'haves' and the 'have-nots'.

This presents a threat to global security: islands of prosperity in a sea of deprivation cannot be safe. The richer countries bear a responsibility to the poorest, because of our history of colonisation in the South and for the unequal trading relationships, characterised by some as neo-colonialism, which continue today. Despite this, aid flows from governments have fallen since the 1990s. In 2003, only five countries – Denmark, Luxembourg, the Netherlands, Norway and Sweden – committed the 0.7% of Gross national income (GNI) to overseas development assistance (ODA) agreed by the United Nations. Other rich countries lag far behind this goal, with the USA committing just 0.14%, Italy 0.16% and the UK 0.34% in 2003.

'The worst sin towards our fellow creatures is not to hate them, but to be indifferent to them; that's the essence of inhumanity.'

George Bernard Shaw

'It is only natural that difficulties arise if we must fight day by day in order to survive while another human being, equal to us, is effortlessly living a luxurious life. This is an unhealthy situation; as a result, even the wealthy – the billionaires and the millionaires – remain in constant anxiety.'

His Holiness the Dalai Lama

Can the others catch up?

In the quest of all countries for development, the rich have a distinctive advantage. We learn in school that hard work reaps rewards and that anyone can prosper in a fair, democratic society. Yet it is not as simple as that. Firstly, states need access to economic resources to invest in their people, through supplying education, health, and clean water, for example, to encourage the development of a healthy society. These resources are clearly lacking and in some cases are diverted towards servicing debts or are invested in the military during times of conflict. Secondly, the poorest countries are competing directly with the richest in the global economic system. The rules of this system often work to the advantage of the richest and to the detriment of the poorest. Poorer countries often argue that they are locked into a dependent relationship with the richest, with little chance of escaping from this. Environmental disasters, conflict and the HIV/AIDS epidemic contribute further to the difficulties poorer countries experience in fostering economic and social development for their people.

Should we be running this race?

'With devotion and enthusiasm, the south copies and multiplies the worst habits of the north.'

Eduardo Galeano, Uruguay

What is the destination of the quest for development? Where is it leading us? Is it merely a desire for greater and greater wealth, or something more than that? Evidence suggests that once people are able to afford the basic necessities of life, increases in income have little effect on well-being. Therefore small increases in access to necessities in poorer countries such as India and Bangladesh were found to increase levels of happiness. Conversely in one study all Americans were found to want more money, regardless of their level of income (Schor, 1998). It seems that the more we have the more we want. There is always something more to buy, something more to have.

The negative effect of this is that our thirst for wealth and consumption in the rich North is threatening the world's finite resources. In the last ten years global CO₂ emissions have risen by nearly 10%. The average household in Britain produces 23.6 tonnes of carbon dioxide each year, ten times more than the average Indian household (International Energy Agency, 2002).

No one would deny the benefits of a more comfortable material existence. Increased prosperity can bring about great improvements in health and wellbeing, as we have seen. But the need is greater than ever for the rich countries of the world, which are becoming more and more affluent, to use their wealth intelligently. Likewise, development in the South must be sustainable, learning from mistakes made in the North.

Development Quiz

(Source: www.worldbank.org/poverty/quiz)

1. The total population in developing countries as of 2000 is 5.2 billion. Of this, how many people live on less than \$1 a day?

A: 1.2 billion. In 1999, 1.2 billion lived on less than \$1 a day, 300 million in sub-Saharan Africa alone.

2. Excluding China, over the last ten years, has the number of people living on less than \$1 a day in the developing world increased, decreased or stayed the same?

A: Increased from 916 million to 936 million in 1999.

3. In 1990, 44 million people lived on less than \$2 a day in Europe and Central Asia. How many people lived on less than \$2 a day by 1999?

A: 91 million.

4. In 2000, the US was ranked the third richest country in the world, based on its \$34,100 gross national income per capita in purchasing power parity terms. What was the GNI per capita in the country ranked as the poorest, Sierra Leone?

A: \$480 in PPP terms.

5. The average income for the richest twenty countries in the world was 15 times the average for the poorest twenty countries in 1960. What is it now?

A: It is now 30 times the average income of the poorest countries.

6. In the US, between 1990 and 1998, eight women died for every 100,000 live births. In Eritrea and the Central African Republic, what is this figure?

A: 1,000

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Find out more

ENVIRONMENT

International Energy Agency

www.iea.org

Statistics about environment and energy use worldwide.

Forum for the Future

www.forumforthefuture.org.uk

Information on sustainable development and the environment.

POVERTY AND DEVELOPMENT

UNDP Human Development Reports

www.undp.org

Contain an index of statistics on income, poverty, health, education among others by country and by region. Ranks the world's countries on an Index of Human Development.

World Bank

www.worldbank.org

A mass of resources and with links to research on almost every topic relating to health and development.

Eldis

www.eldis.org

A comprehensive website providing research on a variety of development issues, hosted by the Institute of Development Studies, University of Sussex.

chapter two

the global playing field



the global playing field

You can see how there are powerful strings being pulled in this global picture. The playing field is the planet, but who are the major players? It is important for any doctor who is interested in making a difference to the lives of society's poorest to know about the major players in development.

The Bretton Woods Institutions: World Bank and International Monetary Fund

'The World Bank is the new 800lb gorilla in world health care', said a senior WHO representative recently. Formed in the ashes of the Second World War in 1944, the World Bank's aim is to 'reduce poverty and improve living standards by promoting sustainable growth and investment in people'. In a world battered by conflict, the Bank aimed to rebuild infrastructure and restore international trade in Europe and Japan. Money was needed quickly and trade was seen as the way forward. The International Monetary Fund (IMF) was set up at the same time to ensure the smooth running of the global economy and to promote international monetary cooperation, exchange stability and orderly exchange arrangements.

The World Bank is the single largest source of funds for health care in low-income countries

The World Bank lends money to countries, rather like your high street bank but on a much larger scale. Poorer countries borrow at lower interest rates, with the poorest eligible for interest-free loans. These loans are for development projects, which in the beginning were physical infrastructure projects such as roads, power and communications designed to

promote trade and growth. These still receive most of Bank lending, but loans for health, education and social protection have increased rapidly. However, these loans come with strings attached, such as currency devaluation, reductions in public spending, increased taxation and trade liberalisation. These strings are known as conditionality packages. More information about this can be found in the 'Structural Adjustment Explained' section.

The Bank has often been criticised for its role in development and health. Critics point out that the conditionality packages associated with structural adjustment have had a deleterious effect on developing country economies, trade and social security systems, health and education. In recent years, however, the Bank has sought to establish itself as a more compassionate organisation. Its recent policies focus more on the needs of the poorest, as seen in the latest World Development Reports, the World Bank's annual reports. It is moving slowly away from the 'one size fits all' strategy of the past towards a more flexible approach. Critics continue to argue, however, that the bank will always be driven by economic goals and has forced economic reform on countries that effectively have their backs to the wall.

One hundred and eighty-one member countries contribute to the Bank's funds. The voting system at the World Bank is simple: one dollar, one vote. Therefore the richest countries have more control. The President of the Bank is traditionally a US citizen, with James Wolfensohn having held the post since 1995. Less developed countries have little influence on World Bank policy. This unequal balance of power contributes to the dependency caused by high levels of debt. This system is unlikely to change in future.

United Nations

The United Nations came into being in 1945, the successor organisation to the League of Nations, which ceased its activities after failing to prevent the Second World War. The aims of the UN were

admirable: to maintain international peace and security; to develop friendly relations among nations; to cooperate in solving international problems and in promoting respect for human rights; and to be a centre for harmonising the actions of nations. The United Nations is an inter-governmental organisation, involving collaboration between 191 member states.

Within this system are a number of autonomous offices active in health and social development such as UNHCR (UN High Commissioner for Refugees), UNDP (UN Development Programme) and UNICEF (UN Children's Fund). These bodies all report back to the General Assembly. The World Bank, IMF and World Trade Organization (WTO) also come under the auspices of the UN, but are more autonomous than the programmes listed above. The entire UN system runs on funds donated by its member states, each represented in the General Assembly by one vote. Since 1993, the UN budget has seen zero growth, due to a general reluctance by member states to provide funding. This has meant cuts in budgets and has created an urgent need for UN agencies to look elsewhere for additional funding.

The UN has been criticised for inefficiency and bureaucracy. Several UN agencies are involved in health matters; competing for the same funds and often replicating each other's work. There has been an increase in inter-agency collaboration in recent years: for example UNICEF and WHO have worked together to establish a code for breast-feeding. Under Kofi Annan's leadership, the UN has also formed a wider network of links with external actors, businesses, non-governmental organisations (NGOs) and international donors. This brings the expertise and innovative qualities of business into the health field. Commentators on these partnerships have stressed the need for the UN to maintain the autonomy and neutrality on which its global reputation is based.

World Health Organization

The World Health Organization is the only inter-governmental global organisation devoted solely to health. When it was established in 1948, the WHO laid down in its constitution that health was a fundamental human right, establishing this in international law. Its objective was 'the attainment by all peoples of the highest possible level of health', health being defined as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. This definition of health remains familiar to every doctor and medical student today. The WHO can list among its achievements the eradication of smallpox, effective control of mass cholera outbreaks and formation of the Essential Drugs List.

In recent years the picture has changed. International donors, financial institutions like the World Bank, NGOs and pharmaceutical companies work alongside and in partnership with the WHO.

The regular budget of the WHO is about US\$800 million (£500 million, €720 million), approximately equal to that of a large European teaching hospital.

Like the UN, the WHO is dependent on contributions from member states. Several of these states have failed to make their payments, meaning that the regular budget has been frozen since the 1980s. Extra contributions from donors, states or other UN organisations are usually earmarked for specific projects and come with conditions attached. The WHO's funding crisis has limited its ability to set its own priorities and has, some argue, increased its dependency on private sources of finance.

During the 1980s and 1990s, the WHO appeared at risk of being sidelined, and was criticised for being bureaucratic, poorly managed and slow to act. Gro Harlem Brundtland's recent term of leadership has

done much to change this image. By forming partnerships with other UN organisations such as UNICEF and the World Bank, the WHO has increased its access to resources and expertise. Concerns remain about whether the WHO should be entering into alliances with the private sector, whose motives often conflict with the objectives of the WHO. For example, representatives from Nestlé, one of the world's largest infant food manufacturers, were present during a series of meetings in 2000 to discuss the setting of WHO/UNICEF guidelines for infant feeding. Authors of research reports commissioned for these meetings reported that findings were stifled, reports were edited by the WHO and the resulting recommendation, of four to six months being the minimum period for exclusive breast feeding, was shorter than that recommended by the majority of experts (Ferriman, 2000).

The new Director General of WHO, Jong-wook Lee, will need to take stock of WHO partnerships, ensuring that its global voice remains impartial. Doctors have also called for WHO to focus more of its resources at country level, and improve coordination of local actions with activities at headquarters in Geneva. However, an effective WHO and United Nations will require more generous funding from member governments, so they can hold their own against the emerging players in health: the so-called new philanthropists, big business and NGOs.

NGOs and the new philanthropists

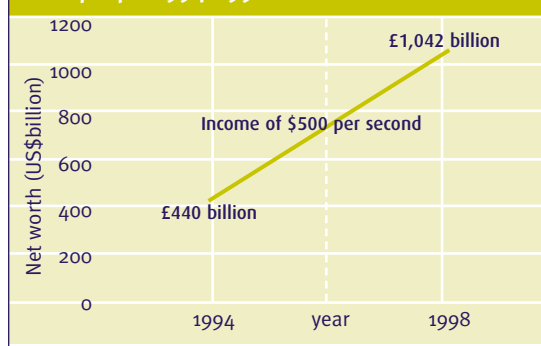
In recent years aid from traditional sources such as governments has continued to fall. At the same time, though, new players have entered the international health field. There has been rapid growth in the number of NGOs and philanthropic bodies such as the Bill and Melinda Gates Foundation. NGOs are a mixed bunch, ranging from multi-million pound international charities such as Oxfam and Save the Children, to small local enterprises in developing countries. As a whole, they control about US\$1.2 billion of resources in the developing world (UNDP, 1999); a sizeable amount, yet dwarfed by the resources of corporations and donor individuals. Their aims and activities vary considerably. Many of the big charities working in health have shifted in

recent years from directly coordinating ground-level health projects to being more active in campaigning on policy issues such as trade, debt and access to medicines. Médecins Sans Frontières, working at ground level in health emergencies since 1971, began its Access to Essential Medicines campaign in 1999, in response to its staff's experiences in the field. Oxfam, a seasoned coordinator of clean water and basic infrastructure programmes in developing countries, is now one of the leading campaigners for fair trade. There seems to be a growing realisation that tackling health problems must begin at the very top right through to field-level work in health centres and refugee camps.

A yearly contribution of 1% of the wealth of the world's 200 richest people could provide universal access to primary education for all (US\$7–8 billion) (UNDP, 1999)

Since 1960, personal donations to good causes have more than trebled from US\$50 billion to more than \$150 billion. In the four years from 1994 to 1998 the wealth of the richest soared, due in part to a flourishing technological industry. Some of this wealth is being channelled into a variety of good causes. The so-called new philanthropists, wealthy individuals or companies who have set up grant-making organisations, have attracted unprecedented attention for their charitable giving. Ted Turner, the media mogul, made headlines in 1997 when he donated US\$1 billion to the UN. The biggest spender of the new philanthropists is Bill Gates, of Microsoft,

Figure 2: Net worth of the world's richest 200 people 1994–1998



Source: Adapted from UNDP Human Development Report 1999.

who has earmarked 60% of his personal wealth for good causes. The Bill and Melinda Gates Foundation has to date pledged US\$16.5 billion for global health, its priority area of funding, in particular for childhood immunisations.

Dilemmas of aid

Money flowing into international health from national governments, NGOs and philanthropists is extremely beneficial, but each of these donors may have their own special interests. Their priorities will not always correlate with the most serious global health needs. In turn, the donors' interests determine the areas in which the aid organisations, NGOs and research institutes will work. They are forced to compete with each other for these resources, a time-consuming task that can divert attention from the 'real work'. Grants usually extend no longer than a few years and come with lots of strings attached, goals to be reached, measurable results and glossy reports to be produced. Those countries and organisations with little experience, capacity or resources to prepare applications for money can be left sidelined. They can end up dependent on partners in developed countries to help them access these new funds.

Donors like results. This can often mean projects are planned in areas most likely to yield swift success, in countries with better health systems and infrastructure: in other words, the simple cases are more appealing. The plethora of donors and global agents for health has also led to a heavy workload for developing country governments who must also coordinate within their health ministries the various global initiatives and country-level projects. This diverts staff and precious resources from health. A different approach is currently being advocated, particularly by donor governments including the UK, known as a sector-wide approach or SWAp, where all funds for one sector, such as health, are put into one pot, the overall coordinator of which is the developing country government. This helps governments in developing countries to set their own priorities and use the money in a more integrated fashion, according to national priorities.

World Trade Organization

Founded in 1995, the World Trade Organization (WTO) is the direct descendant of the General Agreement on Tariffs and Trade (GATT), a treaty signed in 1947. It is the only global organisation that has the power to hold its member states accountable to its rules. Today 142 countries are members. You may be aware that it has been the target of protests by millions of people worldwide. Why?

The WTO exists to regulate all the exchanges which occur through international trade – that is all goods that cross borders. Goods can also include services such as health care, imported medicines and even ideas, known as intellectual property. The WTO subscribes to what is known as 'neo-liberal' thinking – the idea that markets should function with a minimal level of interference from governments. The idea of 'free markets' (free from state control) is championed by the US and other developed nations today. Countries can be held accountable by the WTO under its agreements, and can be forced to change their national laws if other WTO member states believe they are meddling unnecessarily in the market. This may include high tariffs on imported goods or subsidies on food.

It has been argued, however, that this ideology can harm the poor. Less developed economies need a degree of protection in order to develop, and are especially vulnerable to fluctuations in the global economy. The crash in East Asian markets in the late 1990s seemed to support this claim. Countries previously thought to be thriving economically, with healthy levels of growth, such as South Korea, Malaysia, Thailand, the Philippines and Indonesia, saw huge reversals in their fortunes as markets crashed. The human costs were devastating and revealed the vulnerability of the poorest to the volatile play of global market forces. Spending on health in Thailand and the Philippines was cut by over 10%, domestic violence and street crime increased and in Indonesia an estimated 40 million people fell below the poverty line. While this cannot be attributed solely to the policies of the WTO, it is also the case that the organisation is immensely powerful, and actively promotes the neo-liberal values that, many have argued, contribute directly to poverty and ill health.

The WTO has also been criticised by doctors, NGOs and patient groups for its trade rules, which have affected access to healthcare and medicines. For more information, see the 'Bitter Pills' section of this guide. Like the World Bank, but unlike the WHO, dollars mean votes and the WTO is a notoriously closed shop. Discussions are held in secret and it is very difficult for poor countries to make their voices

heard. Yet these decisions have huge effects on people's lives. There have been calls for this powerful organisation to be more accountable and democratic.

Trade has an enormous capacity to revitalise and develop economies. But it seems too often that the right to profits and the protection of businesses are put before the right to health.

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Find out more

The Bill and Melinda Gates Foundation

www.gatesfoundation.org

Department for International Development (DFID)

www.dfid.gov.uk

UK government spending on aid and SWAPs

Global Health Watch

www.ghwatch.org

A project mobilising civil society around an alternative World Health Report.

Global Policy Forum

www.globalpolicy.org

Independent body which reports global policy making

Millennium Development Goals

www.developmentgoals.org

Development goals set throughout the 1990s and agreed by the United Nations member states in September 2000. They set targets in poverty, education, gender empowerment, child mortality, maternal health, access to clean water and sanitation, HIV/AIDS and other diseases, the environment, and developing a global partnership for development.

People's Health Movement

www.phmovement.org

This grass-roots network of health organisations puts the spotlight on international institutions and health policy.

Reality of aid

www.realityofaid.org

Information on international aid flows

UNHCR

www.unhcr.org

UN High Commissioner for Refugees

UNICEF

www.unicef.org

UN Children's Fund

United Nations

www.un.org

WHO

www.who.int

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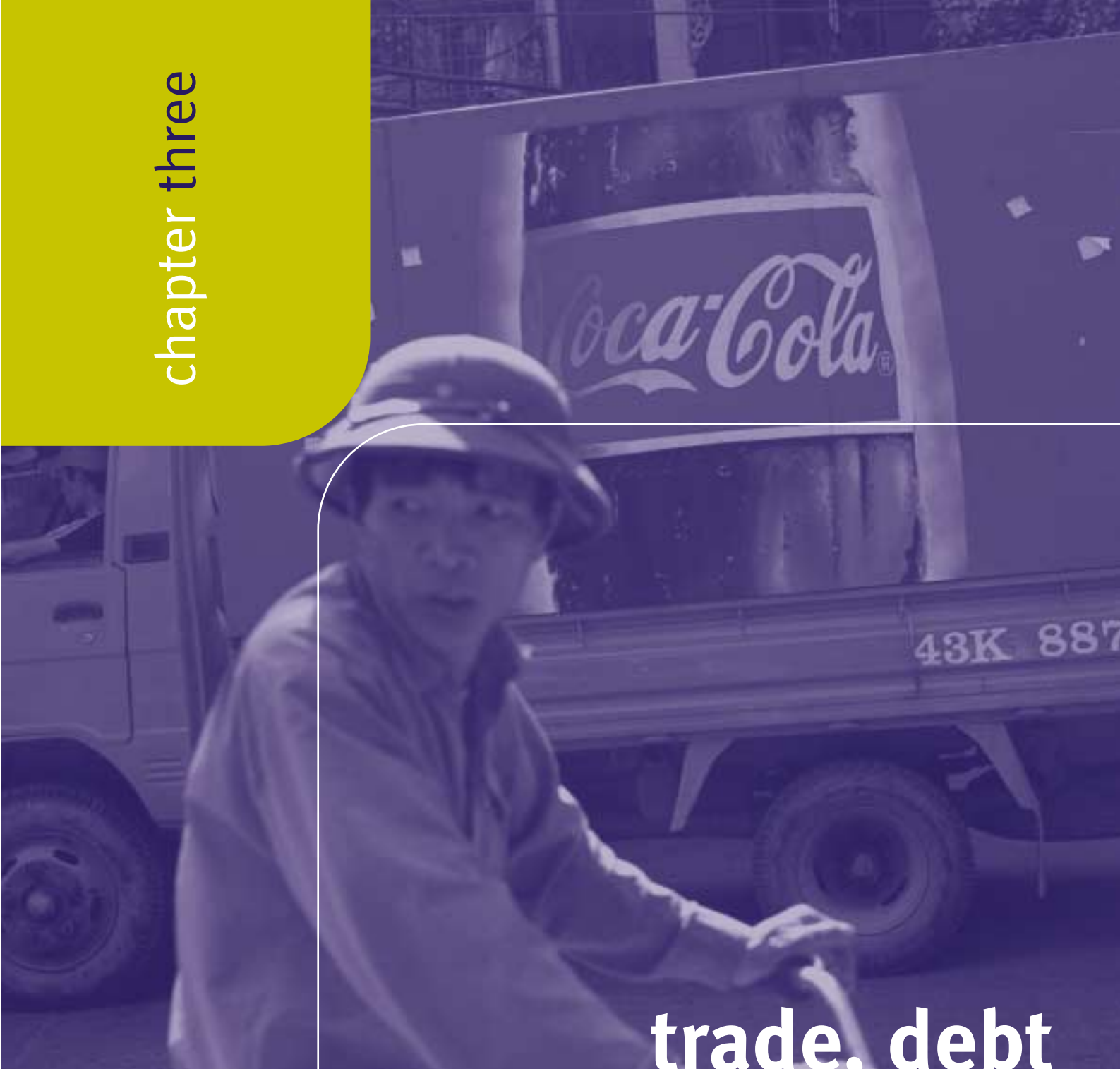
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chapter three



trade, debt and **structural adjustment**

trade, debt and structural adjustment

In 2001, Oxfam estimated that 15 million bags of coffee needed to be burnt to allow the world's 25 million coffee farmers to begin making a profit. An over-supply of coffee on the global market meant it was becoming almost worthless.

In the past, developing countries have been encouraged to export primary commodities. However, if their farmers depend too much on one crop and demand falls, millions suffer the consequences. Smallholders have little bargaining power with the four main coffee producers: Nestlé, Kraft, Procter and Gamble, and Sara Lee. The price slump in coffee has left many farmers destitute. It cost Uganda US\$190 million; crops were abandoned in Brazil, and in Mexico many rural labourers left for the cities.

Rich countries subsidise their farmers by more than US\$1 billion per day.

'Trade not aid' has been a development doctrine. However, while the last decade has seen an explosion of international trade and rapid growth in global income, only a handful of developing countries have reaped the benefits. The example above illustrates the difficulties developing countries face in achieving growth.

Multinational corporations (MNCs) wield unprecedented power. For example, Wal Mart, General Motors and Ford each have a bigger turnover than Africa's entire combined GDP. Fragile economies mean states are often highly dependent on foreign investment.

Facts and figures (Oxfam, 2002)

- Trade can be a force for poverty reduction: a 1% increase in world-export share in each region could reduce world poverty by 12%.
- Low-income developing countries account for less than 3% of world trade
- Increased prosperity in the poorest regions has benefits for all: in 1993 it was estimated that one-fifth of US unemployment was because poorer countries in the South could not afford imports.

How can developing countries compete?

The countries of the world are certainly playing in a global competition as far as trade is concerned. It is said, though, that the playing field is not level. Richer countries like the US and those in Europe advocate the spread of free trading systems throughout the world, with reductions in protection of business by governments and increasing privatisation. At the same time they continue to protect their own economies with subsidies and tariffs which make imports less competitive.

'I don't know how American farmers can sell corn to this country at such low prices. I have heard that their government gives them money. What I know is that we cannot compete with their prices. Imports are killing our markets and our communities.'

Hector Chavez, Smallholder farmer
Chiapas, Mexico (Oxfam, 2002).

The Common Agricultural Policy (CAP)

The CAP is a system of subsidies for Europe's farmers. It means that the EU can export agricultural goods at prices lower than the cost of production. For example all the white sugar produced in the EU is sold at one-quarter of its actual cost. The size of the European market means that these are the prices with which developing countries must compete. All too often they cannot. As a result cheap goods flood international markets. The EU has produced huge surplus food mountains while mouths go hungry elsewhere. Latin America is the worst-affected region – Oxfam estimates that Latin America loses US\$4 billion per year from EU policies alone. The World Trade Organization has failed to change this situation. As more countries are forced to open their markets to comply with the WTO's rules, the domestic market is exposed to cheap foreign imports. The competition can ruin local farmers.

Ghana's rice trade

'Me and my husband earned around 1,000 cedis (in 2004 approximately ten pence) per day in the rice fields. We would help spread the fertiliser and pull out the weeds in between the rice beds. It was not much but it allowed us to buy the food we couldn't grow ourselves. But then the industry collapsed and that source of income disappeared.'

Cecilia Sukpe, Ghana (Christian Aid, 2002)

The effects of opening Ghana's markets to foreign imports under structural adjustment policies in 1983 were swift and unplanned. The government was forced by the IMF and World Bank to get rid of state subsidies on fertilizer and to privatise farm machinery. The new 'free' markets were soon flooded with heavily subsidised cheap white rice from the US.

The Ghanaian rice industry, unable to compete, has since folded. Today Ghana spends US\$100 million per year on importing rice, draining from its coffers precious foreign currency essential for importing equipment and drugs manufactured only outside the country. Ghana could impose import taxes, a practice used by countries like the US and the UK, but it is under further pressure from the IMF to reduce state interference in the market.

Meanwhile, the new US Farm Bill, which was signed in 2002 by President Bush, is expected to raise US subsidies for farmers to the staggering sum of US\$180 billion over ten years. Rice farmers could receive up to US\$8 billion in grants, an amount which exceeds Ghana's combined GDP. Even the World Bank called it 'a sad day for world farmers'.

Summing up – the costs of trade

As we have seen, trade has the potential to change global fortunes. Countries such as India have shown it is possible to attract investment and nurture domestic businesses by setting their own priorities for investing foreign dollars. However, the ability of countries to determine the development of their own markets is key here. Farming is just one area where the poorest countries are the most disadvantaged by unfair trading. The rapid opening of markets to foreign goods has often damaged their ability to encourage domestic industry. This is made worse by the large debt burdens of many developing countries.

Table 2: Top corporations and GDP of countries

<i>Country or corporation</i>	<i>GDP or total sales (US\$ billions)</i>
General Motors	164
Thailand	154
Norway	153
Ford Motor	147
Mitsui & Co.	145
Saudi Arabia	140
Mitsubishi	140
Poland	136
Itochu	136
South Africa	129
Royal Dutch/Shell Group	128
Marubeni	124
Greece	123
Sumitomo	119
Exxon	117
Toyota Motor	109
Wal Mart Stores	105
Malaysia	98
Israel	98
Colombia	96
Venezuela	87
Philippines	82

Source: UNDP, 1999.

Strange subsidies: the European cow versus the Indian farmer

Imagine reincarnation exists: would you rather come back as a cow in Europe, bred for your meat or milk, or as an average subsistence farmer in India. Did you choose the latter? You may want to reconsider your choice...

Statistics show that the average cow in the West receives subsidies from governments which are almost double the average income of an Indian farmer. A single cow is reared on about 25 acres. This is enough space for ten of the world's 1.5 billion subsistence farmers to grow enough to support their families.

The world produces enough grain for 3,600 calories every day for every person on the planet, yet an estimated 800 million (about 18% of the world's population) go hungry every day. Surplus grain from subsidised farmers in Europe, Japan and the US is fed to cattle. The grain fed to one cow for meat would produce six times more calories if fed directly to humans. The extra milk produced by these subsidised cows farmed in rich countries is dumped in developing countries' markets as milk powder and breast-feeding substitutes.

Harmless subsidies or trade distortion? Turn to the section on nutrition for more information about hunger in the world today.

Debt timeline

1973 OPEC, the organisation of oil-exporting nations, pushes up the price of oil. Profits are invested in Western banks. Banks lend the 'petrodollars' to developing countries at low interest rates.

1979 OPEC quadruples the price of oil. Meanwhile recession hits rich countries. Interest rates rise in the US to combat inflation and attract investment. Prices of primary commodities (produced mainly in developing countries) fall.

Debt crisis Debts must be repaid in foreign currency, either from exports or borrowing. Plummeting commodity prices, as the North imports less, force governments to borrow more.

1982 Mexico threatens to default on payment of its loans. The world economic system is thrown into disarray. Many countries are effectively bankrupt, with no way of paying back the sums they owe (approximately US\$800 billion).

1980s Debt rescheduling begins. The World Bank and IMF help the poorest countries pay back the private banks with... more loans. Result: more debt. As a condition of debt relief from the World Bank/IMF, governments must implement Structural Adjustment programmes (SAPs). See 'Structural adjustment explained' on page 22.

1982–87 Approximately US\$700 billion worth of resources is transferred from poor to rich countries under debt rescheduling.

1986 Export incomes are still falling. It is estimated that sub-Saharan Africa loses US\$19 billion due to lost exports in this year alone.

1990s The developing world carries a US\$1300 billion burden of debt. They have already paid back US\$1100 billion. The poorest countries shoulder the bulk of debt.

1996–present Outrage increases throughout the world at the debt problem. The Jubilee Coalition campaign educates millions about the basics of international finance, debt and poverty.

1996–present World Bank launches the HIPC (Heavily Indebted Poor Country) initiative to write off debts owed to them by poor countries. Though a significant step forward, debt relief is based on countries meeting a stringent set of criteria, including continuing structural adjustment. HIPC heavily criticised for being too slow and for imposing policies that harmed the poor.

1998 70,000 people form a human chain around the G8 summit in Birmingham in protest.

2000 24 million people sign the Jubilee Coalition petition.

Debt to date

Progress on reduction of the debt burden has been slow. The 2003 report by Jubilee and the Catholic Agency for Overseas Development (CAFOD) revealed that only eight countries had received significant debt relief. So far, US\$36.3 billion dollars of debt has been cancelled, but this is a tiny proportion of the US\$300 billion of unpayable debt owed by countries classed as ‘very poor and indebted’ and less than a third of what was promised in 1999. The HIPC initiative has also been criticised for forcing governments to adopt policies which harm the poorest and which in some cases have reversed the benefits of debt relief. Countries like Uganda, Malawi, Mozambique and Tanzania have shown how debt relief has freed up money for health and education, but it seems much more is yet to be done.

Structural adjustment explained

Knowing about SAPs is essential to understanding the costs of health care for the poor. Structural adjustment is essentially what it sounds like: altering the structure of a country’s policies in order to bring about defined changes. Structural adjustment programmes were instituted in many heavily indebted developing countries in the 1980s and 1990s. The IMF and World Bank stepped in with loans to help the poorest nations make their payments on time. However, this help came with strings attached, known as conditionality packages.

‘Must we starve our children to pay our debts?’

Julius Nyerere, Former President of Tanzania

Structural adjustment programmes typically instructed governments to cut expenditures, raise interest rates, liberalise trade and investment and privatise areas of the economy previously controlled by the state. The aims of these policies were to resolve problems in their balance of payments (the ratio of money coming into and leaving the economy, primarily through imports, exports and foreign investment), reduce inflation and prevent future economic crisis by promoting longer-term structural reforms.

Structural adjustment brought about periods of economic austerity in many developing countries, characterised by decreased government expenditure, particularly on health and education. It was argued by the World Bank that this process was merely ‘crossing the desert’ and that short-term pain was necessary for long-term economic stability and growth and improvements in quality of life.

However, in most cases the supposed benefits of structural adjustment have not materialised. By the late 1980s the World Bank and IMF were forced to admit that the austerity brought about by structural adjustment in the early 1980s had brought about unnecessary hardship. In 1987 UNICEF published *Adjustment with a Human Face*, a study highlighting the effects of IMF policies on children. This forced both the World Bank and IMF to alter the content of their programmes, and incorporate concerns about social spending and poverty reduction into their programmes.

‘Poor countries cannot afford to wait until they are wealthy before they invest in their people.’

Jeffrey Sachs, special adviser to Kofi Annan,
UN Secretary General

Structural adjustment affects health in a number of different ways, not only through decreased government expenditure on health services. It also affects people’s incomes, the prices they pay for food and other commodities and the quality of services such as clean water and sanitation provided by the state. The overall impact of structural adjustment on health was negative, as it brought about falling incomes, decreased social expenditure and rising food prices.

One aspect of structural adjustment that has been particularly heavily criticised is user fees for health care. User fees – or forcing patients to pay for their treatment – were implemented as part of structural adjustment in the 1990s. Prior to this, health care had, in many cases, been free at the point of access. With the introduction of charges, use of health services and preventive care fell dramatically. The poorest simply could not afford to have treatment.

Delayed treatment means that by the time the patient presents at a health centre, their condition is serious and the cost of care is catastrophic.

Save the Children has been among the many agencies to highlight the impact of user charges on the poor. In its publication *The Bitterest Pill of All*, it was found that fees contributed less than 5% of health care costs in most African countries and decreased use of health services in the poorest communities (Save the Children, 2001). Even a recent report commissioned jointly by the World Bank and the WHO found that user fees failed to raise significant revenues and have disproportionately increased financial barriers to care for the poorest (Arhin-Tenkorang, 2000).

The United Nations Children's Fund (UNICEF) has said that World Bank/IMF policies are largely responsible for the 25% reduction in health spending per person in the world's poorest countries (Cornia et al, 1987). During the first stage of structural adjustment in Zimbabwe (1990–95), the number of people living below the poverty line doubled. Child mortality rose by 13% in the 12-month period between 1992 and 1993 (Mwanza, 1998). Furthermore, the most generous grants often do not go to the poorest countries, but to projects that are most likely to generate measurable success. For example the Bank's largest grant to date was to Mexico, to encourage the development of the private health sector, which has questionable benefits for the health of the poor. 'One of the bank's top priorities is to help stimulate the private sector', said the 1998 Annual Report. This priority can often conflict with meeting health and development goals.

This section concludes with a portrait of Mozambique by the surgeon and writer Jonathan Kaplan, which illustrates the close links between trade, aid, debt and global players in development. This piece was written during the Mozambican civil war in the 1990s.

'In Maputo, the Mozambican capital, the bar of the Cardoza hotel was busy. The drinkers spilled out onto the terrace. Most worked for the parastatal agencies – the World Bank, UNDP, UNHCR, UNICEF, the Red Cross – and some two hundred other aid groups, charities and NGOs whose operatives had descended on the country in a plague of altruism.'

'Twilight was falling and the fruit bats wheeled in the blue air above our heads. Below the bluff on which the hotel stood, freighters full of food aid were lined up to unload at the city's crumbling port. By this stage of the war aid was providing nearly eighty per cent of the country's GDP. The aid industry trade press always had a lot about Mozambique, the sort of headline-grabbing projects which attracted prestige and funding. The IMF and World Bank wanted Mozambique to accept an economic structural adjustment programme; reducing state expenditure on health and education, and abandoning government-subsidized prices for staple foods to the determinants of "market forces". Development agencies were offering "tied" or "bilateral" aid: subsidized programmes that locked Mozambique into service or spare-part contracts with suppliers from the donor nations, thus recycling the aid-dollars back home... Hyper inflation meant most transactions involved bricks of banknotes bundled together with string.'

Jonathan Kaplan, *The Dressing Station*

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Find out more

CAFOD (Catholic Agency for Overseas Development)
www.cafod.org

NGO campaigning against debt and on other development issues

Christian Aid Trade Justice Campaign
www.christian-aid.org.uk

Fair Trade

www.fairtrade.org.uk

Learn more about fair trade alternatives and buy goods online.

International Labour Organization

www.ilo.org

Part of the United Nations system, the ILO works in the areas of trade, employment and social security. Includes information on labour relations in developing countries, poverty and trade.

Jubilee Research

www.jubileeresearch.org

The successor to the massive Jubilee 2000 campaign. It is a network of organisations which campaign and carry out research into international debt. The websites are helpful to give you an essential, simple background knowledge on debt and other issues.

Medact

www.medact.org

NGO for health professionals campaigning about issues around poverty, debt and development

One World

www.oneworld.net

Fantastic site with contributions from partners all over the world and detailed articles about development and health. Country guides written by local volunteers introduce you to the key issues in that country.

Oxfam

www.maketrade4fair.org

Oxfam's site for its fair trade campaign.

Report of the Commission on Macroeconomics and Health

www.cmhealth.org

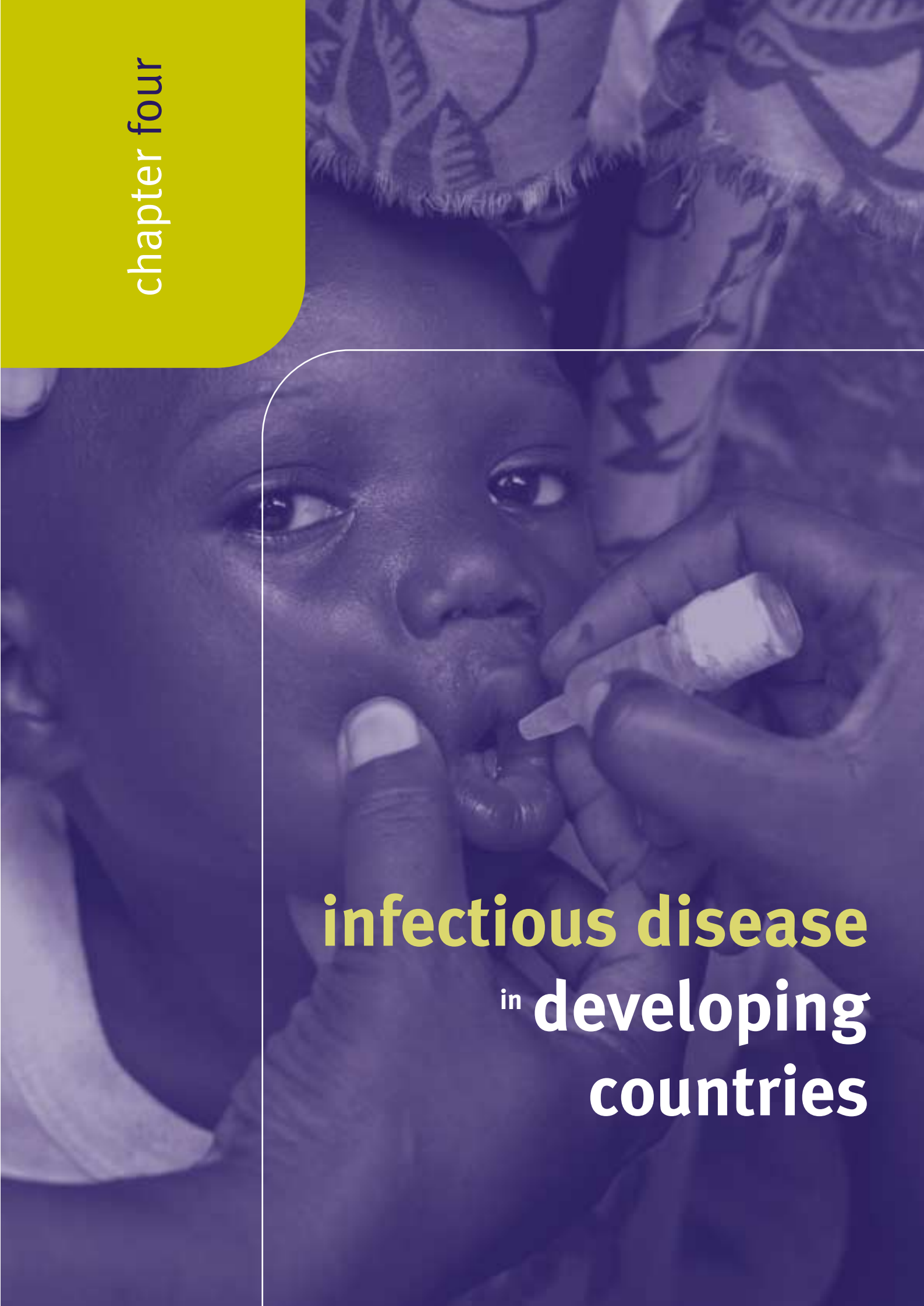
Final report and background papers available on the website.

UNICEF. *Adjustment with a Human Face*.

www.unicef.org

Publication documenting the effects of structural adjustment on child health. Available to buy on the UNICEF website.

chapter four



infectious disease **in developing** **countries**

infectious disease in developing countries

‘The heady scent of molasses is in the air. Workers wait, parang in hand, by the side of the road for the first truck to transport them deep into the sugar cane fields. It’s 7am and we’re in the jeep on the way to the hospital to attend the morning ward round.

‘Two hours, twenty malaria cases and one snake bite later, we sit learning tropical medicine from the Oxford Handbook. Suddenly the small print of Western medicine looms large on previously unfingered pages. Diagnoses normally relegated to the bottom take prime position, mocking our ignorance in the process.

‘Six months later and my final examiners share a joke when I mention a tropical disease. “Maybe in Africa!” they laugh. Yes, maybe...but there’s a lot of people in Africa!’

Esme Gates, Elective in Tanzania

One-third of all deaths each year are due to infectious diseases. More than 90% are in developing countries. During your elective, you will find that diseases that you might never have seen during your training here are commonplace and the effects catastrophic.

Table 3: Common infectious diseases in developing countries

1.	Acute lower respiratory tract infections
2.	Tuberculosis
3.	Diarrhoea
4.	Malaria
5.	Preventable diseases (pertussis, measles, diphtheria, polio, tetanus)
6.	HIV
7.	Hepatitis B
8.	Trypanosomiasis
9.	Leishmaniasis
10.	Schistosomiasis
11.	Meningitis

Read this list, and in particular consider how much you know about each of these diseases. Most are preventable, often with simple, cost-effective measures. However, they continue to kill millions each year. Most are children and most are poor. Take the time to find out more about levels of infectious disease in the country you are visiting and how they are treated. The resources section of this guide is a good place to start.

Malaria

Malaria is a parasitic disease transmitted from person to person by the bite of the female *Anopheles* mosquito. There are 1.5 million deaths and 300–500 million acute cases of malaria each year (WHO), 90% of this burden occurring in Africa. Pregnant women are most at risk, with the disease compounding problems of anaemia, poor nutrition and co-existing illness. The cost of this disease in Africa amounts to more than US\$12 billion each year, according to the World Health Organization, compounding the problem of poverty. Malaria was prevalent in countries such as the US, Canada, Russia and large parts of South America until the 1960s. In India 75 million cases per year in 1950 declined to 100,000 cases by 1970. Why, then, is it still such a problem in Africa?

Professor Jeffrey Sachs, special adviser to the UN Secretary General says, 'It's all about the money. Malaria is treatable... and utterly affordable'. Success in richer areas of the world has been based on a highly coordinated global eradication programme, involving spraying DDT, an insecticide effective against the mosquito, and drainage of swampy areas favoured by malaria vectors as breeding sites. However, the global use of DDT declined rapidly when the WHO programme collapsed in 1975. It was found that DDT resistance had developed among the *Anopheles* mosquito. The chemical was also criticised for its toxic environmental effects. Public health doctors have since called for a return of controlled use of DDT, arguing it is the only effective way to eradicate malaria, and that its benefits outweigh its risks.

There appear to be few practical alternatives for making a large impact on Africa's malaria problem, short of a huge investment in new drugs (as resistance to current medicines is increasing), and in public health programmes and effective health systems to deliver the drugs. The Roll Back Malaria programme, a collaboration between the WHO, UNICEF, UNDP and the World Bank, seeks to invest more resources in tackling malaria. The Global Fund for AIDS, Tuberculosis and Malaria is also bringing much-needed resources at a time when it has been estimated that up to US\$2 billion is needed to achieve the Millennium Development Goal of halving the number of malaria cases by 2010 (WHO, 2001).

Tuberculosis

This curable disease kills more people than any other infectious disease alone with two million deaths annually (Stop TB Partnership). It has a devastating effect on economies as it affects people during their most productive years and treatment regimens take a long time. Malnutrition, poverty, immunosuppression and youth are some of the important risk factors for progression from the latent stage of the disease to symptomatic stages. It is one of the most common opportunistic infections suffered by HIV patients and, together, these two diseases are placing a double burden on health services in developing countries. About half of all AIDS patients will eventually develop TB. There is currently no vaccine available that is

100% effective. Only 16% of patients with TB receive treatment (Stop TB Partnership). DOTS (Directly Observed Treatment Short-course) is the mainstay of treatment in developing countries, but the length of the course and other factors such as lack of diagnostic facilities (the diagnosis of TB still relies on positive sputum-smear microscopy) and the fact that many infectious patients do not have access to health facilities where tuberculosis care consistent with the DOTS strategy is available. Patients often receive care from health providers who are not linked to national TB programmes and whose diagnosis and treatment practices are not consistent with the DOTS strategy – private doctors, clinicians working in health facilities in different branches of the public health system, and those working for employer health services. Many cases therefore remain unregistered and inadequately treated, meaning that TB remains a major health threat (Elzinga et al., 2004). It is estimated that only 45% of TB patients have access to DOTS therapy (Maher, 1999). TB is curable though – and prevalence has fallen by 80% in three years in developing countries that have adopted effective control measures (Frieden, 2002). Public health measures such as improving sanitation, diet and housing, and preventing HIV/AIDS are key measures in tackling TB, alongside full implementation of the DOTS strategy.

Diarrhoeal disease

'More than 13 million children have died through diarrhoeal disease in the past decade.'

UNDP Human Development Report 2003.

Diarrhoeal disease is still one of the leading causes of death each year, particularly in children. It is estimated that diarrhoea causes up to 21% of all deaths in under-five-year-olds. However, disease and death due to diarrhoea are preventable with oral rehydration therapy: a simple mix of sugar, salt and water. Progress has been made to reduce deaths through improved nutrition, promotion of breastfeeding and better supplemental feeding, female education, measles vaccination and improvements in hygiene and sanitation.

‘When we first arrived, one of the chief doctors posed the question, “What is the difference between poverty and culture?” We looked over the Indians’ ramshackle housing – flimsy huts of wood and rusted corrugated sheet metal – their woefully inadequate water supply, their absence of separate sewage systems, and their torn clothing... We saw lack of hygiene manifest itself in the levels of typhoid and cholera. It was hard to believe the things we were seeing were real. We had to re-evaluate everything that we knew, or thought we knew, about the role of medicine and its practice...

‘The Indians are wary of external help and interference from people who have denied them equality for generations, view them as separate to the rest of their society and were happy for things to stay that way.

‘So what can we take from our elective? We experienced an existence neither of us could comprehend – that is, poverty rooted in a bed of politics, culture and bureaucracy. We learnt an important lesson – a great deal more is needed to improve the health of a sub-population than the clinical skills of the doctors present.’

Mohit Kaushal, Christopher Niranjana
Elective in Indigenous Reservation, Costa Rica

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Find out more

Global Fund to fight AIDS, Tuberculosis and Malaria
www.theglobalfund.org

Roll Back Malaria
www.rbm.who.int

A partnership between the WHO, UNDP, UNICEF and the World Bank to coordinate action against malaria.

Stop TB Partnership
www.stoptb.org

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CAUTION
AIDS IS REAL
SPREAD LOVE
NOT AIDS

HIV/AIDS

the **modern plague?**

HIV/AIDS: the Modern Plague?

25 million deaths to date

38 million infected

14 million orphans worldwide

3 million children are sufferers

'Much of the decline in human development throughout the 1990s can be traced to the spread of HIV/AIDS.'

UNDP Human Development Report 2003

HIV/AIDS is a tragedy. Today 8,000 people died of this disease. It has become a disease of poverty among many others: 90% of those with HIV/ AIDS live in the developing world. If you spend your elective in a low-income country, you will almost certainly see many patients suffering from the complications of the virus. The effects of HIV/AIDS are often compounded by poverty, poor nutrition and other infections such as malaria.

'HIV/AIDS has reduced life expectancy from 62 to 47 in sub-Saharan Africa'

UNAIDS, 2002

In poor countries, the majority of people who contract the virus are heterosexual and in their most productive years: 15–49. There has been a dramatic increase in infections among women in recent years – there is now a 1:1 ratio in many African countries. HIV/AIDS has had devastating effects on the social and economic fabric of a country. In some parts of Africa, children are dying before their grandparents. When one or more parents die, the children have a higher risk of severe illness and mortality.

In schools and hospitals, teachers, nurses and doctors are being lost to the virus. One study in Zimbabwe showed that 19% of male teachers and 29% of female teachers were infected (UNAIDS, 2002). In Malawi and Zambia illness and death rates among health workers have risen 5–6 fold. A recruitment crisis is happening in some African countries – new staff simply cannot be trained fast enough. Future effects on the economy are uncertain, though it has been estimated that in those countries with HIV rates higher than 20%, annual GDP falls by 2.6%.

Why?

No single factor accounts for the scale of the epidemic. Most cases of HIV/AIDS are transmitted sexually and a wide variety of factors influence sexual behaviour. Migration of male workers from rural areas to the cities increases risk behaviour as migrant men often visit commercial sex workers. In many cases these men will then return to their wives and pass the infection to them. A culture of stigma and discrimination about the disease itself means that few people are tested and only become aware of their HIV status when they become ill. Condom use is not common, particularly between married couples, and the low status of women means they often have little control over contraception use.

Many commentators have argued that with HIV/AIDS, as with many other health problems, the problem is money. The countries where the disease is most prevalent are also among the world's poorest. Resources to provide and coordinate educational, social and medical actions to tackle the disease are in short supply. Gaps in the funding for HIV/AIDS prevention in six African countries ranged from US\$50 million to US\$200 million. Even in richer countries, such as the UK, where a concerted public health effort controlled the spread of the virus in the past, the incidence of HIV/AIDS is increasing again.

'From day one I became accustomed to feeling for an enlarged spleen and lymph nodes in any child, for in sub-Saharan Africa these are the characteristic signs of probable 'retroviral' disease: HIV. AIDS is very prevalent in the hospital population. I recall the morning when one of the doctors in the paediatric gastroenterology ward got back a negative test result on one of the children. The doctors were so surprised they were talking about it for days... So familiar is the story that suspicions are raised immediately any child is brought into hospital by Gogo (grandmother). Where is the mother? All too often she has died, leaving her child this deadly legacy.'

Andrew Brent, Elective in South Africa.

Tackling HIV/AIDS: future actions

The commitment to fighting HIV/AIDS from national governments in the last decade has been remarkable and there are success stories to be told. Uganda has reduced HIV prevalence from 14% to 5% in less than a decade (UNDP 2002, Lancet 2004). Brazil has successfully contradicted the infection levels forecast ten years ago, with a commitment to a legal right to free, affordable HIV medication. Annual AIDS deaths in Brazil are now a third of what they were in 1996. Tackling the epidemic depends on coordination of intervention in many areas of society: in the family, the school, the health centre and the workplace. Behaviour change must take place on a large scale to tackle the risk behaviour that contributes to the spread of the virus. However, for this to occur women must be empowered to be able to make choices about their bodies. This means educating both young women and young men, and encouraging delaying the age of marriage.

Effective reproductive health services must also be available to make appropriate contraception available and to treat existing sexually transmitted diseases that increase the transmission of HIV. Fighting the stigma associated with the disease is vital to encourage those at risk to seek testing and

treatment. Effective antiretrovirals must be made available to prevent mother-to-child transmission of HIV and for treatment of AIDS. To tackle the problem of low access to antiretrovirals, in 2003 the WHO began the 3 by 5 Initiative, which aims to provide antiretroviral treatment to three million people living with AIDS in developing and transition countries by the end of 2005.

Much research is also being done into a possible AIDS vaccine, though the prospect still seems a long way off. The International AIDS Vaccine Initiative, a broad partnership between the WHO, World Bank, health ministries, research institutions and NGOs, continues to carry out much of this work. Access to any future vaccine and the continued prevention of HIV/AIDS, like access to antiretrovirals, will be dependent on strong, effective health infrastructure and services and continued political commitment.

'All but one... John Phiri is 18 months old. He is in a children's ward of the District Hospital in Malawi. He is suffering from a fever and is fatally dehydrated. Madrind, his mother, is also sick with the virus. She is John's "guardian" but she is so weak she can barely look after herself. Three of Madrind's five children and her husband have already died, as will John soon. Only her oldest boy Alinafe – whose name ironically means "God is with us" in Chewa – who is six, will possibly survive.'

Mendel, 2003

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Find out more

Action Aid

www.actionaid.org

Information about their current campaigns and a photo exhibition of Gideon Mendel's photo report from sub-Saharan Africa.

Global Fund to fight AIDS, Tuberculosis and Malaria

www.theglobalfund.org

Johns Hopkins University AIDS Network

www.hopkins-aids.edu

Useful and up-to-date medically-oriented information about HIV/AIDS.

Médecins Sans Frontières

www.msf.org

Information about the campaign for access to HIV/AIDS medicines.

National AIDS Trust

www.nat.org.uk

Find out about the theme for this year's world AIDS day and find out about current international campaigns.

UNAIDS

www.unaids.org

The UN Joint Programme on HIV/AIDS. Its annual reports are especially useful for country by country statistics on the epidemic.

UK Consortium on AIDS and International Development

www.aidsconsortium.org.uk

UK-based NGO with a useful research-focussed site.

WHO 3 by 5 Initiative

www.who.int/3by5/

Information on the global initiative to get three million people living with HIV/AIDS in developing and transition countries on to antiretroviral treatment by 2005.

My elective in Mozambique

Kim Sigaloff describes the ups and downs of spending her elective in one of Africa's poorest countries.

In March/April 2003, I spent an elective rotation working in the Internal Medicine department of the Maputo Central Hospital in Mozambique. Mozambique, on the eastern coast of southern Africa, has been ravaged by civil war until relatively recently. Although the official language is Portuguese, most of the doctors speak at least some English (about half of the medics are foreigners). Many of the patients speak only Shangaan or Ronga, the local African languages.

I was shocked by the impoverished state of the hospital, and even more so by the severity of the conditions which patients were suffering. The yearly budget is said to be approximately US\$7 million. The tight budget results in low salaries for the medical staff, a lack of equipment and an erratic supply of consumables. HIV/AIDS is the most common disease on the internal medicine ward. Sixty per

cent of hospital beds are taken up with seropositive patients. It manifests itself as TB, Kaposi's sarcoma, pneumonia, meningitis and various types of fungal infections. Antiretroviral treatment is available for only the very few patients who can afford it.

I imagine that being a patient in this hospital must be very difficult. It is very common that patients see one of their neighbours (in a room of ten) die each day. It was rare to see patients being discharged. When a lot of patients were admitted at once, mattresses were put on the floor in the middle of the ward. Distribution of food was inefficient, with patients having to rely on their family to feed them. The bedside manner of the doctors was often inadequate with little time spent communicating to patients. The system certainly has its organisational faults, though the doctors do their best, given the circumstances.

It was difficult to play the role of a student-observer in the hospital for

very long without becoming frustrated. When you see so much suffering around you it is very hard to accept that you are merely a medical student and can do hardly anything to help. Certain lessons learned translate directly to the practice of medicine in a Western hospital. The fear severely ill people experience must be universal. Because people are poor, struggling to stay alive or to feed their families does not mean that psychological factors become less important.

The overall impression of my stay was positive. Even though facilities are poor, supplies unreliable and the illnesses serious, Mozambicans don't consider the situation to be hopeless. Faced with such conditions and problems in Europe, we would probably be tempted to give up, but here, efforts continue to be made for the patients, and most are not in vain.

Kim Sigaloff,
Elective in Mozambique

chapter six

bitter pills
access to essential
medicines

bitter pills: access to essential medicines

Medicines are big business. The pharmaceutical companies, collectively termed ‘Big Pharma’, enjoy some of the highest profits of all industries and the annual turnover of the largest companies dwarfs the national income of most developing countries.

Table 4: Big pharma and big profits

GlaxoSmithKline	US\$29.8 billion *
Bristol-Myers Squibb	US\$19.4 billion
Roche	US\$15.6 billion
Kenya	US\$10.7 billion **
Zimbabwe	US\$6.3 billion
* turnover/year	** gross national income

Essential drugs remain priced out of reach of the majority of patients in developing countries and research into new treatments for the diseases of the poor – TB, malaria and leishmaniasis (Kala Azar), for example – is neglected. It is estimated that one-third of the world’s population lack access to essential medicines. The journey of a drug from its conception and development to the patient is complex and there are many weak links in the chain.

Table 5: From idea to patient: the drug development chain

1.	Research and Development
2.	Production
3.	Quality control
4.	Distribution
5.	Information and marketing to health workers and the public
6.	Adequate storage of medicines
7.	Prescribing
8.	Dispensing via the pharmacy
9.	Financial accessibility: can the patient pay?
10.	Availability

Research and development of medicines for the poor

A study published in the Lancet found that between 1975 and 1999, 1,393 new medicines were developed and brought to market. Of these, only 16 were for tropical diseases and TB (Trouiller et al, 2002). Private companies exist to make a profit and logic follows that they will focus research and development efforts on money-spinning medicines for diseases of affluent countries and lifestyle drugs such as medicines for baldness or erectile dysfunction. As some diseases are consigned to the past in the West, production of medicines to treat them has been abandoned, as it is unprofitable.

‘Doctors in poor countries are forced to use old and ineffective treatment on patients who are dying of treatable disease because profit, not need, is driving the development of new medicines.’

Morten Rostrup, International Council President of Médecins Sans Frontières

The major neglected diseases are malaria, TB and sleeping sickness. It can take many years for new drugs to reach the market and there are virtually none in current development. To make matters worse, resistance to old medicines is increasing. Sleeping sickness affects 500,000 people per year in Africa alone, 60 million remain at risk and incidence is increasing. Yet the only available treatment is arsenic-based compounds and the disease is increasingly resistant to these. Production of the most effective medicine, eflornithine, is no longer profitable and has been abandoned. This demonstrates how, even though the treatment is known to be effective for a disease that is killing 150,000 people a year, profits dictate whether it is produced or not. Incidentally, eflornithine is still manufactured in cream form, which

is sold as an effective hair remover in the US. The WHO acquired the license from Aventis, the patent holder, in 1998, and it has since been trying to find a company to manufacture the drug long-term.

This example shows us how our knowledge and technology in medicine is often not used to save lives. Market forces and big business do not work for health but for money. New ways need to be found to encourage research into these neglected diseases. Recent years have seen new collaborations between the public and private sectors to fund this. The Drugs for Neglected Diseases Initiative, launched in 2003, is a partnership between WHO, MSF, research centres in developing countries and drug companies. It will work to encourage research and development of new drugs for diseases of the poor.

Financial constraints: from health centre to patient

Even where the drugs and equipment already exist, financial constraints mean that doctors and health staff are simply unable to get their hands on them. A medical student on elective in Zimbabwe reported the following situation:

'Patients are routinely given prescriptions for drugs, rather than drugs themselves. Supplies of drugs, antibiotics, alcohol for swabs and reliable blood regularly run out and cannot be replaced. Even gloves, drips and syringes are in short supply, exposing both patients and medical staff to body fluids in a country where HIV is officially acknowledged to infect 25% of the population and is probably nearer double that. Elective patients are routinely turned away because of lack of pethidine or morphine.'

Iain McNamara, Elective in Zimbabwe

The generic producers versus Big Pharma: the case of HIV/AIDS drugs and global trade rules

Domestic production of essential drugs is also one route forward to ensuring access to medicines. India and Brazil are two examples of countries with flourishing pharmaceutical industries producing affordable non-branded (generic) medicines. Increased competition from these manufacturers has resulted in a dramatic reduction in the cost of antiretrovirals – from US\$10,000 per year to US\$200 per year today (MSF, 2002). Developing country governments have successfully confronted massive opposition from US and European drug companies to defend their right to produce cheap drugs.

The TRIPs agreement formed the basis for their complaints. This is a set of rules laid down by the World Trade Organization to protect intellectual property rights. Medicines were initially considered like all other goods under this agreement. This allowed the patent holder of a drug to control its price for 20 years and to monopolise production. This, argue the big pharmaceutical companies, provides them with the resources to continue research and development into new drugs. Drug access campaigners respond that most 'new' drugs are not in fact new drugs at all, but modified versions of old ones. In addition more than half of the costs of R&D are met by the public sector. This was the case for Zidovudine, which prevents mother-to-child transmission of HIV, but was still priced out of the reach of many developing country governments.

'Young girls – our children, our grandchildren – they are dying before we die.'

Elizabeth Chipepa, a 79-year-old Zambian woman who is raising her three great-grandchildren after her grand daughter died of AIDS (www.iavi.org, 2003).

The big drug companies sought to prevent smaller manufacturers in developing countries from producing identical drugs for HIV/AIDS. A case was brought against the South African government for permitting cheap production of antiretrovirals (ARVs). This was in the face of a mounting loss of life in South Africa and at a time when the cost of ARVs for one

year was US\$10,000. The case was spectacularly dropped at the last minute after worldwide outrage, setting an important precedent. In Doha in 2002, the WTO's member states agreed that governments were free to 'take all necessary measures to protect public health' and that the TRIPs agreement should be implemented in a manner 'supportive of WTO members' right to promote access to medicines for all'. This is an important step forward. The introduction of generic ARVs has seen them priced within the reach of millions more. Largely as a result, Brazil has reduced deaths from AIDS by 82%.

'I witnessed how a mother took her son, who was suffering from methicillin-resistant Staphylococcus aureus, home to die, since she was not able to afford the treatment with the necessary antibiotic, vancomycin. I had not expected situations like this in a country that still prides itself as "socialist."'

Carsten Flohr, Elective in Vietnam

During an elective in a developing country, you will witness difficulties faced by patients and health staff in securing drugs. Patients may be unable to pay for their prescription, or the drug may simply be off the shelves, discontinued or priced out of range of health budgets. In many countries, patients simply self-prescribe, preferring to buy drugs from local pharmacies. There are well-known problems with substandard or counterfeit drugs in developing countries, meaning treatments are less effective or even harmful. It is important to remember the global as well as the local forces that prevent the poorest from accessing essential medicines. New strategies will be vital to tackle the lack of attention given to medicines for diseases of poverty.

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Find out more

Global Fund to fight AIDS, Tuberculosis and Malaria
www.theglobalfund.org

International AIDS Vaccines Initiative
www.iavi.org
One of the global vaccine partnerships

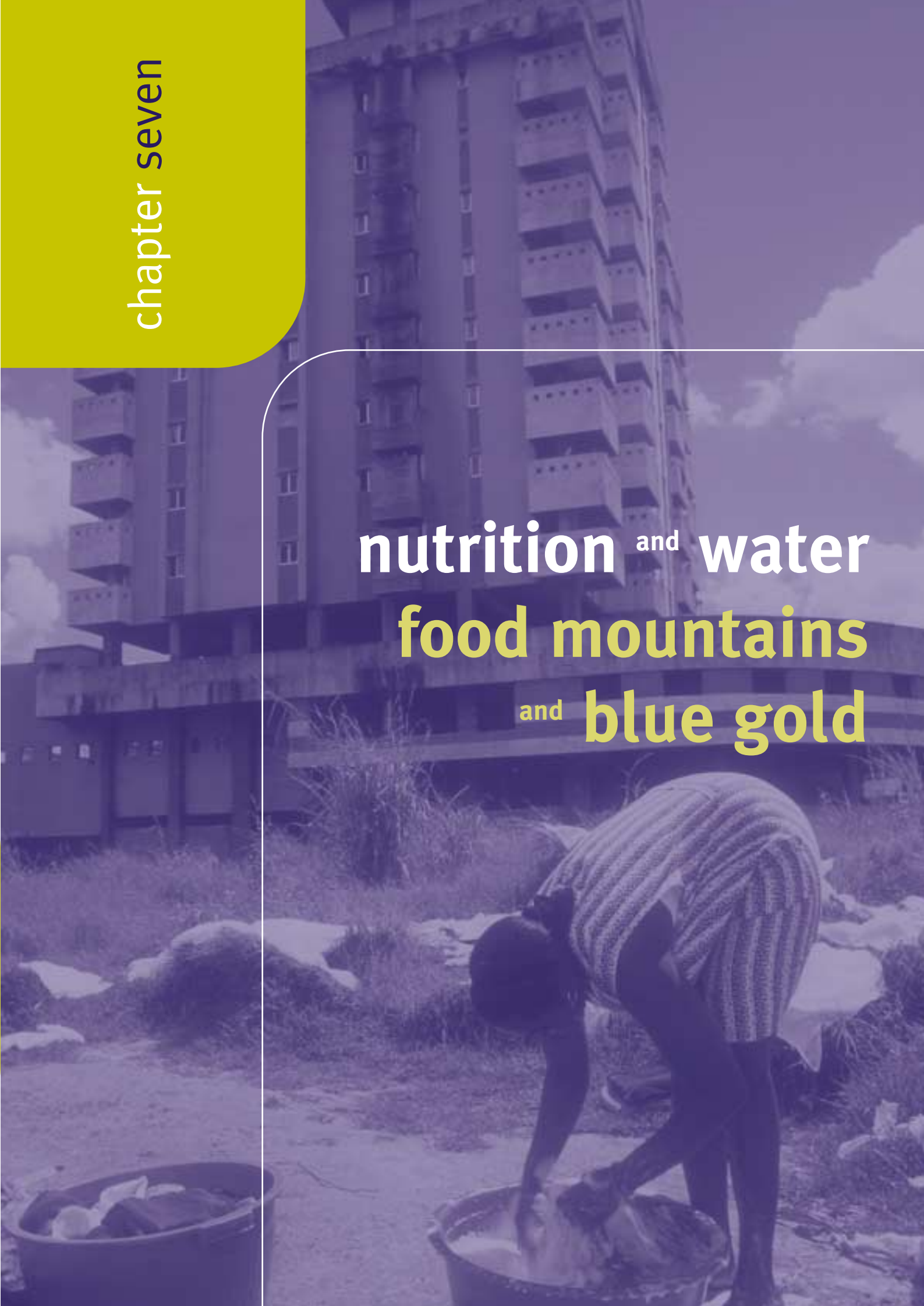
Médecins Sans Frontières
www.msf.org
Essential website for information on the campaign for essential drugs

World Health Organization
www.who.int
The latest Essential Drug List

World Trade Organization
www.wto.org
Information on TRIPs

chapter seven

nutrition and **water**
food mountains
and **blue gold**



nutrition and water: food mountains and blue gold

The world produces enough grain for 3,600 calories per person per day. Why, then, do people still go hungry?

More than one-fifth of the world's population are chronically hungry, at risk of dying from lack of food or diseases linked to malnutrition. Malnutrition has its greatest impact on young, rapidly growing infants and children, with dire consequences for their physical and mental development. In addition, poor growth at this stage of life is later associated with complicated labour and therefore increased maternal and perinatal mortality. Undernourishment during pregnancy and lactation also leads to increased maternal and foetal mortality.

Undernutrition and disease go hand in hand, with the same underlying causes. One can not be treated without also considering the other.

The problem isn't that we don't produce enough food; in fact the world produces enough grain for 3,600 calories per person per day. The problem is distribution. Whereas a third of adults in some developed countries are overweight, the majority in developing countries are undernourished. This unequal consumption explains why, according to Oxfam, there is actually a net flow of food from the poorest countries to the richer ones: our overconsumption and strong purchasing power determine other countries' food intake. But even where there is enough food, much of the population may go hungry simply because they are poor.

Many look to the agricultural sector to solve the problem of hunger. The Green Revolution and genetically modified foods have been put forward as solutions to the problem of world hunger. However, some would argue that the dependence on expensive

sources of seeds and the potential risks posed by GM foods might actually add to the problems of food security. This would suggest that diversification, to reduce vulnerability to environmental extremes and improve long-term security, would be more beneficial.

Famine

Famine is often thought of as a sudden, extreme event, caused by an environmental disaster such as a drought. In fact, famines often occur without any reduction in food output. The Ethiopian famine of 1973 actually occurred in a year of increased agricultural output, according to one of the world's leading voices on famine, Nobel Prize winner Amartya Sen (Sen, 1981).

Famines occur due to a reduction of what are known as people's 'entitlements' to food. This may occur as a result of their crops failing year on year, loss of their security in terms of livestock, or loss of their employment and therefore their ability to purchase food. Only a proportion of the population is ever affected, so the key is once again market forces, which direct available food towards the wealthy (often in urban areas) and away from the rural poor.

'No famine has ever occurred in a properly functioning democracy.'

Sen, 1981

Famines are not actually difficult to avert. In the past India suffered from regular famines but now, despite the prevalence of chronic hunger, they are a thing of the past. Only sub-Saharan Africa, in particular Ethiopia and Sudan, continues to suffer famines. The reasons are a combination of poor early warning systems; poor infrastructure to transport food from areas of plenty to areas of deficiency; and a lack of accountability between the government and its people.

Field notes from Ethiopia: the problems of treating severe malnutrition during nutritional emergencies

At present, all emergency feeding programmes depend upon Therapeutic Feeding Centres (TFCs), where inpatients receive Formula 75 and Formula 100, highly appropriate therapeutic milks, in quantities tailored to the individual's needs. Medical and supportive care complements this essential, as patients present with a complicated picture of malnutrition with associated septicaemia, hypothermia, hypoglycaemia or severe dehydration. However, severe malnutrition is a complex condition with important economic, psychological and social elements. The medical emphasis of the TFC model of care ignores these other aspects of the condition and in doing so often inadvertently aggravates the situation.

TFCs require huge amounts of resources, skilled staff and imported treatment products meaning they are very expensive and highly dependent upon external support. This central approach to care and high staff requirements undermine local health infrastructure, disempower communities and promote the congregation of people. Congregation of severely malnourished patients inside the centres promotes infection. The congregation of communities around TFCs promotes breakdowns in public health, an

important cause of mortality and morbidity during famine. Admission of a child into a feeding centre requires that the carer, usually the mother, leave the family for approximately 30 days. Given a mother's importance to household food security and food supply, it is likely that the negative impacts are profound. This would be particularly damaging for younger siblings, many of whom might also be moderately malnourished.

My recent trip to Ethiopia, to assist a large international NGO in planning and setting up emergency famine relief programmes in a small highland district, illustrates the limits of TFCs. The target population was 400,000 people living within a 40km radius of the district town. Approximately 20% were under five years of age and the estimated prevalence of severe malnutrition was 20%. Therefore 16,000 severely malnourished children required therapeutic feeding. Internationally accepted standards stipulate that a TFC should have a maximum capacity of 100 inpatients and one carer for every ten patients. To treat this number of people according to these standards would have required 40 TFCs operating at full capacity for four months, with 40 skilled centre managers, at least 20 logisticians, 160 nurses and 400 carers.

No agency, be they UN, Red Cross or NGO, could implement a quality programme of this size. Even if it were possible, the huge

requirements for skilled local staff would place intolerable demands on the local health infrastructure. In the event, our TFC programme took several months to become operational and never achieved a capacity of more than 100 patients. Data on mortality do not exist, but most people involved with the programme believe that many of the children must have died before adequate treatment became available.

During the summer of 2000, similar problems with coverage limited the impact of many of the TFC programmes in Ethiopia. By September, two months after the peak of the nutritional crisis, agencies had finally started scores of TFCs throughout the country. These TFC programmes will last approximately six months and the majority will be due to close between January and April 2001. This coincides with the hunger gap in the area, during which time the numbers of severely malnourished will probably increase.

This poses difficult problems for agencies. Should TFCs remain open to cater for the growing numbers and risk being drawn into prolonged costly interventions? Alternatively, should they close just as the need for them increases? Neither solution is desirable.

Kate Sadler, *Nutritionist with Valid International and the Centre of International Child Health at the Institute of Child Health, University College London*

Water and sanitation

There is no hunger where there is water

There are more than one billion people without access to safe water and another two billion without sanitation, most of whom live in sub-Saharan Africa and Asia.

The consequences of this are extreme. Dirty water is responsible for 6,000 child deaths each day due to diarrhoeal disease. Where little water is available, farms are unproductive and women have to spend their days collecting and carrying water instead of working and caring for their families. This often involves a day-long expedition, starting before dawn, carrying a crippling weight of water. The consequences for women's health and that of their families and communities are huge. The importance of water may be seen in the transformation of a community after a water source is installed. Productivity increases, bringing wealth that may be used for community projects such as schools; women are able to work and care for their families; and simple things like bathing, washing clothes or cleaning are no longer huge tasks.

Poor sanitation is another major reason behind the high rates of infectious diseases experienced in developing countries.

Travelling in a developing country, particularly early in the morning, you will probably see people squatting in fields, by roads or railway lines and on beaches. This is partly due to tradition, but also because of economic reasons and cultural objections to latrines. Where they are installed, superstition and embarrassment may prevent them from being used, and, of course, they may be expensive to install in the first place. However, the simple toilet can make a huge difference to rural and urban communities alike. Burying faeces in a selected location can prevent contamination of water supplies and reduce the incidence of cholera, worms and diarrhoeal disease. Using a covered latrine will reduce flies and bad smells. And certain latrine models also enable production of safe, nutrient-rich fertiliser.

The Millennium Development Goals aim to halve the number of people without safe drinking water and basic sanitation by the year 2015. In some countries, such as South Africa, this has already been surpassed, demonstrating that when made a major priority, this goal is realistic. Access to water and sanitation has now been recognised as a human right and so will hopefully be a higher priority in the future. Investing in clean water is a hugely cost-effective and well-proven route to health for all members of society.

Bottle feeding and malnutrition

Breastfeeding is still on the decline in many developing countries, despite the protection it offers against infection, its contraceptive value, its low cost and the emotional and psychological bond it helps to develop between mother and baby.

Despite the fact that even malnourished mothers produce high-quality milk, many women are convinced that their milk is inferior to that which comes in a well-packaged and well-advertised tin. You will probably see tins of baby milk with pictures of plump, healthy babies on sale in the developing country you visit. The cost compared to the price of staple foods will probably be quite astounding. It is therefore not surprising that women have to overdilute it to make it go further.

'Can a product which requires clean water, good sanitation, adequate family income and literate parents to follow printed instructions, be properly and safely used in areas where the water is contaminated, sewage runs in the streets, poverty is severe and illiteracy is high?'

Edward Kennedy, 1978

Waterborne diseases fed straight to immunocompromised babies cause what are now common conditions in many parts of the world – diarrhoea, vomiting, respiratory infections, malnutrition, dehydration and commonly death – known as Bottle-Baby disease.

4,000 babies die each day as a direct result of bottle-feeding

Nonetheless, many companies continue to break the WHO/UNICEF International Code of Marketing of Breast Milk Substitutes, advertising direct to consumers and also via hospitals where you will still see free samples and posters put up in return for equipment and sponsorship.

For more information see www.ibfan.org

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Sen A. *Poverty and Famines: An Essay on Entitlement and Deprivation*. Oxford: Clarendon Press; 1981.

Find out more

Food and Agriculture Organization

www.fao.org

United Nations agency working to reduce world hunger. Their annual 'State of...' publications offer a good background to food security, world fisheries, forests and agriculture.

Green Cross International

www.greencrossinternational.net

NGO campaigning for access to water. The website has a 'water clock' that counts down to the achievement of the Millennium Development Goals.

Hunger Notes

www.worldhunger.org

Website providing information about the state of world hunger, food security and trade distortions with contributions from every region of the world.

International Baby Food Action Network

www.ibfan.org

Public action group working to improve infant and child health through the promotion of optimal feeding practices.

Water Aid

www.wateraid.org

International NGO working for improved access to safe water and better sanitation for the world's poorest. Their website has wide variety of information as well as offering opportunities to get involved with campaigning and fund-raising.

World Health Organization

www.who.int/archives/who50/en/prevention.htm

Find out the achievements of the World Health Organization during its 50th anniversary (1948-1998), 50 years of International Public Health.

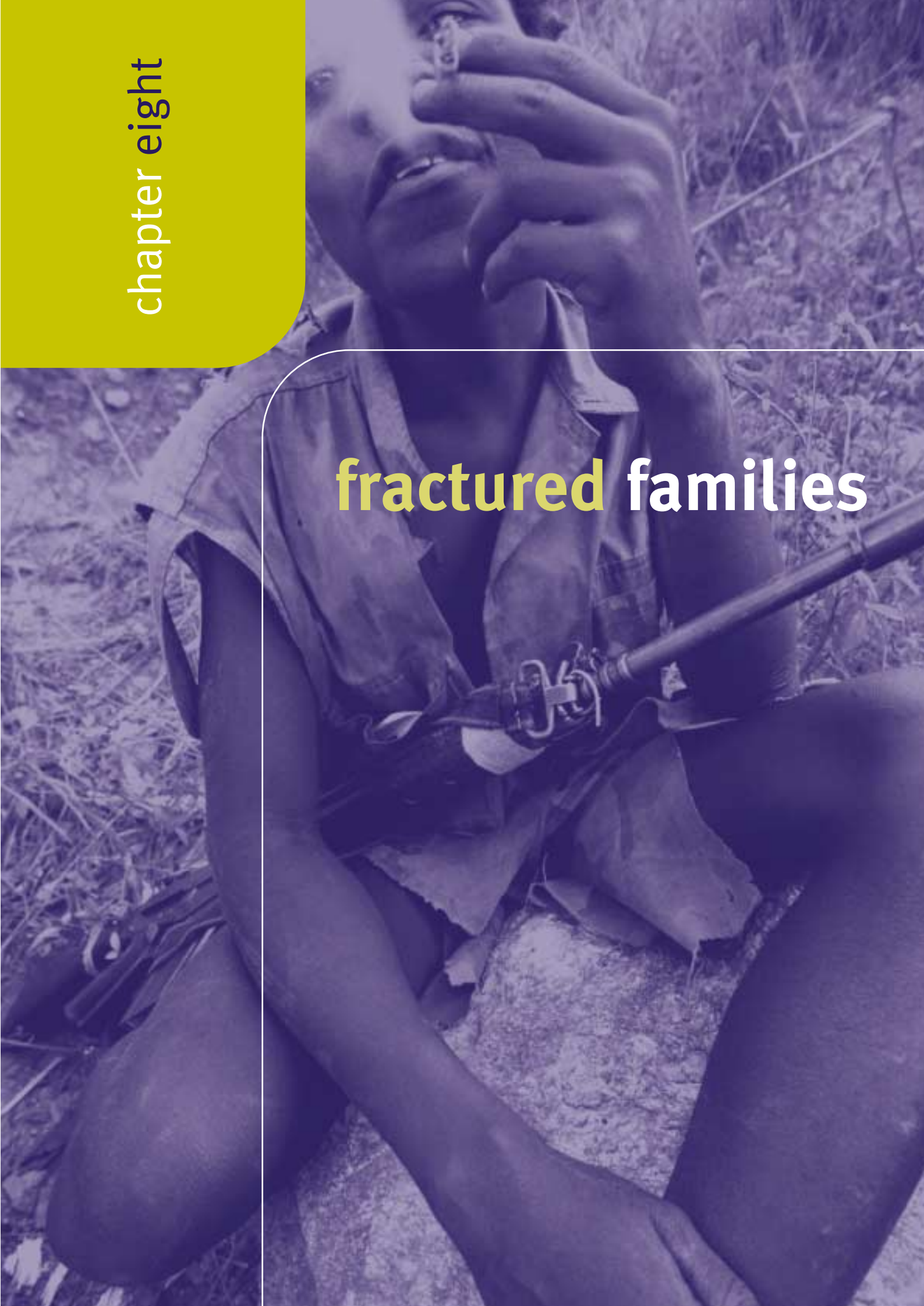
World Water Council

www.worldwatercouncil.org

International think tank on water and development issues.

chapter eight

fractured families



fractured families

During the minute you spend reading this page, at least 20 children will have died. None of these children will have reached their fifth birthday and 18 of them will live in the developing world. Almost all of their deaths were preventable.

Maternal mortality remains astonishingly high in developing countries and millions of women each year suffer serious ill-health as a result of childbirth. Interventions to reduce maternal and infant mortality are well-known and tried and tested in richer countries, but poor women face many barriers to accessing the care that is needed. HIV/AIDS among pregnant women is a serious problem; in Botswana, one of the worst affected countries, an average of 34% of pregnant women aged between 15 and 24 years are affected (UNAIDS, 2002).

In every country of the world, women and children have the greatest need for adequate health services. More than any other indicator of health, maternal and infant death rates demonstrate the difference between the rich and the poor. In a woman's lifetime, the risk of dying during pregnancy or childbirth is one in 9200 in Spain, whereas in Nepal this risk is one in ten (Save the Children US, 2000).

Why do women die in childbirth?

Motherhood can be dangerous. 600,000 women die each year and 15 million are left with long-term, serious illnesses from their pregnancy (WHO and UNICEF, 1996). The main causes are preventable: bleeding, infection, hypertension, prolonged labour and unsafe abortion. Yet too few women receive adequate care during their pregnancy and especially

in the crucial period after they give birth. The health of the newborn starts with the health of the mother: complications of childbirth and pregnancy contribute to a shocking 1.5–2 million babies' deaths in the first week of life per year (Safe Motherhood, 1997). The WHO Mother-Baby Package describes four core interventions in the health sector: family planning, quality antenatal care, a clean, safe delivery and access to essential obstetric care in case of emergency. Currently too few women receive adequate care: in less-developed regions 35% of women receive no antenatal care at all and an estimated 42% of women deliver without a skilled attendant (WHO, 2001).

Status of women

A purely medical analysis of mother and child health is in danger of ignoring the inequalities that exist between men and women across the world today. These are certainly more evident in poorer countries. From birth, girls and women receive poorer nutrition, education and health care. They carry out 67% of the world's labour, yet earn 1% of income and own 1% of the world's property (Zapata and Bennett, 1997). Globally, more than two-thirds of the illiterate are female. Evidence from countries such as Sri Lanka, where women enjoy relatively good education and social freedoms, has shown that improving the status of women is one of the most important routes to improving life expectancy and reducing poverty. Of all the indicators of development, the one which correlates most strongly with life expectancy is female literacy.

*'If you educate one woman,
you educate a family.'*

Sonia Lewycka, a technical adviser with the Mwai Mwana project in Malawi, is working with women's groups to bring about better newborn care and reduce mother-to-child transmission of HIV. She describes some of the reasons why women don't receive this life-saving care.

There are many proven interventions which can reduce maternal and neonatal deaths, but with so few women actually attending health services for antenatal care, delivery or post-delivery care, it is difficult to get these services to them. In Malawi, around half of women deliver at home, and there are many barriers to them accessing

appropriate health services. For some, it is simply that transport, food, a new chitenge (a piece of cloth) to wrap the baby and other economic factors prevent women from making the journey to a health facility. For others, there are strong cultural barriers. For example, in parts of Malawi it is believed that a woman should give birth to her first-born child at home. With many women getting married very young, the potential for complications with a first-born child is increased. Delays in seeking health care when there is a complication can also arise if women prefer to see a traditional practitioner first. Women say, "don't tell the doctors this, but the nurses shout at us so we

don't like coming here..." The nurses themselves are over-worked and underpaid and often low in morale. Attrition due to HIV, as in other public sectors, puts an enormous extra burden on the system.

So as well as improving essential obstetric and neonatal services in facilities, there is also a need to focus on increasing uptake of health services through community-based initiatives.

Sonia Lewycka, *Technical Adviser Mwai Mwana Mother and Child Health Project, Malawi, and Institute of Child Health, University College London*

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Find out more

Family Health International
www.fhi.org

Johns Hopkins Program for International Education in Reproductive Health
www.jhpiego.org
Research centre with a focus on reproductive health

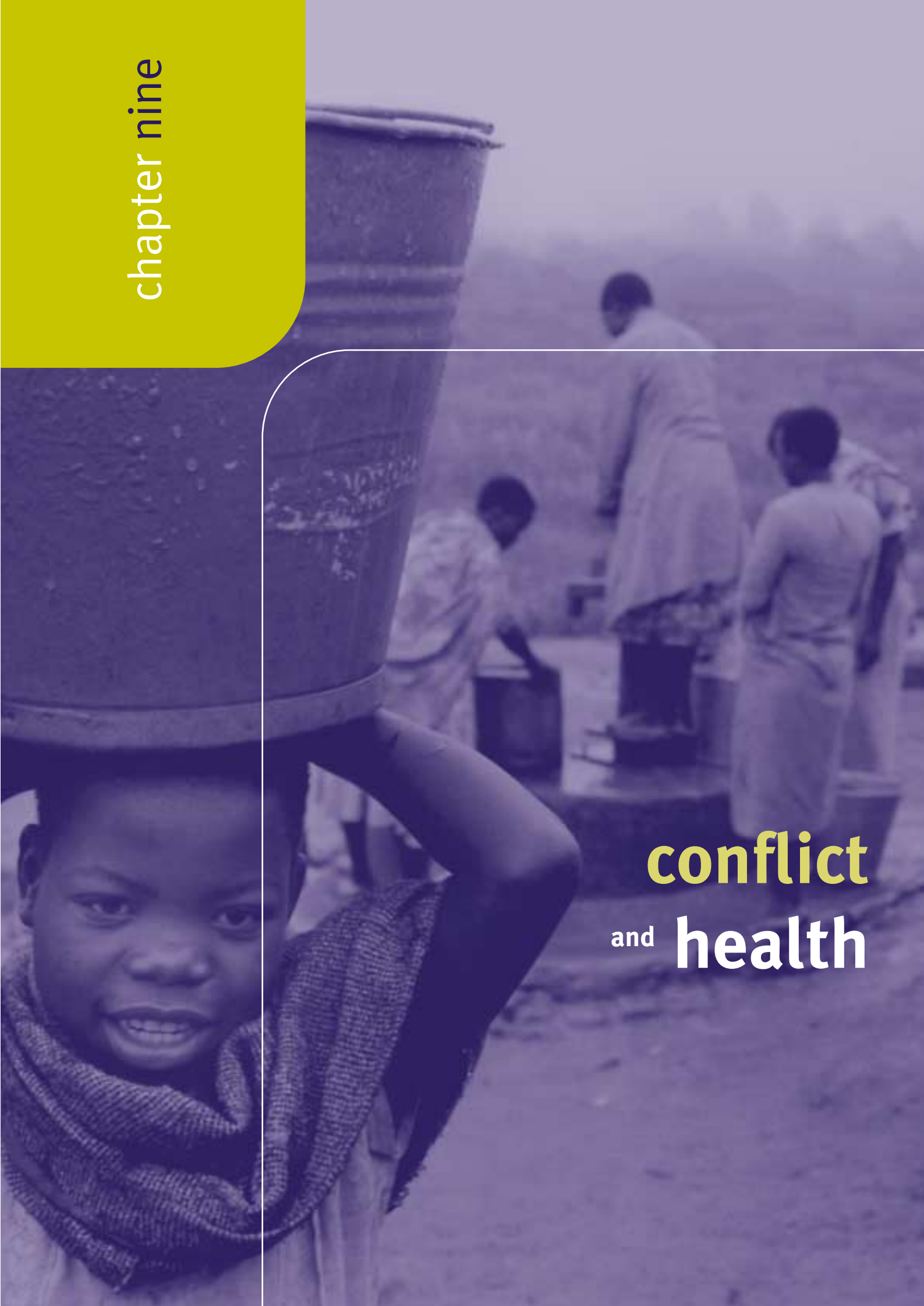
Save the Children UK
www.scfuk.org.uk

Save the Children US
www.savethechildren.org
Current research and campaigns for child health and welfare

UNICEF
www.unicef.org
Especially State of the World's Children, their annual report with country by country statistics.

WHO database
www.softgeneva.ch/RHR
Maternal health statistics for every country and region

chapter nine

A photograph of a young girl in the foreground, looking directly at the camera with a slight smile. She is carrying a large, dark, cylindrical metal container on her head. She is wearing a dark, textured shawl or scarf. In the background, several other people are visible, some carrying similar containers, in what appears to be a dry, outdoor setting. The entire image has a purple tint.

conflict and health

conflict and health

The twentieth century was characterised by an unprecedented level of conflict and an accompanying movement of people fleeing violence, terror and oppression. Encouragingly, since the 1990s, peace and democracy have increased throughout the world. Recent troubles threaten this trend.

More and more, wars take place within states rather than between states. Increasingly, civilians are a target in ethnic conflicts. The killing of 800,000 people in 100 days of 1994 during the Rwandan genocide and the death camps of the Balkans are stark examples. Conflict in Afghanistan and Iraq and enduring troubles in Israel, West Africa, Indonesia and Colombia have left millions wounded, killed or displaced from their homes.

‘When elephants fight, the grass gets trampled.’

African proverb

These are just some of the stories. No region has been free from conflict. Violence directly harms health. War also destroys health systems; it cuts off supply routes and devastates physical infrastructure. Hospitals and health centres can be isolated without water, drugs, equipment and electricity. Preventive care is neglected: who can vaccinate their babies or have antenatal check-ups when even shelter, food and security are desperately uncertain? Sexual violence and physical and psychological torture of civilians are hallmarks of war.

Even after war is over, its legacy of destruction can continue. The use of toxic chemicals irreversibly damages health. In Vietnam, decades after the chemical Agent Orange was used by US forces, high rates of spina bifida and cancer persist among those exposed. The campaign for the worldwide abolition of landmines continues.

‘There is no peace without development, no development without peace.’

Kofi Annan, UN Secretary General

Forced to flee: the state of the world’s refugees

- 20 million refugees estimated by UNHCR
- Almost one in every 300 people on the planet is a refugee
- 5% seek asylum

‘A person who is outside his/her country of nationality or habitual residence; has a well-founded fear of persecution because of race, religion, nationality, membership in a particular social group or political opinion; and is unable or unwilling to avail himself/herself of the protection of that country, or to return there, for fear of persecution.’

Definition of a refugee, Article 1, Geneva Convention, 1951

Becoming a refugee overnight

My name is Shiv Prasad Adhikari. I am 22 years old and I am classified as a refugee.

According to WHO, 'health is a state of physical, mental and social well-being and not merely the absence of disease or infirmity'. During conflict and war, human rights abuses plunge people into hostile situations. Detention, torture, rape, psychological torment and propaganda compel a person to exist in a state of constant fear. Such a state adversely affects your spiritual as well as mental well-being. It takes away the joy of existence. It is a situation of hopelessness. Such is the history of the deteriorating health of my community, the Bhutanese refugee community.

Residing in makeshift huts, relying on charity to meet our daily needs for food, made us feel bewildered and confused. The makeshift dwellings provided by UNHCR are far from adequate. They are jam-packed with hardly any privacy. The camps are located in the Bhabar belt of the Terai, Nepal, where scorching heat, mosquito infestation, torrential rains, leaky roofs and lack of clothing add to the misery. Such an abnormal surrounding has hit hard the health of the unfortunate youth and children.

The various donor agencies are doing their best. But inadequate coordination means even ordinary communicable diseases like dysentery, diarrhoea, upper respiratory tract infections, pneumonia, are still out of control. Sex abuse, teenage

pregnancy and weak mothers bearing underweight, malnourished children have become commonplace. The mass unemployment, spreading crime and the lack of opportunity to lift ourselves up, means we fear for the future. Depression is widespread and suicide rates are high.

The commitment of donor agencies to my community decreases with every year. Despite our will, our efforts and the skills we possess, we are becoming a sick society. The world community, at this hour, cannot remain passive to the problems caused by conflict and forced movement of people.

Nobody chooses to be a refugee.

Shiv Prasad Adhikari, Nepal.

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Find out more

Amnesty International

www.amnesty.org

Research and action for preventing and ending human rights abuses worldwide. Useful for up to date country profiles and reports.

Centre for International Development and Conflict Management

www.cidcm.org

Research institute which publishes annual reports on the scale and effects of international conflict.

François-Xavier Bagnoud Center for Health and Human Rights

www.hsph.harvard.edu/fxbcenter

Research centre dedicated to health and human rights.

ICRC

www.icrc.org

The International Committee of the Red Cross is the oldest and perhaps best-known agency protecting and assisting people affected by armed conflict and civil war.

International Campaign to Ban Landmines

www.icbl.org

An international coalition of organisations campaigning for the abolition of landmines. Links to national sites and information.

Medact

www.medact.org

Medact's global Health Studies Curriculum contains an in-depth section on the links between conflict and health.

Medécins Sans Frontières

www.msf.org

Humanitarian aid agency which also raises awareness about the issues of access to essential drugs, trade laws, refugees and conflict.

Physicians for Human Rights USA

www.phrusa.org

An organisation of health professionals working for human rights.

The Refugee Council

www.refugeecouncil.org.uk

The largest UK agency providing advice and support to refugees and asylum seekers. The latest information about UK asylum policy.

UNHCHR

www.ohchr.org

The UN High Commissioner for Human Rights. The website has copies of international human rights treaties and reports by country on the state of human rights.

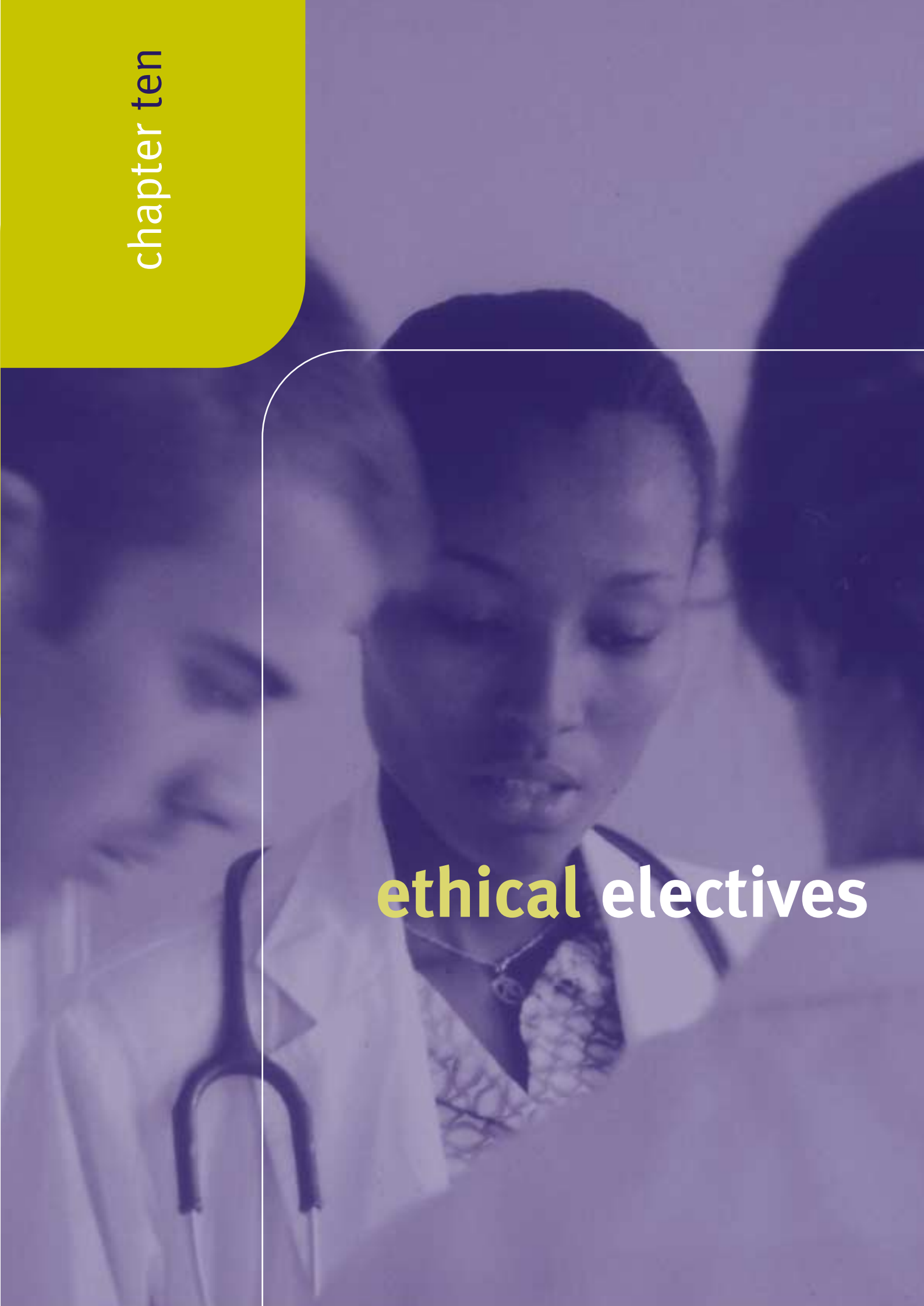
UNHCR

www.unhcr.ch

The UN High Commissioner for Refugees leads and coordinates action to protect the millions of refugees worldwide.

chapter ten

ethical electives



ethical electives

Many people say that going to a developing country for your elective means performing practical procedures and taking on responsibilities that you wouldn't be allowed at home. Some students avoid going to these same countries for fear of getting into situations that they wouldn't be able to handle. For a lot of students, recognising how much they are getting from their elective and not wanting to be a strain on the system makes them want to give something back and do something to help.

Doing things you wouldn't do at home is a very difficult ethical area. Students on elective to less-developed countries often find themselves being expected or asked to things they wouldn't normally do. Iain McNamara found himself on elective in Zimbabwe during a strike by junior doctors.

'I had spent the previous two years under training in the John Radcliffe Hospital, Oxford. Every stage of my development as a medical student had been carefully monitored by watchful senior staff. Suddenly, I had been elevated to qualified status in a foreign country. There was work to be done... My first ward round passed in a blur. This baptism of fire saw me performing procedures that I probably would never have done in the UK, and in conditions that are never seen in the UK.'

Iain McNamara, Elective in Zimbabwe

It is often worthwhile thinking about why you would not be willing to do this at home and about whether you are really capable of performing it alone. Supervision may be necessary to ensure safety, but carries the risk of taking important personnel away from their jobs.

Even situations you might feel confident dealing with at home may be beyond your abilities when the diseases, available treatments and social situations of patients are unfamiliar. If you are expecting to have to treat patients, make sure that you learn as much as possible about relevant diseases, the available treatments, public health issues and the social set-up before you go, and ask the advice of the people around you when you are there.

However much you may feel, 'I'm almost a doctor!', you're not. Every country has a registration procedure for medical professionals and would not allow someone to practice as a doctor without it. Even if people assume you have more knowledge than you do, and even call you 'Doctor', you should not take on this role and in particular should never let patients or staff think that you are qualified. This issue is less likely to come up if you are working in a larger teaching hospital, where medical students may have a better-defined role.

Some would argue that, even as a student, you have knowledge and skills which can be used for the good of others and therefore have a moral obligation to help. In a life-saving situation this certainly applies, and we all have a 'good citizen' duty to intervene. However, relief agencies have been criticised in the past for allowing medical students to work in emergency situations, even in the face of urgent need. It should therefore be the same for everyday clinical practice – except for the most urgent emergencies, if you're not qualified, don't do it.

As if all this wasn't enough, there are also legal issues to consider. Although there have been no cases brought against medical students on elective in low-income countries, there is a good reason why you

don't see students wielding a scalpel on elective in the US. As a student acting as a doctor, you are on questionable legal ground and would be in a very difficult situation if something went wrong. Perhaps we would hear of more law suits if the patients injured were wealthier, more vocal and aware of their rights. In fact, patients who find themselves being treated by elective students are likely to be the poorest, with the lowest expectations of health care. One student commented that the patients he was seeing expected to die and found it a pleasant surprise that someone was attending them. However, ultimately, giving patients the best possible care must be your first concern. No patients are obliged to help with your medical education, so they should always be given a choice and, of course, informed that you are a student.

It is also worthwhile considering the longer-term effects of helping out. The hospital may become dependent on students to fill in gaps, even downsizing its staff, leading to poorer patient care, particularly if, for some reason, students stop coming. An elective student who found herself filling in as a lone GP in rural India had no choice but to do her best, feeling she was the only option for her patients (Harris, 1998). In fact, within a short time, the organising charity stopped placing students at the request of local people, instead employing experienced doctors on long-term contracts (Greenwood, 1998).

The good news is that as students we have a lot to offer. In some situations, teaching English to health workers and students may be the most useful thing you can do. Where there are medical students, educating one another about your different knowledge areas is a real possibility and bringing teaching materials or learning aids may be a valuable longer-term contribution. You could facilitate future student exchanges or research links, which will benefit your host hospital long-term. Also, doing a relevant and realistic research project could be really useful to the place you are staying.

Learning at least some of the local language before you go so that you don't need translators is a good start to avoid putting added strain on an already stretched system. In this respect, fitting in with existing medical elective programmes will also reduce any possible negative impact.

To avoid getting into difficult situations, the best thing you can do is think carefully beforehand about what you hope to gain from your elective and what you feel capable of doing. Then discuss with your supervisors at your host hospital exactly what they expect from you and how you could be most helpful to them. Talk to your medical school and insurers about what they consider you capable of doing. Look forward to your time there and plan it well. The elective can be the most exciting time of your clinical training, but it doesn't have to involve putting yourself or your patients at risk.

Elect to teach?

Four London medical students, some basic computer knowledge and an elective with a difference

It seemed a fairly unlikely scenario – four of us (only one having really good IT skills) teaching computer skills in Tanzania. We wondered whether UK medical students, probably more familiar with computers, could usefully share skills with students in Tanzania. If this worked, maybe the scheme could be used more widely. Having contacted staff at Muhimbili University College of Health Sciences (MUCHS) in Dar es Salaam, who were willing for us to attempt our project, we made contact with fourth-year students in preparation.

How we were received

You might think that four British medical students coming in and ‘telling the natives what to do’ might not be received that well, and these were real concerns that we had too. To our huge relief and surprise, we were met with genuine interest and an overwhelming desire to be one of the students selected for the tuition. This was quite daunting as we soon realised that there was never going to be enough time to tutor everyone.

We often had to commandeer the computer room, due to the real lack of functioning terminals that they had available. This was much to the dismay of other students despite our polite explanations that we were running an impromptu class. Not only were we from a different continent, but also here we were trying to deny them of one of their few pleasures of the day – checking emails in an air-conditioned room. The next time you walk in to your nearest computer room and there isn’t one free, don’t get annoyed and spare a thought for your Tanzanian counterparts who only have eleven computers online between roughly 600 of them!

Our own learning curve

Despite some of our reservations about doing an IT project whilst on our elective we can honestly say that it was fun. Sometimes we would be struggling to get our point across and then bang! – you could see it from the students’ faces that they had understood. And it also gave us a real feeling that we had done something different on this elective from anything our contemporaries had done before.

By running this project we had been able to help in a very small way with the medical education that the medical students were receiving. That is not to say that tutoring twelve students on how to use a computer more efficiently will pull Tanzania out of the health crisis that is hitting the country so hard. As more privileged medical students from the western world that we so clearly are, it is important to give something back to our counterparts and not just expect them to act as interpreters for us on ward rounds.

One final point to emphasise is the friendships that we developed with the Tanzanian students. Of course we did a lot of socialising (playing football on the red earth pitch will be a lasting memory for one of us) but by doing this scheme it brought us closer to understanding what it is like to study medicine in Tanzania. At times it felt like we were really close with some of the guys and girls there, and not just viewed as another set of UK students passing through. That feeling alone made it all worthwhile.

**Eoin Young, Rob Melvin,
John Coombes, Miriam Samuel.**
Elective in Tanzania.

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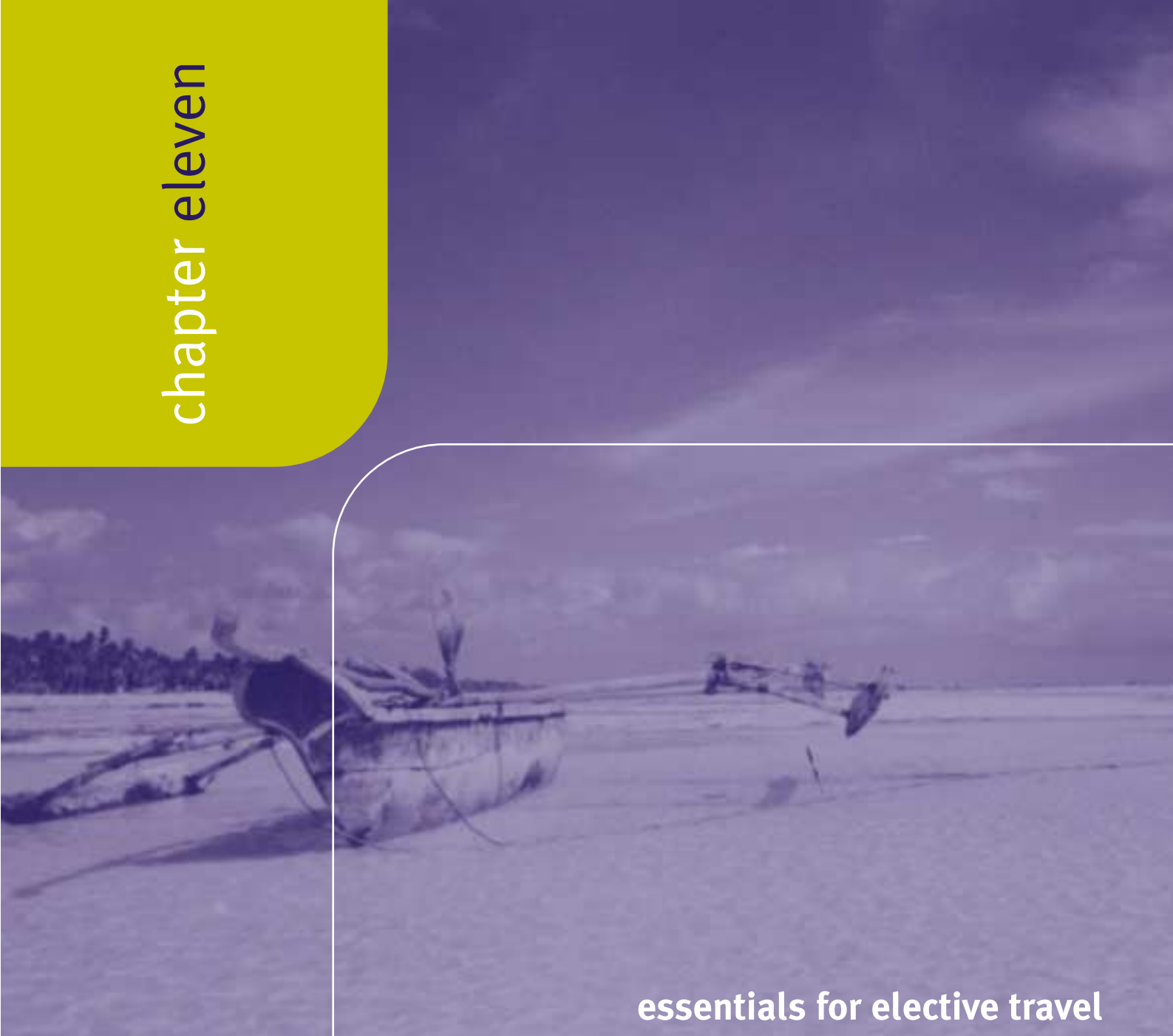
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chapter eleven



essentials for elective travel

know before
you **go**

essentials for elective travel: know before you go

‘The really happy person is the one who can enjoy the scenery, even when they have to take a detour.’

Sir James Jeans

In the months before you leave...

Vaccinations for travel

Some medical schools will give you advice on health before you go. It is worth booking an appointment with your doctor to make sure your vaccinations are up-to-date and to obtain any prophylaxis, for instance for malaria, that you might need.

You can find out what you will need for the country you are visiting at the following websites. Check these regularly as recommendations can change.

UK Department of Health website
www.doh.gov.uk/traveladvice

WHO International Travel and Health site
www.who.int/ith

Post-exposure prophylaxis for HIV/AIDS and other diseases

You need to be prepared for every eventuality, and a needlestick injury is a possibility if you are carrying out invasive procedures. First of all protect yourself as you would normally, following the principles you have been taught at medical school. In countries where HIV prevalence is high, your risk is increased. There may not be local guidelines or procedures in place, so you need to be aware before you leave. It is a good idea to take your own antiretrovirals and be well aware in advance of the current procedure for prophylaxis. Most medical schools will be able to advise you of this and will be able to help you get a prescription.

The US-based Centers for Disease Control and Prevention publishes up-to-date guidelines for post-

exposure prophylaxis. The website is www.cdc.gov. Also check your national department of health for its current recommendations – such as the Expert Advisory Group on AIDS in the UK (www.doh.gov.uk/eaga). However, the guidelines used in this country may not be transferable to a developing country, where resources, drugs and testing facilities are less frequently available. The following information is adapted from the US and UK guidelines. These are liable to change and it is your responsibility to know the up-to-date policy and practice before you leave.

Immediately after a needlestick injury, the wound and skin site should be washed with soap and water without scrubbing. Mucous membranes should be flushed with water. There is no evidence that use of antiseptics is more effective, though it is not contraindicated. Encourage free bleeding. Chemoprophylaxis is then given as early as possible. Currently, the knowledge about the efficacy of these drugs is incomplete and they may have toxic side effects. There may be potential risk to a pregnant woman and her foetus.

Chemoprophylaxis currently consists of a basic four-week regimen of Zidovudine and Lamivudine for most exposures and the addition of a protease inhibitor (Indinavir or Nelfinavir), for increased risk, or where resistance to the drugs is suspected. You should be followed up with counselling, HIV testing (at six weeks, twelve weeks and six months) and for Hepatitis B and C infection. You should also take measures to prevent secondary transmission during the six-month follow-up period. The patient who is the source of the exposure should also be tested for HIV status, though this may be difficult if you are working in remote areas with poor access to testing kits. You may want to contact your own medical school after a needlestick injury. Again the best advice is ‘know before you go’. Check if your

insurance would cover repatriation after such an injury.

The risks may deter you from going to a developing country on elective. This would be a great shame as the benefits of electives in such areas are many, and health staff are also at some level of risk in the UK. This guide intends to make sure you can make an informed choice and know where to find the information you need.

'You are likely to feel bombarded at an emotional level. I have never felt such highs, nor have I felt such lows.'

Amlan Basu, Elective in India

Checklists

- ☐ Think about the options available to you before you go – which country, a rural or urban placement (or both?), a research project or practical work?
- ☐ Think about what you want to gain and what you can offer.
- ☐ Work out a budget and look into funding opportunities.
- ☐ Read about the country – the links in this guide will help you with this.
- ☐ Learn some of the language and find out about local customs and dress code.
- ☐ See your doctor for any immunisations and prophylaxis you will need. Plan to do this at least six weeks before you go, as some immunisations need to be adequately spaced.
- ☐ Check your passport is up-to-date and apply for any visas you will need.
- ☐ Buy your travel insurance and make sure its cover is appropriate. It must include emergency treatment, hospitalisation and repatriation.
- ☐ Buy yourself a good guidebook and do some reading.

- ☐ Likewise read around some of the tropical diseases and conditions you may be unfamiliar with.
- ☐ Start preparing a medical kit – check the expiry dates on any medicines and equipment.

Just before you leave

- ☐ Take photocopies of your passport and any other important documents such as your travel insurance policy. Make sure you have the 24-hour emergency number. Leave the copies with a trusted friend or family member.
- ☐ Leave a copy of your itinerary and contact details with someone.
- ☐ If taking medication with you, also carry a copy of the prescription and a GP's letter. Pack it in your hand luggage.
- ☐ Take enough money, check the expiry date on your credit/debit cards and also back-up funds such as travellers' cheques or sterling or US dollars, depending on where you are going.
- ☐ Confirm your flights and accommodation if you need to.
- ☐ Clearly label all your bags.

What to take

Travel light. It is said you should pack all the clothes you need and then take out half. This is a good rule of thumb. Be ruthless. You should take the following items:

- ☐ **Bag** Always a good start. Make sure it is comfortable and that you can carry it.
- ☐ **Money wallet** This does not mean a neon bum-bag. Something discreet and light so it's not too sweaty under your clothes.
- ☐ **Smart appropriate clothes** This sounds obvious, but too many elective students turn up looking like they just fell off the beach. If you are at all in doubt, buy some local clothes. You might feel daft but you'll look a lot more foolish in a sarong, and attract much more attention.
- ☐ **Beachwear**
- ☐ **Nightwear**
- ☐ **A warm jacket** Don't be fooled. Even tropical climates can get chilly at night or at altitude.
- ☐ **Waterproof** It rains too.
- ☐ **Travel wash** Tip: don't bother with that squeezable detergent travel wash, it won't last and will gum up your bag. Laundry soap is much easier to use and less messy. It might be easier and cheaper to buy when you arrive.
- ☐ **Clothes line** (aka string) Always better than drying your pants on the back of your rucksack.
- ☐ **Plastic bags** A multitude of uses, you will discover just how many.
- ☐ **Toilet paper** You can usually buy this in all but the most remote places, to save you some space.
- ☐ **Passport photos** Always essential, especially if you lose your passport.

- ☐ **Photocopies** Of your passport, travel documents and insurance.
- ☐ **Photos** Photos of your family, friends and home town are great for giving you something to talk about and establishing a rapport with your hosts. And perhaps for remembering why you left.
- ☐ **Travel diary** Inscribe those philosophical musings and record the epiphanies you have on the road. And the emails of your new friends.
- ☐ **Guidebook and phrasebook** To make friends and not get lost.
- ☐ **Passport and vaccination records**
- ☐ **Swiss army knife, needle and thread**
- ☐ **Medical kit**
- ☐ **Sun protection**
- ☐ **Torch**
- ☐ **Sleeping bag or sleeping sheet** This will depend on the climate, but the latter is much lighter.
- ☐ **Gloves and some surgery dressing** Some dressings will be useful for minor accidents. Gloves are always useful on hospital wards.
- ☐ **Educational materials** Information that will be useful for you while you are there, and that your hosts can use after you have gone.

What to leave behind

- ☐ **Jewellery and expensive watch** You will either lose it or worry about losing it.
- ☐ **Electrical appliances** You don't really need your hairdryer.
- ☐ **Toxic or corrosive substances** This includes booze.
- ☐ **Trendy clothes** Forget it, you're going to look odd however hard you try. And forget anything that needs too much ironing.

Women travellers

'I would suddenly be surprised to realise that the women couldn't sit and drink with the men, that I wasn't allowed out on my own as a young, unmarried woman; shocked... at the undefined caste system which dictated who one could and couldn't speak to.'

Jessica Westall, Elective in Sri Lanka

It is important to remember that, as a woman abroad, you may well be treated very differently from a man. This is easy to forget, when you have grown up or studied in a society where women and men enjoy relatively equal opportunities. You may feel frustrated by this at times. Be patient.

Women can also be more vulnerable than men to unwanted attention. You can help yourself by making sure you dress appropriately and don't take risks. You may feel it is your right to dress how you like. True, but people will be more open and respectful to you if you don't look too strange. If you are in doubt, look to local women for an idea of how they dress and behave. Ward off unwelcome advances firmly. People will be curious and want to talk with you, though if you feel uncomfortable, walk away.

Language and culture

'I was all alone in a country where everyone spoke a language I could not begin to understand... I was unable to communicate and unable to do the most simple things without help.'

Layla McCay, Elective in Japan

Make the effort to learn even a few words of the language and you will be greatly rewarded. Even an attempt to speak a few words of the local language will usually be met with delight and humour. It is also usually very useful in bargaining! Be aware that if you go to a country where English is not widely spoken, it will be harder to interact with patients. In Asian countries, where other alphabets are widely used, you may be unable to read patient notes, test results

or follow road signs. You may want to study the language of the place you are visiting before you leave to get more out of your experience. Use your university language lab – it's usually free – or take an intensive course on your arrival in the country – it will also help you find your feet.

'Find out about the economic status, political climate and culture of the country you are going to visit. Try and study its history, how it became part of the "developing world" and what this label means for it now. Doing this will help you understand the behaviour, attitudes and lifestyle of the people around you, making you less prone to culture shock.'

Alice Shiner, Elective in Tanzania

This guide aims to give you an introduction to the underlying causes of poverty and ill-health in the world today. For people living in developing countries the problems associated with poverty, such as political unrest, disease and death, are part of everyday life. The situation in the country you visit may at first be difficult to understand. Prepare yourself for this by finding out a little before you go. The references section of this guide will show you where to start.

Making connections

'During my elective in Cuba I met many wonderful people who shared with me their ideas about their country, its successes and failures and who showed me many other facets of their Cuban lives. My experience and understanding of this extraordinary country was enriched by the friends I made, not to mention my salsa skills...'

Olivia Bayley, Elective in Cuba

'Wherever we went, people always wanted to know our age, nationality, the number of our brothers and sisters and whether we were married. The ability to mutter a least a few phrases in Vietnamese therefore made our visit not only medically rewarding but an unforgettable cultural experience.'

Carsten Flohr, Elective in Vietnam

Your elective is an opportunity to meet a wide variety of people. People will welcome you as a guest into their lives; repay them by sharing your world and your experiences with them. Take photos of your family, your friends, maybe some music from your country.

'Twenty years from now you will be more disappointed by the things you didn't do than by the ones you did do. So throw off the bowlines, sail away from the safe harbour. Catch the tradewinds in your sails. Explore. Dream. Discover.'

Mark Twain

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The Yellow Book

www.cdc.gov/travel

Published every two years by the US-based Centers for Disease Control, this is a handbook for health care providers about travel health.

UK Foreign and Commonwealth Office

www.fco.gov.uk

Know before you go: country advice and general tips.

Post-Exposure Prophylaxis

UK guidelines

www.doh.gov.uk/eaga

US Guidelines

www.cdc.gov

links, websites and further reading

Please look at the end of each section for a detailed set of references by each topic. Listed below are the best of the rest and other useful links.

Useful general websites

CIA

www.cia.gov/cia/publications/factbook

A fact book from the US intelligence agency with essential details on every country in the world.

International Federation of Medical Students' Associations (IFMSA)

www.ifmsa.org

Organisation of medical students active in international health issues.

Medical Students' International Network (MedSIN)

www.medsin.org

The UK medical students' association active in international health among other areas.

UK Foreign Office

www.fco.gov.uk

Regularly updated information on the world situation, with official warnings on trouble spots.

Other nationalities see your government's equivalent site.

Travel health and tropical diseases

Centers for Disease Control and Prevention:

www.cdc.gov

London School of Hygiene and Tropical Medicine:

www.lshtm.ac.uk

UK Department of Health:

www.doh.gov.uk/traveladvice

Careers and courses

There are a wide variety of careers open to doctors wishing to work in international health. Look beyond the organisations you may have heard of – look at the

websites of NGOs in this guide to get ideas. The websites below are just a start. An undergraduate or postgraduate course in international health is a very good start.

International Committee of the Red Cross

www.icrc.org

International Health and Medical Education Centre, University College London

www.ihmec.ucl.ac.uk/IntHealthElective/FAQs.htm

Offers the BSc in International Health for all medical students and an International Health Elective programme with placements in Bangladesh, Brazil, Cuba, Ecuador, India, Nepal, Peru, Tanzania and Zambia for students at UCL. The Elective Programme includes a four-week Special Study Module in International Health. IHMEC also has an elective and international health library open to all.

Liverpool School of Tropical Medicine

www.liv.ac.uk/lstm

Postgraduate training in tropical medicine and international health, Liverpool, UK.

London School of Hygiene and Tropical Medicine

www.lshtm.ac.uk

Postgraduate training in tropical medicine and international health, London, UK.

Médecins sans Frontières

www.msf.org

One World Network

www.oneworld.net

Information on volunteering and job vacancies to give you an idea of the experience you will need.

Royal Tropical Institute www.kit.nl

Postgraduate training in tropical medicine and international health, Amsterdam, The Netherlands. Courses are generally in English.

Voluntary Service Overseas

www.vso.org.uk

You will need clinical training to work with many of these organisations. The degree of training required will vary by post and organisation.

glossary

Unfortunately the language of international health and development, like much of medicine, is littered with jargon. Don't let this put you off! As with most areas of life these complicated terms often disguise simple concepts. Wherever possible, we have tried to explain in the text of this guide. This glossary will help you with other terms in international health and development.

Balance of payments

A financial statement summarising the flow of goods, services and investment funds between residents of a given country and residents of the rest of the world.

Debt servicing

The total of repayments plus interest paid in goods, services or foreign currency on debts to international organisations such as the World Bank and International Monetary Fund, private banks and bilateral donors such as Western governments.

Developing countries

Low- and middle-income countries in which most people have a lower standard of living with access to fewer goods and services than do most people in high-income countries. There are currently about 125 developing countries with populations over one million; in 1997, their total population was more than 4.89 billion.

GATS agreement

The General Agreement on Trade in Services. This agreement of the World Trade Organization was made in 1995. It seeks to liberalise international trade in services such as banking, education, healthcare, rubbish collection, tourism and transport, so they are under the control of market supply and demand.

Green Revolution

An organized effort beginning in the 1960s, sponsored by the United Nations Food and Agricultural Organization (FAO), to increase world food production by introducing high-yield cereal varieties.

Gross domestic product (GDP)

The total market value of all final goods and services produced in a country in a given year, equal to total consumer, investment and government spending, plus the value of exports, minus the value of imports.

Gross national income (GNI)

GDP plus the income accruing to domestic residents from productive activities abroad, minus the income earned in domestic markets accruing to foreigners abroad. GNI is the new name for GNP.

Gross national product (GNP)

The same as GNI.

Human Development Index (HDI)

An index created by the United Nations Development Programme and published in its annual Human Development Report that ranks all countries according to economic (GDP per capita), health (life expectancy at birth) and education (adult literacy and school enrolment) indicators, producing a ranking of development.

Income poverty line

A level, such as US\$1 per day, below which those whose income is less are considered to be poor.

Infant mortality rate (IMR)

The number of deaths of infants between birth and one year of age per 1,000 live births.

International Monetary Fund (IMF)

An organisation set up between governments to monitor and smooth financial exchanges on a global scale. Interventions by the IMF to help countries in difficulty are usually associated with rigorous conditions designed to improve a country's balance of payments, including reductions in government spending and subsidies, and encouraging exports. For more information, see 'Structural Adjustment Explained' on page xx.

Life expectancy at birth

The age to which a newborn child would be expected to live if current mortality trends continue unchanged throughout the child's life.

Maternal mortality ratio (MMR)

The number of maternal deaths per 100,000 live births.

Millennium Development Goals (MDGs)

A set of development goals adopted by the United Nations member states in September 2000. The MDGs establish targets, to be achieved by 2015, in poverty, education, gender empowerment, child mortality, maternal health, access to clean water and sanitation, HIV/AIDS and other diseases, the environment, and developing a global partnership for development.

Organization of the Petroleum Exporting Countries (OPEC)

An organisation of oil-exporting nations. Its member states are Algeria, Indonesia, Iran, Iraq, Kuwait, Libya, Nigeria, Qatar, Saudi Arabia, the United Arab Emirates and Venezuela.

Purchasing power parity (PPP)

A method of measuring the relative purchasing power of different countries' currencies over the same types of goods and services. Because goods and services may cost more in one country than in another, PPP allows us to make more accurate comparisons of standards of living across countries.

Sector-wide approaches (SWApS)

A policy-setting mechanism whereby the government takes responsibility for setting policies that apply to all public activity in the sector including that financed by donors. All significant funding for the sector supports a single sector policy and expenditure programme under government leadership with participation of key stakeholders.

Structural adjustment programme (SAP)

Set of policies advocated by the World Bank and International Monetary Fund in the 1980s and 1990s. The rationale behind structural adjustment was that developing countries needed to reduce the role of the state and liberalise their economies in order to achieve economic growth. For more information, see 'Structural adjustment explained' on page 22.

Transition countries

Countries whose economies used to be centrally planned by the government but are now undergoing transition to base their economies on the market. Most transition countries are in the former Soviet Union and Eastern Europe.

TRIPs agreement

The World Trade Organization's agreement on Trade-Related Aspects of Intellectual Property Rights is an international agreement on intellectual property that was enacted in 1994. It establishes a standard set of global rules for each WTO member state on intellectual property, including copyright, patents and trademarks.

UNCTAD

The United Nations Conference on Trade and Development.

Vertical programme

The selective targeting of specific interventions that are not integrated into broader sector-wide policies. Vertical programmes are attractive because they often show quick results and are easier to manage than sector-wide approaches, but have been criticised because they are often unsustainable, divert resources from other important areas, and may reflect donor rather than local needs.

World Bank

Development bank which provides loans, policy advice, technical assistance and knowledge-sharing services to low- and middle-income countries to reduce poverty.

World Health Organization (WHO)

The United Nations specialist agency for health, governed by the United Nations member states through the annual World Health Assembly. Its activities include the setting of global norms and standards in health and stimulating research and development into health issues of international importance.

World Trade Organization (WTO)

A global organisation made up of member states, which works to regulate the international trade exchanges between these states.

the **elective** pack



International Health and
Medical Education Centre

Many medical students go on electives ill-prepared for the challenges that will face them in different societies and different health systems. This Elective Pack aims to help remedy this by providing the tools to understand the actors, issues and processes of international health, and how they link to produce the situations that students will be faced with. It also examines issues around ethical electives, encouraging students to see their time abroad as a two-way learning experience and discouraging ‘medical tourism’.

This pack is primarily of use to students travelling to developing countries on their elective, but will also be helpful for those medical students who travel to more developed parts of the world and those interested in global health issues.

