ETHICAL DILEMMAS IN GLOBAL HEALTH

CONTENT

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Cover: Woman in a township in South Africa grieves about her son
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WE CAN'T ESCAPE ETHICAL DILEMMAS

Everything is politics, they say. The same can be said of ethics, especially when considering the definition of an ethical issue as 'a problem or a situation that requires a person or organisation to choose between alternatives that must be evaluated as right (ethical) or wrong (unethical)'.[1] Sounds fairly easy, just choosing between right and wrong. However, the reality on the ground often doesn't allow for fast-track or easy choices. In the era of globalisation, applying moral values to health issues may have become even more complex. On the other hand, is it really necessary to single out the 'global' dimensions of a health issue when dealing with ethical dilemmas? Maybe not.

This edition of MTb corresponds with the thematic focus of the NVTG annual symposium which focuses on ethical dilemmas in global health (November 9, the *Rode Hoed* in Amsterdam). Dr Ann Phoya, one of the keynote speakers of this conference, will illustrate how Malawi – the country with one of the severest shortages of health workers – has managed to scale up HIV services and improve maternal health through a targeted Human Resources for Health Strategy. Two articles in this edition deal with her work in Malawi and the wider context of agenda setting in favor of applying ethical considerations to a joint plan to address the human resources for health crisis worldwide.[2]

Our 'Letter from the Tropics' this time takes us to the emergency ward of a health facility located near the Amazon border between Ecuador and Peru. A Western trained medical doctor is confronted with the implications of having sworn the Hippocratic Oath 'that he will do everything in *his ability and judgement* to save a person's life'. Clearly, in his daily practice the hard-fought right of informed consent is being brought to the test.

Ethical dilemmas galore: in humanitarian aid, in the fight against HIV/AIDS, in conducting global health research and balancing research agendas, in participating as a medical doctor in the EU asylum procedure, and as a local public health practitioner in a postwar context along the Myanmar-Thailand border. This MT*b* presents several such dilemmas in global health. The hard part, as one of the authors in this edition concludes, is that many ethical problems are simply not easy to answer. The list of situations in which ethical dilemmas arise is long. The truth of the matter is: *'We can't escape them. When confronted, our responsibility is to reason our way through them, identify the best options (or the least bad ones), and to act according to our best judgment'*.[3]

ETHICAL DILEMMAS ARE NOT EASY QUESTIONS, AND THEY SHOULD NEVER BE SOLVED BY EASY ANSWERS

How to reach such judgment? Practical guidelines may be helpful in dissecting ethical issues and in justifying one action over the other, as the WHO outlines in its Ethical Guidelines. Other – more direct – ways are training courses in ethics, like the one for health practitioners in Thailand. Trying to ask the right questions and engage different stakeholders is always a good starting point. We are looking forward to your engagement in the discussions during our annual symposium: (Human) Resources, Research and Rights: Ethical dilemmas in Global Health.

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1. http://www.businessdictionary.com/definition/ethical-issue.html
2. Five-year action plan on 'Health Employment and Inclusive Economic Growth'. http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_18-en.pdf'
3. See for more on this: Stapleton G, et al (2014) in: Glob Health Action 2014, 7: 23569. http://dx.doi.org/10.3402/gha.v7.23569

Ethics in global health

An introduction based on WHO guidelines

When you realize that core values like fairness, responsibility or autonomy are central themes in ethics, its importance in global health becomes clear. These are concepts that play a role in ethics in general, in health ethics in particular, but they have special aspects when reflecting on global health. What is ethics in global health exactly? Why is it important? And what is the practical use of ethics for physicians, public health workers or policy makers? The World Health Organization (WHO) published guidelines on this topic, and this article will give an introduction to ethics in global health based on these guidelines.

WHAT IS RIGHT OR WRONG?

Before we dive into the practical ethical dilemmas in global health, we need to understand the definition and some background of ethics in general. Ethics can be defined as 'the branch of knowledge that deals with the moral principles that govern a person's behaviour or the conducting of an activity'.[1] These moral principles can be based on very different world views or philosophies, which in turn can lead to very different understandings of what are right or wrong behaviours or activities.

Throughout history, several philosophical visions have been described, four of which I will briefly mention.[2] Box 1 shows different visions and the questions they ask when reflecting on right and wrong. Utilitarianism pays attention to the consequences of an act, and defines what is right by the greatest happiness for the greatest number. It is not about personal happiness, but the positive consequences for most people. Deontology does not primarily consider the consequences of an act, but the normative principles – what should be done – are leading. In a way, the first two views work in different directions: utilitarianism defines what is right according to the outcome (most happiness), deontology defines what is right based on the starting point (moral duty). Whereas deontology is based on overall, general moral principles, the third view, liberal individualism, focuses on the principles or rights of the individual. Every individual has his or her own rights, defining what is right or wrong. On the other end of this spectrum, we find communitarianism. This idea emphasizes that not only individuals have rights but also communities. This idea highly values social practices, and what is best for the community is leading in defining right or wrong.

These philosophical ideas can easily be translated to ethics in healthcare, for example when judging the introduction of a new treatment. Does it increase health for most people, or only serve a minority? Is it our moral duty to treat those patients? Do the patients have a right to receive this treatment? Does treating these patients serve society?

HEALTH ETHICS

Health Ethics is a broad field that focuses on ethical dilemmas not only in healthcare but also in health policy and health research.[3] Health ethics tries to understand the values that play a role in actions and decisions in these areas, some common examples of which are autonomy, fairness, compassion, honesty, freedom and trust. Ethics is often complementary to the law; a law may require people to do what is ethically right, but of course something may be legal and still be wrong from an ethical point of view.

ETHICS IN PUBLIC HEALTH AND CLINICAL CARE

If we consider the values mentioned above and the different possible underlying views from Box 1, it becomes clear that healthcare is full of potential ethical dilemmas. A broad distinction in healthcare is public health versus clinical care, which introduces a major ethical dilemma. Public health focuses more on prevention of disease, which may be the best thing to do when looking at the most health for the most people. But when resources are scarce, paying more attention to prevention may take away needed resources from treatment.[3] For example, treating HIV-infected people with antiretroviral therapy may significantly prevent transmission of the disease, but does this justify treating patients that do not (yet) benefit from treatment themselves? And may this strategy take priority over treating patients that already suffer from the disease?

Non-communicable diseases also pose difficult dilemmas. These diseases are often the result of people's unhealthy lifestyle, but to what extent do governments have the right or the moral obligation to change such behaviour, for example by imposing taxes on alcohol, smoking, or sugar?

A final and very practical ethical dilemma that physicians face on a daily basis is the issue of informed consent. How much information about a treatment should be given to a patient? When, if ever, should a physician's professional opinion take precedence over a patient's right to make a voluntary and free decision to accept or reject treatment?[3] The relevance of this topic is clearly demonstrated in the letter from the tropics further in this issue, which is full of practical examples and written by two doctors in tropical medicine.

ETHICS IN MEDICAL RESEARCH

Most people are familiar with the ethical issues involved in medical research, in terms of protecting the rights of participants in clinical trials. But there are many more questions to be asked. Who benefits from the research? Particularly in global medical research, do wealthy researchers benefit most or local people participating in the study? What level of care should be provided to participants in the control arm of a trial, especially if the quality of usual care in the setting is low?[3] Which specific topics are investigated? Only diseases or therapies that lead to potential commercial success?

ETHICS IN GLOBAL HEALTH

Of course, all the issues mentioned above apply to global health. Still, there are some special ethical aspects involved when we take a global perspective. The big gap in health and health care between high-income and low- and middle-income countries is already a major ethical problem - a matter of injustice, inequality and compromised human rights. This is aggravated by the 'brain drain' of trained health professionals from low-resource settings to wealthier countries. What is the balance between individual free choice of relocation and the need to improve the health of the most vulnerable populations?[3] Another

aspect of global health ethics is related to cultural relativity. For example, can female genital mutilation be right for certain cultural groups if it is in line with their beliefs, or should we stand up and protect these women and children?

HOW TO HANDLE ETHICS IN PRACTICE?

Once you realize the importance of ethics in global health, you might wish for some practical guidance in handling all these dilemmas. The 2015 WHO guideline [3] ends with a section on three key strategies on practical ethics. First, philosophical theories (like those described in the first section of this article) may help in explaining an ethical issue and justifying one action over another. Next, ethics committees can be of great value, in clinical care as well as in research. Third, ethical decision-making frameworks can be developed for specific topics in order to provide guidance on how decisions ought to be made and by whom. One example is a guideline developed by the WHO on managing ethical issues in infectious disease outbreaks; see box 2.[4] Finally, the importance of engaging all different stakeholders is emphasized.

These 'key strategies' may be less easy to use in practice than hoped for, but ethical dilemmas are not easy questions, and they should never be solved by easy answers. Asking the right questions and trying to understand the underlying values of all the people involved (including yourself) may bring you a bit closer to an answer.

BOX 2

ETHICAL FRAMEWORK: EXAMPLE OF INFECTIOUS DISEASE OUTBREAKS

As a result of the ethical issues that arose during the Ebola outbreak in West Africa in 2014 – 2016, the WHO wrote a comprehensive guideline, or ethical framework, about managing ethics in disease outbreaks.[4] The framework discusses 14 specific topics, addressing key issues in outbreak management such as involving the local community, public health surveillance, rapid data sharing, emergency use of unproven interventions and the restriction of freedom of movement. Each topic starts with key ethical question, followed by the issues that should be considered when answering these questions.
For example, consider the question 'Under what circumstances is it legitimate to restrict an individual's freedom of movement during an infectious disease outbreak?' The following aspects should be carefully considered when looking for an answer: justifiable grounds, based on the best available evidence; least restrictive means; costs; ensuring humane conditions; addressing financial and social consequences; due process protections (providing mechanisms for individuals to challenge the appropriateness of their restrictions); equitable application; communication and transparency.
By structuring all the main topics in outbreak management and their ethical considerations, this guideline provides useful guidance for all professionals involved in infectious disease outbreak planning in all sectors.

WHO GUIDELINES ON ETHICAL ISSUES IN PUBLIC HEALTH SURVEILLANCE (2017)

- Ethical issues in patient safety research: interpreting existing guidance (2013)
- Standards and operational guidance for ethics review of health–related research with human participants (2011)
- Guidance on ethics of tuberculosis prevention, care and control (2010)
- Basic principles for treatment and psychosocial support of drug dependent people living with HIV/AIDS (2006)
- Guidance on ethics and equitable access to HIV treatment and care (2004)

HTTP://WWW.WHO.INT/ETHICS/ PUBLICATIONS/YEAR/EN/

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Training a 'lost generation' in ethics
Developing a training course for local public health practitioners in a postwar context

THE NEED FOR MULTIDISCIPLINARY TRAINING IN HEALTH AND RESEARCH ETHICS IN LOW- AND MIDDLE-INCOME COUNTRIES

The development of local capacity to address ethical dimensions of public health research is critical in addressing the significant disease burden shouldered by populations in low- and middle-income countries (LMICs). However, the complex realities of poverty, faltering education systems, poorly resourced health services, political marginalisation, and diverse cultural beliefs can pose significant challenges for developing sustainable capacity in ethics expertise and programmes that meaningfully engage the communities served. Building the capacity of local research teams is needed to empower and engage local populations and to create a more holistic approach to communities that considers the ethical, social, cultural, political and historical dimensions essential for successful public health programming. The ethics training course detailed below represents an approach to social science training that combines international and academic expertise in ethics with local expertise and cultural knowledge for innovative ethics programme development, where current development models are lacking.[1, 2]

THE MYANMAR–THAILAND BORDER, THE SHOKLO MALARIA RESEARCH UNIT AND MALARIA ELIMINATION

As an LMIC setting, the Myanmar-Thailand border provides a prime example of the difficulties in developing a training programme in ethics for local practitioners. From the Thai state's perspective, mass movement of persons from Burma/Myanmar began in 1984, as 'persons fleeing fighting' massed in informal shelters along the border region were permitted entry into neighbouring Thailand through formalised 'temporary shelters'.[3, 4]

The Shoklo Malaria Research Unit (SMRU) began studying multi-drug resistant falciparum malaria in 1986 in the refugee camps housing these displaced persons from Myanmar in Tak Province, Thailand. At that time, malaria, as the primary cause of death and morbidity, was the most serious health problem facing this population. In the process of changing the modern therapeutics of malaria infection, the SMRU - via concerted efforts with local partners - relegated malaria to a rare cause of illness and death among the 130,000 people who now live in the camps. These gains were extended to the predominantly Burman cross-border migrant communities along the border, estimated at around 200,000 migrants, reducing falciparum malaria transmission to nil on the Thai side of the border. Beginning in 2014, an unprecedented coordination of local ethnic health organizations in Eastern Karen/Kayin State, Myanmar, led by the SMRU's Malaria Elimination Task Force (METF), resulted in the establishment of 1,200 malaria posts coupled with mass drug administration campaigns to greatly reduce falciparum malaria across Karen/Kayin State.

The METF programme has been a hard-fought success. Fifty years of systematic disenfranchisement of Burmese and Karen communities along the border region of Western Thailand and Eastern Myanmar have led to broken education and health systems, greatly limiting local capacity development via multidisciplinary public health training. Community Engagement (CE), the backbone of the METF programme, aimed at promoting local community participation in the border region, quickly discovered that local health workers needed multidisciplinary skills and a firm grounding in social science and ethics to ensure success of the

programme for malaria elimination.

DEVELOPING A COURSE IN ETHICS

Working with Professor Decha Tangseefa, a political science professor and social science researcher at the Faculty of Political Science at Thammasat University, Thailand, the CE team originally developed a framework for CE that later constituted the '9 Dimensions'.[5, 6] This framework grew out of years of social science research among refugees and migrants along the Myanmar-Thailand border, led by Prof Tangseefa, building on three major themes to conceptualize the complexities of this 'in-between space': power, place, and people.[7-9]

Following completion of the Targeted Malaria Elimination Programme (TME) and in the course of the METF programme, senior CE Team members reflected and identified their own shortcomings in training on issues of ethics and yearned for a deeper understanding of the multidisciplinary approach needed for successful CE. The CE team and technical advisors to the TME programme met with Prof Tangseefa to develop a course in ethics and social science for local health practitioners that addressed many of the key areas necessary for CE. This was based on a participatory approach, where 'students' met with the 'instructor' to identify areas where the participants required further instruction. Key areas to be covered in the course included: ethical theory, research ethics, justice, gender and care ethics, human rights, humanitarian intervention, poverty, development, immigration, and globalization and economic justice.

These topics were covered in monthly training modules led by Prof Tangseefa, which included group work culminating in monthly presentations by CE team members over the course of 9 months

in 2017 and 2018. Over this time, the course evolved to meet the needs of the local practitioners, most importantly including changes in text befitting the level of training and language abilities of the CE Team members.[10] This nearly year-long process culminated with a short 'writing course' to prepare a manuscript for the '9 Dimensions' as used in the TME and subsequently used as a CE guide for the METF Programme.[11-14]

THE '9 DIMENSIONS' INCLUDE:
I. History of the people
II. Space
III. Work
IV. Knowledge about the world
V. Intriguing obstacle (rumour)
VI. Relationship with the health care system
VII. Migration
VIII. Logic of capitalism influencing openness and
IX. Power relations.

WAYS FORWARD

The course described here is a longitudinal course for ethics and social science training among historically marginalised groups. Most CE team members have completed secondary education, with only a few going on to complete higher levels of education. As alluded to above, they represent a 'lost generation' of health practitioners. Time, significant investment, and political will are still needed to develop local capacity for conducting ethically sound public health programmes as a stop-gap measure until the Myanmar health system is itself able to reach marginalised communities along the border. This course represents a 'bottom-up' approach that leverages academic expertise to address the needs expressed by local practitioners.

The architects of this course understand that much remains to be done to make such courses in global ethics more sus-tainable. A full course would allow for 'reflection' to adjust the curriculum to meet local practitioner needs, including baseline evaluations to determine goals as well as metrics to 'grade students' at the completion of the course. The group work and presentations provided the instructor an opportunity to assess participant understanding of ethics topics covered through didactics, but this could be supplemented with testing through midterm and final exams. Elements of the TDR Global Competency Framework [15] or similar grading schemes may provide a more robust method of assessing local practitioners' knowledge and skills in ethics, research operations, quality and risk management, and scientific thinking.

However, those who developed this course understand its potential to engender a 'grassroots' approach to training in ethics that provides real skills to local practitioners in addressing practical ethical dilemmas as they arise organically in the field. The backbone of both the TME and METF programmes was the CE Team members' ability to navigate a rugged, culturally diverse, and politically polarized post-war environment to attain and sustain high levels of community participation for anti-malarial mass drug administration. This course further bolstered the sustainability and versatility of the CE team via a multidisciplinary approach to conceptualising health inequities in this dynamic border region. In addition, it will enable local practitioners to cut across disease-specific programming, often dictated by international bodies and donors, and advocate for meeting the broader public health and development priorities of the local communities.

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Global health equity, ethical dilemmas and how to address them

'Injustice anywhere is a threat to justice everywhere. We are caught in an inescapable network of mutuality, tied in a single garment of destiny.' Martin Luther King Jr wrote these words in 1963 from jail. I did not know them until someone from the South African Treatment Action Campaign used them as a counter argument when I argued that antiretroviral drugs were too expensive for a country like Mozambique.

My first reaction was, 'So what?' It was March 2000, and I was working in Mozambique for Médecins Sans Frontières. Of course, I lived and worked according to the cosmopolitan principles that King had so aptly expressed, even though his formulation was unknown to me until then, so I didn't really feel concerned. But Zackie Achmat, from the Treatment Action Campaign, explained that I thought and acted as a nationalist. We had children with AIDS in our hospital tents. The price for antiretroviral treatment was about US$ 10,000 per person per year. We knew that we could significantly lower that price to $1 per person per day, which also happened a year later. But even then I thought it was still too expensive for Mozambique, where the healthcare budget was only $5 per person per year. 'Why do you take the poverty of Mozambique as your starting point?' Zackie asked. 'Why don't you look at the wealth in the world? Humanity is rich enough to pay for AIDS treatment for everyone who needs it.'

People who work for development cooperation or humanitarian aid like to believe that they have a cosmopolitan conviction, but that is not self-evident.

Development aid serves to help countries address their own problems; some organizations have even taken variations of 'Help them to health themselves' as their fundraising slogan. Humanitarian aid is more generous, but only for crisis situations and only for their duration. The idea behind it is the same: the party ultimately responsible for people's health is the state they live in, not humanity. That is a nationalistic starting point. Or, as philosophers say it (because nationalism is a loaded term), a 'statist' concept of justice.

By the end of 2002, Mozambique had one of the most ambitious antiretroviral programs in Africa. The price had dropped to $1 per person per day, still too expensive for Mozambique. Funding came from the Global Fund to fight AIDS, Tuberculosis and Malaria. This fund, founded in 2001, encouraged countries such as Mozambique to be ambitious and not to worry about future funding. New funding would be made available if the money was used correctly, didn't disappear into the wrong pockets, and the countries needed continued support. In other words, humanity would carry the burden via the Global Fund.

In July, the AIDS 2018 conference took place in Amsterdam. With the exception of a glimmer of hope for an AIDS vaccine, there was an atmosphere of realism and even some resignation. It's not going well with the fight against HIV and AIDS. The richer countries have been sending signals for some time now that the story, or the 'dream', of humanity carrying the financial burden is over. International financing is drying up. Developing countries have to fund their own efforts. Today, the taps are being closed for middle-income countries, tomorrow for low-income countries.

What that means, in practice, I saw in Kenya earlier in July, where I did a study for the Netherlands Aids Fund. The medicines are still provided for free but not the consultations and the tests. Orphans who know that they are HIV positive don't ask for medication because they can't afford the tests. If they wait too long, they become very ill or die before they receive their first treatment.

What happened between 2001 and 2018? The creation of the Global Fund was driven by two motives that complemented each other: injustice and insecurity (even fear). The absurd injustice that people and children were dying of a disease that had been brought under control in richer countries, and fear that an uncontrolled AIDS epidemic in Africa would be dangerous for Europe and North America. The fear vanished some time ago. When it became possible to host the 2012 AIDS conference in Washington DC because the USA had finally withdrawn its entry ban for people with HIV, it was welcomed as a great victory by activists. A minority saw the writing on the wall and warned that the decreasing level of fear would also lead to decreased funding. Since 2012, international funding for the fight against HIV has indeed decreased.

Since then, the injustice motive has also turned itself against the fight against HIV and AIDS. The Global Fund has taken tuberculosis and malaria on board, but for all other health problems the situation has remained as it was: temporary international assistance, no real burden-sharing, and therefore the cheapest possible healthcare. As a result, for example, we hardly know how many children are born with diabetes

I WILL CONTINUE WEARING MY RED AIDS RIBBON WITH PRIDE

in Africa; long-term treatment is too expensive, so we simply don't test. In Cambodia, a person with diabetes complained: 'I wish I had AIDS'.[1] The feeling that the fight against AIDS was receiving too much money came quietly but never disappeared, despite passionate pleas from people like myself emphasising that there was too little money and attention for health in poorer countries, and not too much money for the fight against AIDS. On top of that, not to be underestimated, a global banking crisis erupted and nationalism increased – let's call a spade a spade.

Is the cosmopolitan dream finally over? I don't think so. The cosmopolitan perspective is probably going to go through a few 'desert years'. But sooner or later, humanity will again understand that increasing inequalities - climate change, epidemics, and conflicts - to name but a few, will never be solved from a nationalistic perspective. But we need to get ready while waiting for the tide to turn. The cosmopolitan perspective also introduces new ethical dilemmas. To argue that health is a human right is one thing; to argue that the associated obligation falls on humanity is another.[2] How should humanity shoulder this responsibility? Should we have a global tax or some other way to ensure that wealthier countries cannot simply change their mind every now and then? Should humanity's responsibility be directed towards poor people, or towards poor countries? Where does the responsibility of the state end and the responsibility of humanity begin? Should poor people living in wealthier countries receive more assistance, or should humanity reward states that are trying hard to mobilise domestic resources? Should all health problems be a common concern, or only some health problems? Should

we broaden the mandate of the Global Fund and turn it into a global fund for health? And, most importantly, who should take these decisions?

None of these questions have easy answers. But one thing I know for sure: returning to the idea that the party ultimately responsible for people's health is the state they live in, and not humanity, is not the answer. I hope that the 'Resources, Research and Rights: Ethical dilemmas in Global Health' conference will start addressing some of these issues.

In the meantime, I will continue wearing my red AIDS ribbon with pride.

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We cannot allow this plan to fail: invest in health workforce

With changing lifestyles and ageing populations, chronic diseases have become increasingly common. Bearing this in mind, it has been predicted that by the year 2030, there will be a demand for 40 million new jobs in healthcare worldwide, most of these in high-income countries. In this same period, the shortage of healthcare workers in low-income countries will have grown to 18 million. These numbers are clear and point to the same conclusion: now, more than ever, we need a global strategy to tackle this unequal distribution. Wemos is glad that the 70th World Health Assembly in Geneva in 2017 unanimously adopted the five-year plan 'Health Employment and Economic Growth' at (WHA 2017).

The five-year action plan on 'Health Employment and Inclusive Economic Growth' that was adopted during the World Health Assembly in Geneva in 2017 provides a pathway for sustained and evidence-based investments in a strong health workforce, worldwide. Dr Ann Phoya, President of the Association of Malawian Midwives (AMAMI), and keynote speaker at the NVTG Congress on Human Resources, Research and Rights (9 November 2018) will look at the merits and possible pitfalls of this plan. Based on her experiences in Malawi, she will highlight lessons learned from previous initiatives to strengthen the health workforce. But most of all, she will call for attention to the responsibility of governments and international actors to invest in the development and deployment of a strong health workforce, based on their duty to fulfil the right to health, and the right to access a skilled, motivated and supported health worker, for everyone, everywhere.

The response to the plan from WHO member states [1] was overwhelming. New Zealand even concluded its partici-pation in Geneva during the WHA 2017 by saying, 'We cannot allow this plan to fail.' This sense of urgency calls for the next necessary steps. The WHO, the International Labour Organization (ILO), and the Organization for Economic Co-operation and Development (OECD) are working together to execute the plan.

SECURE SUFFICIENT FUNDING

First, money is needed to train health personnel and then to fund jobs. Many low-income countries lack the necessary funds. While ministries of health usually have a fairly good idea of what is needed in terms of health personnel, the budget negotiations with the ministry of finance often are not successful. This is because the health workforce is seen as a recurring cost. To counter this, WHO, ILO and OECD have come up with evidence that new jobs in the health care sector stimulate economic growth. Zambia and Zimbabwe have chosen an original approach to get approval from their ministers of finance for additional health budgets: they present it as an 'investment case'. But this is not always a formula for success.

THE RESTRICTED BUDGET AND SUBPAR WORKING CONDITIONS ARE A BREEDING GROUND FOR THE MIGRATION OF HEALTH WORKERS

The WHO has drafted guidelines [2] to determine the required number of health workers to guarantee universal access to health services. While it takes health needs as a starting point, in its approach towards the labour market it looks at supply and demand and is guided by a country's financial capacity to pay for the health workforce. This approach has a downside: it means that if a country has insufficient financial means, it cannot meet its health workforce demand. That is why Wemos rather advocates a human rights approach: everyone – worldwide – has the right to have access to health care.

REMOVE RESTRICTIONS

Next to sufficient national funds, international co-financing for schools and jobs is indispensable. The problem with this is that in the past the IMF and the World Bank have restricted their health financing to certain limits as a condition for their loans. Although these limits are now called 'recommendations', ministers of finance remain too stringent and prefer to limit their financial efforts. In Geneva at the WHA 2017, countries like Zambia, Zimbabwe and Botswana made it clear that they have shortages of fiscal and budget space. As a result, too little money is budgeted for the health workforce and recently graduated health personnel are left unemployed as there are no vacancies. Also, salaries in the public sector are (temporarily) 'frozen' and working conditions are far from ideal. As a reminder: we have seen this same situation in the EU member states during the latest financial and economic crisis. And since budgets are once again increasing, the number of vacancies has sky-rocketed, for example in the Netherlands.
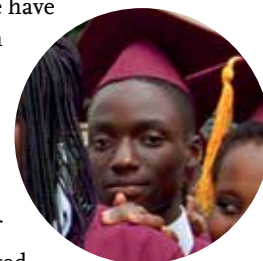
KEEP PROVIDING SUPPORT

International donors who, until recently, invested in the health workforce, for instance via salaries or top-ups, now hardly do so anymore because they do not want to finance recurring costs. The underlying idea is that spending more

money on the health workforce would not be a sustainable solution. Colleagues from low- and middle-income countries tell us that financial support is still lacking. This is why Wemos is encouraging high-income countries to keep providing financial support to countries that need it the most. In an interconnected world, this is not just an optional commitment: the universal right to health obliges us to do so.

INVEST IN EDUCATION

Investments are also needed from high-income countries here. The restricted budget and subpar working conditions are a breeding ground for the outward migration of health workers, which is another factor undermining health systems. The prospect of thousands of vacancies in high-income countries is a huge red flag. To prevent a disastrous 'pull' effect on health personnel in low-income countries, high-income countries need to take a closer look in the mirror and invest more in health education and training. The WHO Global Code of Practice on the International Recruitment of Health Personnel [3] is definitely still relevant in this light, and that is why Wemos will continue advocating for its implementation with partner organizations.
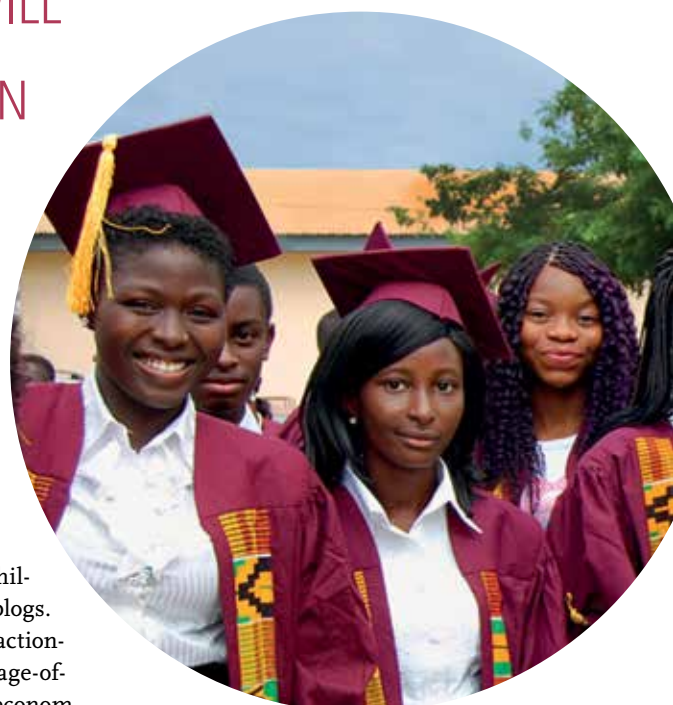
WORK INTERSECTORALLY

According to the ILO, health workers should organise themselves so that they can collectively advocate for adequate working conditions. The ILO also promotes an intersectoral approach. Ministers of health must therefore talk with their colleagues in education, employment and finance to collectively reach good agreements. This is exactly what Wemos has argued for during the past years. We brought together different ministries, unions, civil society organizations, and employers in the healthcare sector to discuss financing, education and working

conditions in the health sector. Encouraged by our newest insights from Geneva, we will continue doing this together with our partners in the Health Systems Advocacy Partnership.

BY THE YEAR 2030, THERE WILL BE A DEMAND FOR 40 MILLION NEW JOBS IN HEALTHCARE WORLDWIDE, MOST OF THESE IN HIGH-INCOME COUNTRIES

Read more about the plan in Mariëlle Bemelman's and Mit Philips' (MSF) blog in BMJ: https://blogs.bmj.com/bmj/2017/07/24/new-action-plan-to-address-the-global-shortage-of-health-workers-fails-to-address-economic-constraints-to-its-implementation/

This article is an adaptation of a blog which was published on the Wemos website (July 2017): www.wemos.nl/en/we-cannot-allow-this-plan-to-fail-invest-in-health-workforce/

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Working for a stronger maternal and child health care system in Malawi

Interview with Dr Ann Phoya

One of the key speakers at the NVTG conference 'Human Resources, Research and Rights: Ethical dilemmas in Global Health' this coming November is Ann Phoya, who originally trained as a midwife, later received a PhD, and for many years worked to improve Malawi's health care system. One of our editors, Andrea van Meurs, spoke with her about trends in Malawi and what she considers the biggest challenges in maternal and child health.

BIOGRAPHY
Ann Maureen Phoya (PhD, Public Health Nurse, and Registered Nurse Midwife) started her career working as a midwife in Lilongwe, Malawi. She encountered the problems women face in labour and combined her midwifery experience with an advisory role in maternal health programs. Five years ago she retired from working at the Ministry of Health where she had served in various positions, as Director of the Sector-Wide Approach, Director of Nursing and Midwifery Services, and Safe Motherhood and Family Planning programme manager. After her retirement, Dr Phoya joined the University of North Carolina (UNC) Malawi Program where she served as Director for Safe Motherhood Projects funded by the Bill and Melinda Gates Foundation. The project sought to address the major causes of maternal mortality in Malawi.

Currently she is the President of the Midwives Association of Malawi and working as Clinical Director at The Organized Network of Services for Everyone's (ONSE) Health Activity. ONSE is the USAID Malawi's flagship program for health.[1] As President of the Midwives Association, she plays an advocacy role for midwives among health sector players including the government. Their aim is to ensure access to quality maternal and child health services, including family planning, as a strategy for reducing maternal and neonatal mortality and morbidity. Their overarching goal is to accelerate Malawian governmental efforts towards achievement of the Sustainable Development Goals in 2030.

MATERNAL HEALTH IN MALAWI

Globally, maternal mortality has significantly declined in the past two decades. In Malawi, the maternal mortality ratio (MMR) declined from 1120 per 100,000 live births in 2004 to 439 per 100,000 live births in 2015.[2] Despite this improvement, Malawi's MMR is still one of the highest in the world, and to achieve Millennium Development Goal 5A (75% reduction of MMR) in 2015, a steeper reduction down to an MMR of 155 per 100,000 live births would have been required.[3] Today, a 15-year-old Malawian girl has a one in 29 lifetime chance that she will eventually die from a pregnancy-related condition.[4] Maternal deaths account for 16% of all deaths to women aged 15-49.[2]

Reflecting on these trends, Dr Phoya comments: 'Since 1990 a combination of efforts have contributed to the decrease in maternal mortality in Malawi. It started with important political commitments. First of all, traditional birth attendants were forbidden to help women deliver at home, because when a complication occurred they were not able to manage it. Moreover, the

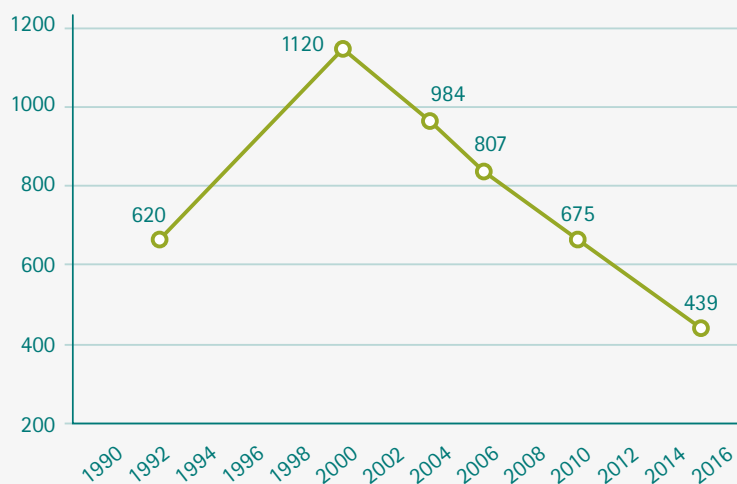MALAWIAN MATERNAL MORTALITY RATIO PER 100,000 LIVE BIRTHS

Figure 1. Trends in Maternal Mortality Ratio from 1992 - 2015.
Source: Malawian Demographic Health Survey 1992, 2000, 2004, 2010 and 2015-2016.[2]
Maternal mortality ratio (MMR) is defined as the annual number of female deaths per 100,000 live births from any cause related to or aggravated by pregnancy (excluding accidental or incidental causes).
Nota bene. The strong increase in MMR from 1992 to 2000 is thought to be due to the AIDS epidemic.

government pays for antenatal care and hospital care during labour and after delivery. A further important contributing factor is that the government has invested in improving the training programme of midwives. Midwives are adequately trained nowadays to manage the major killers, such as post-partum haemorrhage, complications of abortion, uterine infections, pregnancy induced hypertension and pre-eclampsia.'

Despite these improvements, even bigger challenges remain. 'I saw the difficulties women faced to reach the hospital; the ambulance did not come in time, or it was in time, but then there was not enough fuel because the budget of the district hospital was too low.' Also, there is still a severe shortage of midwives in Malawi. 'The government trains as many midwives as possible, but as the population of Malawi is growing fast, there is still a shortage. Sometime so many deliveries take place at the same time that there are not enough professionals, delivery beds and supplies for all the women.'

TODAY, A 15-YEAR-OLD MALAWIAN GIRL HAS A ONE IN 29 LIFETIME CHANCE THAT SHE WILL EVENTUALLY DIE FROM A PREGNANCY-RELATED CONDITION

IMPROVEMENTS ARE REQUIRED AT ALL LEVELS OF THE HEALTH SYSTEM
Dr Phoya makes it clear that efforts to reduce maternal mortality should tackle the whole health system. Earlier she worked together with the United Nations

Safe Motherhood Initiative, designing strategies to avoid all three types of delay that are associated with high maternal mortality: 1. Delay at the level of the household in recognizing problems and in deciding to seek care, 2. Delay on the
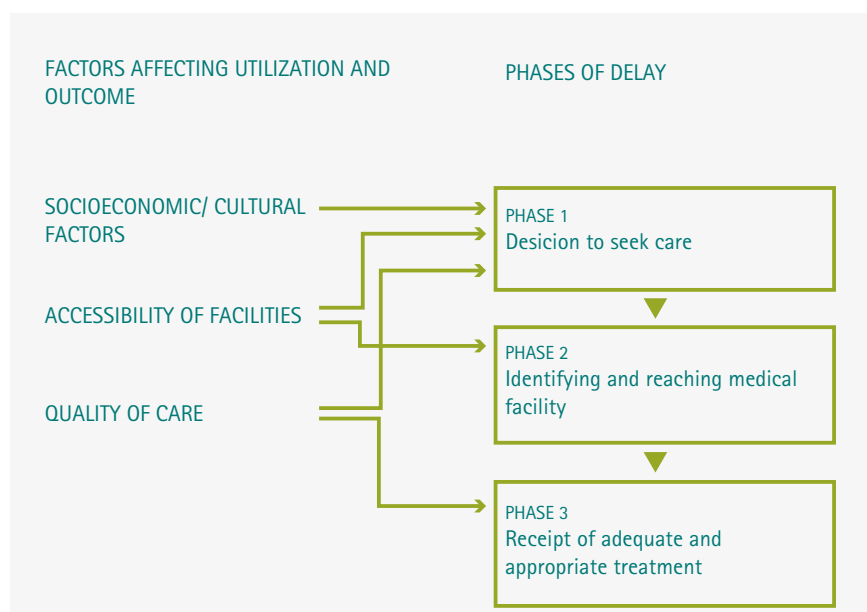

Figure 2. The Three Delays model which is often used to improve maternal health systems

part of communities in providing transport for a parturient woman to get to a health facility, and 3. Delay on the part of health professionals within the health facility in providing appropriate care according to the woman's needs (Figure 2). 'If you address just one problem, you will encounter the next one. So to make a difference, you always have to reduce all three types of delay.' She highlights one part of the project. 'We started with an intervention at community level. By providing knowledge to the community, families were able to make a timely decision to utilize health service when help was needed. Women were provided with information during their antenatal period on what is normal in pregnancy, danger signs of pregnancy and delivery, and where to go for help.' The project also addressed the second source of

delay, transport. 'We looked at the effectiveness of the utilization of ambulances. In addition, maternity waiting homes were built where mothers came to the facility and waited until labour started.' One of the most important interventions they made was within the health system itself. Dr Phoya and her team trained the health workers to identify and manage complications, and they improved the provision of equipment and supplies. 'To achieve real improvement, one has to look at the entire problem chain.'

CLANDESTINE AND UNSAFE ABORTION IN MALAWI
One of the major causes of maternal mortality is unsafe abortion. It is estimated that 6-18% of maternal deaths are the result of complications after unsafe abortion. Each year 141,000 Malawian women have abortion, more than half of them clandestine.[3] A staggering 60% of all these abortions result in complications that need medical treatment. Restrictive abortion laws do not stop abortion from occurring, they just drive

it underground, forcing women to resort to unsafe procedures. Unsafe abortion is an urgent public health priority in Malawi, which the government tries to manage since the adoption of the Sustainable Development Goals in 2015.[5] That same year, a Special Law Commission was installed by the Malawian Government to review the restrictive abortion law.

Dr Phoya was one of the team members of the Commission. 'The recommendation of the Special Law Commission was not to totally legalize abortions, but to define the conditions under which women can obtain an abortion: allow legal abortion for a woman's physical or mental health, pregnancies resulting from incest or rape, and pregnancies of foetuses with severe malformation. If adopted, this would be a significant step forward to reduce maternal mortality.'

The recommended Malawi's Termination of Pregnancy Bill has now been awaiting approval for two years. 'Abortion is controversial in Malawi. Up to 80-90% of the population is Christian, and the church rejects abortion irrespective of the circumstances. The Commission took into consideration that Malawi is a Christian country but also acknowledged the harsh events that women may encounter which can be life threatening.'

Helping Malawian women to avoid unintended pregnancy is critical to reduce the incidence of abortion and possible complications and deaths. 'We also very strongly recommend family planning programs, so that unintended pregnancies can be prevented.' Research from 2015 shows that more than half of all pregnancies in Malawi were unintended, and almost one-third of those unintended pregnancies ended in abortion. 'The goal is not for more women to have abortion, but for those who need it to have services available for safe abortion.'

LEADERSHIP

Ongoing research shows that leadership is one of the key health systems factors affecting the performance of maternal health services at facility level. Good leadership is essential for effective health systems development.[6] Dr Phoya agrees. 'But, unfortunately

reproductive and maternal health staff in Malawi are not trained to manage a health facility. They need better managerial skills to provide more effective and efficient health services.' So, which important leadership characteristics can make a change? 'We need people who can lead others, people who know what challenges are involved in providing the necessary services, people who can organize teams and sit together with them, and people who know what possible solutions in health care are available. A good leader can advocate for resources.' These characteristics are not learned during a busy working day; they need to be trained. 'A health provider needs to balance clinical and technical skills with leadership skills.' As an advocate for quality maternal and child care, Dr Phoya recommends that midwifery training should contain different skill sets (technical, clinical and leadership skills) to ensure the availability of midwifery managers who can also lead others. 'Moreover, our training should include training in an open feedback culture. We need to brief each other that this is the way we would like to do business, and that feedback is not intended to discourage but to encourage each other.'

TIPS AND TRICKS FOR FOREIGN MEDICAL DOCTORS WORKING IN MALAWI

Malawi has a very low health professionals population ratio of 1 healthcare worker for every 8,300 people (totalling doctors, clinical officers and medical assistants).[7]

'The day that Malawi will have enough of its own medical doctors will not come soon, so there is enough room for foreign doctors to work in Malawi. My advice for young medical doctors who come to our country is to first carefully look and learn what the local people do and become a little bit more aware, because Malawi has a different culture. Work as a team, and decide together where and how you want to support each other. Moreover, learn how feedback is best provided.'

'Before you start working, read as much as possible about Malawian culture. Then you will not be amazed why

people are doing the things they do. Take time to learn and understand. Then you will be able to cope. But you should also know that you are working in an environment where you do not have all the resources that you normally have in Europe. You have to improvise. We have shortages of supplies and staff. At first that will be a shock, but eventually you will learn. But most important of all, create a solution that will be sustainable after you leave.'

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RESTRICTIVE ABORTION LAWS DO NOT STOP ABORTION FROM OCCURRING, THEY JUST DRIVE IT UNDERGROUND, FORCING WOMEN TO RESORT TO UNSAFE PROCEDURES

Hidden evidence of torture
Medico-legal reports in the European Union asylum procedure

15-9-2015, Serbia. Refugees protest at the Serbia-Hungary border.
(Photo UNHCR Igor Pavicevic)

THE MIGRATION CRISIS AND EUROPEAN UNION ASYLUM SYSTEM
One of the greatest human rights challenges and ethical dilemmas of our time is how to deal with migration. The international community is currently faced with close to 70 million forcibly displaced people mainly due to conflict and violence, almost one percent of the world's population. [1] The European Union (EU), like most countries elsewhere in the world, has the duty to offer international protection, based on the ratification of UN treaties, and to grant asylum to people who are fleeing 'persecution or serious harm' in their own countries. [2,3]

The magnitude of the problem has made complying with these international agreements while at the same time keeping the EU stable and safe very challenging. The recent refugee crisis, with around 1.2 million asylum applications in 2015 and 2016, caused the EU to introduce controversial border control measures, reducing the influx to 650,000 applications in 2017. [4] Almost half of these applications were approved, with approval rates greatly differing among member states. [5] The Common European Asylum System (CEAS) aims to ensure equal treatment of asylum applications in all member states. Recent CEAS legislation formally recognised the Medico-Legal Report (MLR) as an important tool to investigate 'signs that might indicate past persecution or serious harm' (see text box Article 18). [6] This report presents the challenges concerning the MLR in the EU asylum procedure, which were defined last year in an EU project involving NGOs from the Netherlands, Hungary and France, as well as leading experts from other member states.

ASYLUM SEEKERS IN THE EU NEED TO PROVE THEY ARE FLEEING PERSECUTION OR SERIOUS HARM

THE ROLE OF THE MLR IN THE ASYLUM PROCEDURE

CASE

An Ethiopian woman applies for asylum in the Netherlands. She claims she has been tortured in prison due to her husband being part of the Oromo Liberation Front (OLF), an organisation that fights for the rights of the Oromo people and is prohibited by the Ethiopian government. Her asylum is denied, because she cannot give enough details about the detention and her husband's work for the OLF. The accounts are not deemed credible. Her lawyer asks for an MLR from iMMO (see text box iMMO for more information). The 6-hour medical examination by a medical doctor and psychologist reveals around 40 scars all over her body and symptoms of Post-Traumatic Stress Disorder (PTSD), which is also diagnosed in the medical record. While becoming highly emotional, she gives more information about the detention and tells of being raped multiple times. The scars on her legs are evaluated as being highly consistent with her accounts of being beaten with a stick. It is also concluded that the PTSD makes it likely that she avoided talking about the traumatic events in the asylum application. Her lawyer submits the MLR and asylum is granted, based on the supporting medical evidence.[7]

LEGAL ASPECTS AND CONTENT OF MLR

Assessment of an asylum application is done by establishing the facts of the claimant's account, and evaluating if there is a legal basis for asylum. The burden of proof lies with the applicant, who often has little to no objectively verifiable evidence to support his or her story. An MLR may contribute to the assessment of the credibility of a claim by examining the plausibility of any previous ill treatment.

The MLR consists of a forensic evaluation of physical and psychological signs and symptoms. For example, certain scars may be typical for a stated torture method. Furthermore, psychological problems may explain why the applicant finds it difficult to disclose traumatic events. Avoidance, a feature of PTSD, can cause delayed disclosure. Moreover, the interview with a health professional, rather than with an immigration officer, may bring forward new information.

ARTICLE 18

MEDICAL EXAMINATION

§1. Where the determining authority deems it relevant for the assessment of an application for international protection (...), Member States shall, subject to the applicant's consent, arrange for a medical examination of the applicant concerning signs that might indicate past persecution or serious harm. Alternatively, Member States may provide that the applicant arranges for such a medical examination. (...) Medical examinations carried out in accordance with this paragraph shall be paid for out of public funds.
§2. When no medical examination is carried out in accordance with §1, Member States shall inform applicants that they may, on their own initiative and at their own cost, arrange for a medical examination (...).
§3. The results of the medical examinations referred to in §1 and 2 shall be assessed by the determining authority along with the other elements of the application.

AVAILABILITY OF THE MLR

FEW MLRS REQUESTED BY IMMIGRATION AUTHORITIES

The recent EU legislation requires immigration authorities to call for an MLR 'where the determining authority deems it relevant for the assessment of an application' (see text box Article 18). Yet, authorities rarely request MLRs and asylum seekers are therefore forced to independently arrange for an MLR. In the Netherlands, about 10 MLRs per year are requested by the immigration services, compared to 100 MLRs per year being submitted by applicants, executed by iMMO.[8]

Jurisprudence, yet to be developed, may guide immigration authorities in determining which conditions call for an MLR and could further the availability of MLRs.

CAPACITY PROBLEMS OF NGOS

EU legislation does not provide a basis for payment of the MLR when submitted by the applicant (see text box Article 18) and it is usually not paid for by immigration authorities. For example, iMMO has produced around 600 MLRs and thus far only received financing by immigration authorities for 47. NGOs therefore predominantly rely on private funding and volunteer health professionals to execute the examinations. [9] Capacity problems create long MLR waiting times, causing additional costs for member states, and stressful and potentially harmful prolonging of the uncertainty about the applicant's future.

Lack of funding also gives rise to the ethical question: 'Which requests for an MLR should be granted and which should be refused?' It's hard to define how such decisions ought to be made, as multiple factors need to be taken into account such as country of origin, medical signs and symptoms, and legal obstacles to an MLR being of value. iMMO rejects approximately 20% of the requests for an MLR, partly because of capacity problems. Scarcity of resources also gives rise to the need to shorten examinations and reporting. However, this proves to be difficult due to the complexity of the examination and the thoroughness of the conclusions demanded by the immigration authorities. On average, the examination takes 4-6 hours and over 20 hours of subsequent analysis and report writing.

Without measures for reliable financing of MLRs, capacity problems and therefore undesirable and costly prolonging of the asylum procedure will remain.

DIFFERENCES IN EXAMINATION AND INTERPRETATION OF MLRS

PURPOSE OF MLR

MLRs are used for different purposes throughout the EU. For example, in Hungary all asylum seekers are detained in detention centres, and NGO medical reports are used mainly to challenge this detention. In France, few MLRs are produced because NGOs fear that

their introduction will disadvantage asylum seekers who are not suffering from physical or psychological sequelae resulting from torture or violence. In the Netherlands and the UK, NGOs have been producing MLRs for many years, and both the judiciary and government acknowledge the value of these reports.

USE OF THE INTERNATIONAL GUIDELINE AND PROPER EVIDENTIARY STANDARD

The UN adopted Istanbul Protocol (IP) is the established international guideline for torture investigations and is recommended in EU asylum legislation. It gives detailed information on the principles of forensic medical examination and reporting on torture and related forms of violence.[10] However, forensic doctors employed by the government to investigate asylum applicants usually have a background in national criminal investigations and therefore often lack the necessary knowledge of torture practices and effects and the application of different standards of proof. This can lead to MLRs that are of little value. The evidentiary standard in criminal law is 'beyond reasonable doubt', whereas in the asylum procedure the story ought to be 'plausible', and the 'benefit of the doubt' principle applies in certain cases.[11]

INTERPRETATION BY IMMIGRATION AUTHORITIES

The MLR is not always treated as expert evidence by immigration service decision makers, nor given due weight, despite the fact that the MLR is included in the European Asylum Support Office (EASO) training for EU immigration services.[12] For example, the expertise of experienced health professionals or the clinician's expert opinion on the cause of the medical conditions are sometimes disputed.[13] When authorities question the MLR conclusions, a second opinion is rarely requested, although this is common practice in other areas of law. Interdisciplinary meetings are not often held, and creation of mutual understanding can prove to be difficult.

EU TRAINING MANUAL

A structured MLR format could reduce the existing differences between member states. Well-trained health professionals would ensure reliability and usefulness of the reports, and training of legal workers would create more consistent interpretation. For that end, a training manual for health professionals and legal workers was developed in the aforementioned EU project.[14] The common standards presented in the manual are based on the IP and include guidelines for health professionals, required competencies of the health professional, tools for legal workers to appropriately incorporate the medical findings in the decision-making process and, lastly, measures for self-care due to the potentially traumatising nature of the work.

CONCLUSION – THE MLR HAS BEEN FORMALLY RECOGNISED BY THE EU BUT CHALLENGES REMAIN

Immigration authorities need to determine if there is a legal basis for international protection, and asylum should be granted if previous persecution or serious harm is plausible. An MLR, produced according to the existing guidelines and by trained health professionals, can be of assistance in difficult cases by providing objective information regarding the stated histories. An MLR can make hidden traumas visible by exposing physical and psychological injury potentially related to ill treatment. It is acknowledged to be a valuable addition to the credibility assessment in the asylum procedure. While formal EU recognition of the MLR is an important step forward, challenges regarding availability, financing, uniformity, quality and interpretation of the MLR by immigration services remain. An EU training manual with common standards for the MLR was developed to address some of these challenges. Further development and implementation of policies and guidelines by lawmakers, (EU) judiciary, and immigration authorities will conceivably create additional improvements.

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iMMO - institute for Human Rights and Medical Assessment – www.stichtingimmo.nl

iMMO is a non-governmental organization in the Netherlands that focuses on forensic medical assessments of suspected victims of torture and inhumane treatment in the context of the asylum procedure. The examinations are executed by medical doctors and psychologists, mainly volunteers.

21-10-2015, Croatia. A line of refugees is escorted by police to buses to the registration centre. (Photo UNHCR Mark Henley)

The 'gringo' doctors: how can we sustain their noble cause?

My personal perspective on sustainability and medical brigades

In 2015, I volunteered in a community project in Malawi. One inspiring community member I met there made a lasting impression on me. Imagine a tiny remote village, crossed by nothing more than dusty roads. The first individual you encounter along one of these dusty roads is Mercy, a fifty-year old woman with a smile from ear to ear. She kindly greets you with the Malawian saying 'Muli bwanji? Ndili bwino kaya inu?'

Unfortunately, Mercy is part of the large group of people living with HIV. When I first participated in the agricultural activities of the HIV support group that Mercy is part of, I immediately noticed Mercy as the leader of the group, the one who works the hardest while joking around the most. I soon realised that Mercy has been of irreplaceable value in establishing this gathering of women living with HIV, as she was the first one to stand up and to start breaking the stigma around HIV in her community. Thanks to her initiative, these underprivileged women not only have a daily nutritious meal, but also gather for weekly support group meetings in which they learn to stay healthy and cope with their HIV status. Mercy's courage to fight for her own rights and those of her peers sharing the same fate, while living a tough life herself, made a huge impression on me.

I participated in two medical brigades in the coastal communities of Panama and the Amazon of Ecuador both as a medical student and translator. The inspiring idea of serving remote communities that cannot visit a doctor without having to walk or boat for hours motivated me to contribute to the noble cause of medical service trips. But I believe that the most important aspect is to secure continuity and sustainability of care. Imagine what would happen if a group of 'gringo' medical professionals provides the best, warm-hearted, medical attention possible to a community, without working together with the somewhat 'undernourished' health care system in the region. Would the local government still be triggered to improve its health services? Or would the system start to rely on the arrival of the 'gringo' doctor every now and then?

In my view, the goal of the NGO behind a medical brigade should be to collaborate with the local government to improve its health care services. In this way, the NGO can make sure that, in the end, the communities they serve remain healthy without the services of the 'gringo' doctors.

During my medical service trip in Panama, no local medical professionals were involved in our work, we could not easily refer patients to the government health centre and, if a patient ran out of medication in the meantime, there was nothing he could do. I had a completely different experience in a similar brigade in Ecuador. I saw how this foundation did an incredible job by establishing a sustainable relationship with the Ecuadorian Ministry of Health, allowing us to refer our patients to the health centre when needed. Likewise, we worked together with the community health workers responsible for promoting health in their community and ensuring the continuity of care. I believe that working closely together with local health services and skilled community members incredibly enhances the success rate of a medical aid foundation.

Mercy, the Malawian woman who inspired me, is a great example of a person who can play an essential role in establishing a sustainable relationship with the local health care services. Moreover, such a person can safeguard the continuity of care by motivating local health care workers to shoulder responsibility for maintaining a healthy population. From my experiences with the different communities I have lived and worked in until now, I believe that people like Mercy exist in every society. I have always met wonderful people who acknowledge the challenges their community faces and are eager to gather their group of likeminded people together to find a solution. I believe we would miss out on a great opportunity if we were to exclude their strengths and capabilities from our strategy to improve the lives of their neighbours.

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Research and training of medical doctors in intercultural mental health care in rural Chiapas, Mexico

Ten years ago, the World Health Organization launched the mhGAP programme in order to improve mental health care in low-income countries through training of primary health care workers in management of the most prevalent mental health conditions.[1] In 2014, an MTb edition was dedicated to this topic, and the main message was that, in order to be effective, the mhGAP programme needed to be adapted to local and cultural contexts.[2]

In Mexico, neuro-psychiatric diseases are responsible for most of the healthy life years lost due to disability.[3] However, although the country ratified the United Nation's Convention on the Rights of People with Disabilities in 2007, no successful strategies have yet been implemented to improve mental health care services in rural settings.

In Chiapas, a southern Mexican state with more than 4 million inhabitants, there is only one ambulatory mental health care centre, situated in the capital city. Other than that, psychiatric care is concentrated in a few regional hospitals and the private sector. The Health Secretary recently organized a few mhGAP training sessions for primary health care workers.[4] However, in socio-culturally diverse Chiapas, where traditional healers are an important part of the local health care system, the challenge is to offer training that takes into consideration the large local variety of illness perceptions and healing practices.

MENTAL HEALTH RESEARCH IN HOSPITAL SAN CARLOS
Hospital San Carlos (HSC) is a rural, private, not-for-profit hospital in Chiapas that serves 80% of the indigenous population, principally Tzeltal speak-

ing people of Mayan descent.[5] Mental health problems rank sixth in the list of most frequent diagnoses at the HSC outpatient clinic: mostly anxiety and depressive disorders.[6] In 2014, the hospital started a mental health project with the aim of providing primary mental care according to the mhGAP programme, including psychological and psychiatric services. Patients who present at the outpatient clinic and are referred to a psychologist or a psychiatrist are first seen by a general practitioner.

In an attempt to strengthen sociocultural understanding and communication during clinical encounters with mental health patients, we carried out a qualitative research study in 2017 on patient illness experiences.[7] Eight patients of Tzeltal origin were interviewed using the McGill Illness Narrative Interview (MINI) method, which has been validated for the Spanish language. [8] We also interviewed medical doctors working at HSC in order to obtain information about their perceptions of the illness experiences of their patients. To triangulate data, a focus group discussion was held with the medical doctors to discuss the results of the interviews. In addition, 20 randomly selected clinical encounters with mental health patients were observed. Our most important findings are presented below.

UNDERSTANDING THE PATIENTS' SUFFERING FROM A SOCIOCULTURAL PERSPECTIVE
Patients and medical doctors both stated that doctors often do not make the correct diagnosis. The doctors' explanation for this is that, during medical consultations, Tzeltal speaking patients usually mention only their somatic condition. They rarely see a causal relation between physical symptoms and adverse life events which they may have experienced. Moreover, patients who suffer from mental disorders, which

in local language may be called *susto** or nervios, believe they require *costumbre*** or need to visit a traditional healer. They consult a medical doctor only for the treatment of physical problems. From patient narratives, however, it became clear that mental suffering and somatic expressions are embedded in their social environment and can be understood as a way of coping with certain adverse social situations.

TZELTAL SPEAKING PATIENTS RARELY SEE A CAUSAL RELATION BETWEEN PHYSICAL SYMPTOMS AND ADVERSE LIFE EVENTS

The two examples below illustrate some of the socio-cultural explanations cited by patients with mental disorders and make it clear that physical symptoms can be seen as an expression of social adversity.[9]

* Susto: illness caused by a traumatic experience, such as an accident, an attack by a dangerous animal, or near drowning

** Costumbre: ritual or religious actions undertaken in the community to treat and prevent disease, for example praying, using herbal teas, or rituals performed by a traditional healer

Juan, aged 28, homosexual and as a result not accepted by his family and community, battles with the question whether homosexuality is a disease or not. He says: 'My head feels like a mill that twists me, and my blood jumps strongly. It is as if my veins where the blood passes are going to tear apart.' Juan's anxiety symptoms are an expression of suffering from his socially not accepted homosexuality. His symptoms also seem to be part of the 'micro politics' of his social interaction, as Juan presents them to his social surrounding as an explanation of his homosexuality as a disease that might be cured.[10]

Feliciano, who is 33 years of age, suffers from anxieties caused by uncertainty around his mother's and his own condition and his search for remedies. His mother became sick and they searched for the right treatment for three years. 'We went to see doctors who did not detect what the problem was. We went to herb healers, but my mother didn't get cured. We only spent money. In a laboratory, they found out that she had typhoid: it gives high fever and she felt as if she would die. She took pills, but that didn't help much. They gave her some injections, but then she got gastritis and an ulcer. It got very complicated. She stayed in the city while I was working on the field, but then I fell sick as well.' Feliciano suffered a herpes infection of his eye. Although he visited several doctors, including an ophthalmologist, he lost vision in one eye. Then he started to present anxiety symptoms: fast heart beating and chest oppression. As his frustrations accumulated because of his failed attempts to find help, his anxiety problem worsened. His symptoms were an expression of his personal internal suffering, partly caused by the ineffectiveness of the local health care system. Feliciano's condition can be seen as an expression of his interaction with his social surroundings.

TRAINING OF MEDICAL DOCTORS IN INTERCULTURALISM

Standard medical anamnesis may inhibit a practitioners' understanding of the patient, as illustrated in the following dialogue.

Doctor: 'I'm going to ask you some quick questions in order to know you better: Do you have any allergies?'

Patient: 'They have given me a medication for spots that I got, but I got nose bleeding.'

Doctor: 'Were you ever operated on?'

Patient: 'No.'

Doctor: 'Do you take medication?'

Patient shows a bag full of medications and comments: 'I have many body pains.'

Doctor: 'Has something happened in your life?'

Patient hesitates in answering.

Doctor: 'Now I will examine you.'

If medical doctors in the intercultural setting of Hospital San Carlos had a more open and holistic attitude towards patients' expression of suffering, patients would be more open, allowing doctors to obtain a better understanding of their patients' condition. A clinical consultation must therefore be based on the patient's perceptions that include somatic aspects as well as emotional experiences. An integrative approach to body and mind needs to be established when evaluating the patient's condition. A shift has to take place in mental health care as well as in general practice to see the body as a symbol system on an individual, social and cultural level. To achieve this, Hospital San Carlos has implemented a cultural training programme for medical doctors that consists of Tzeltal language classes, training in open question interview techniques, and knowledge building of local culture by the team of medical practitioners, based on the collection and review of patient narratives.

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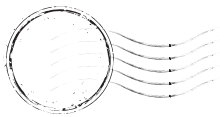
Informed consent: why are we still trying?

With only seven years of experience as a medical doctor, half of which as a doctor in tropical medicine, I can't say I am a senior specialist. However, I have worked in several countries in three different continents. And even though every country is unique in its own right and the differences in culture and politics are obvious, you do come across commonalities, such as poverty and violence. Ethical issues are definitely a third shared aspect. This may be less expected but, from my own experience, I can say that the ethical issues to be dealt with are comparable across low- and middle-income countries around the world.

To understand what, from an ethical point of view, is right or wrong, try to imagine the following situation. You're working in the Amazon rainforest on the border between Ecuador and Peru. At seven o'clock at night, a young woman arrives at your emergency department. She is unconscious due to extensive blood loss caused by an artery dissection in her upper arm by a machete. She needs surgery, but before loosening the tourniquet she will need a blood transfusion. You decide to search for blood donors in the little village where you are working, but as you have experienced before, the people of the village, Indian descendants of the Quechua, are afraid to drain a bag of blood from their veins. They believe it gives you mal aire, bad influences, or they think it is all the blood you have and you will die. Even though this last conviction is certainly false, and you don't share the first one, as a medical professional, you do have to respect these fears.

Now imagine that this situation is actually happening. This young woman is almost dying there in your emergency department, on your watch! You have sworn the oath of Hippocrates that you will do everything in your ability and judgement that is reasonable to save her life. You know from your own experience that the Quechua have great difficulties in expressing their own opinion. When communicating with a Western medical specialist, this becomes practically impossible. You know that, if you ask them to donate blood, they won't say no. Even though it's obvious to you that they don't want to do it, within an hour, you manage to 'convince' four people to donate their blood and you save the woman's life. From an ethical point of view, this was an act of paternalism where the young woman is the only one who benefited. Is this wrong? Is failing to wait for the honest opinions of the donors not abusive? On the other hand, you have sworn that you would do everything in your ability to heal people and that is what you did. Is that wrong? The patient survived and the four donors are still in perfect shape. But at the risk of having mal aire?

Imagine another real-life situation, this time in Sierra Leone. A nine months pregnant woman is brought into the hospital because of fits. Eclampsia. After starting treatment for her eclampsia, you conclude that she doesn't have enough dilatation and she will need a cesarean section. An ultrasound demonstrates that the baby has already died. This turns out to be her ninth pregnancy, and the woman does have some children who are alive. Therefore, you also would like to sterilize her to prevent more pathology in new pregnancies. The first thing you have to do before you proceed is ask for informed consent. The pregnant woman is eclamptic and therefore not able to communicate with you, so you will have to talk to her husband. There you go then: 'I have to do an emergency cesarean section, meaning that we will have to make a large cut in the abdomen of your wife so we can take out your dead unborn son. Since her condition is very dangerous, we need to sterilize her as well to prevent new pregnancies.' Of course, if you had more time, you would explain it better with examples and even drawings. But you do not have this time.

In this situation, no medical professional would doubt that you are doing a good job by performing the caesarean and the sterilization. But what if the husband does not agree? What if he doesn't believe that his unborn son is already dead? He would not understand the ultrasound. He believes that the fits are the result of shamanism. You can explain as much about anatomy and pathology as you like, but the husband will not understand or believe you. What is then the value of trying to ask his informed consent? Is this a waste of very valuable time? Of course, not every surgery in Africa is this urgent. But even small and non-emergent interventions like hernia repairs are difficult to explain if the beliefs of the patients do not fit with those of Western medicine.

You may wonder what the value of informed consent is throughout low- and middle-income countries. In my opinion, you are just trying to convince your patient of the indication you have for an intervention, while this person has no clue as to what you're saying. So why waste time and effort in doing this? Most likely you are only making the patient or the family more anxious than they already are. Or they will doubt your skills even more. Should we then stop asking for informed consent in low- and middle-income countries? Certainly not. However, there is no easy answer how to solve this delicate issue. Should the doctor get more freedom to decide if the patient or family are qualified to be asked for full consent? When in doubt about these qualifications, should the medical professional be allowed to reduce the amount of information so that the patient is merely notified instead of having to give permission for what is about to happen? But this of course brings us back to the issue of paternalism.

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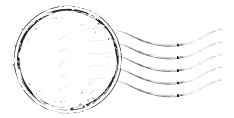
RESPONSE: Why not at least try?

Working in a low- or middle-income country (LMIC) brings several challenges, like dealing with limited resources, language barriers, and sometimes a harsh climate. One of the hardest challenges, however, is dealing with different cultural and moral values. For three years I worked in a district hospital in Zimbabwe. I remember a ninety-year-old woman who was brought to the hospital by her family. She had been admitted several times over the last weeks. After careful examination, I did not find new developments. I discussed the situation with her, together with the nurse in charge and the family. We discovered that the family was not comfortable with taking care of the woman at home, which I could easily understand considering the care difficulties the family was facing in such a limited resource setting. The sister in charge, however, was extremely upset after the consultation. How could the family be so inhumane, unwilling to take care of their mother and grandmother after she had raised the family?

I realized that my Western worldview influenced the way I thought about taking care of family members. Working in Zimbabwe opened my mind to the fact that moral values are different across the globe. It has given me the richness of knowing those differences and keeping the best of both worlds. I learned that there is more than one truth when talking about topics like time, family relations, life and death, respecting elderly people, and the amount of information that is given to patients.

Just as a tropical doctor abroad learns to deal with limited resources along the way, he or she will also get more experienced in dealing with different moral values. The difference between these two challenges is that the latter touches your own personality. It's more difficult to deal with a lack of informed consent, for reasons that you do not understand from your own perspective, than to deal with a lack of resources. Getting to know more about the people, the way they think and the background of their moral values, helps to understand why they make certain decisions different from what we expect.

As an outsider, I realized that I was the one who had chosen to work in a cross-cultural setting. Most people I worked with in Zimbabwe did not choose to work with me. It helped me to respect the local cultural and moral opinions. Working together brought opportunities to show and share something of the values I was raised with. Trying to truly understand the difference in background and learning from experienced local nurses taught me the local views and helped me to prepare patients for their theatre procedures.

Compared to other LMICs, people in Zimbabwe do have a relatively high education level. The local way of asking for informed consent was to ask patients to place a signature (or a cross if no signature was available) for agreement to undergo a certain procedure. I don't believe all patients fully understood the implications of their signature. Despite the relatively high education level, I don't think they had enough understanding of medicine to be able to interpret risks and consequences. This means the depth of the informed consent is definitely not the same as we are used to in the Netherlands. However, that does not mean we should not try to find ways of communicating indication, procedure, and risk with patients and their relatives in a way that connects with their knowledge and beliefs, to make sure the main issues are being communicated. The fact that we do not fully succeed does not mean we should not try. It is certainly not a waste of time, if not just because of the patients' right to information, then because of our own values as a surgeon to inform our patients before we take them to theatre.

Just as we can learn from the families that are used to taking care of their relatives, the different way of dealing with informed consent in LMICs helps us reflect on our own system in the Netherlands. Of course, the majority of patients want to know exactly what will happen and what might go wrong. But not all patients are helped by the detailed way we share the risks of complications these days. Is it really helpful to explain that the risk of complications is 1/1000 for a procedure if not performing the procedure is not an option? I think we should be willing to take some of the responsibility on our own shoulders, since informed consent can be used as an easy way of burdening our patients with it. However, we should continue trying to inform our patients prior to procedures in the best way possible, depending on circumstances like medical situation, education level and cultural background.

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Turning the World Upside Down: the search for global health in the twenty-first century

Author: Nigel Crisp
Published by: Taylor & Francis Group,
2010, 209 pages, EURO 24.99

Which message would you expect from a person who ran the world's biggest health service for five years, the NHS in England? An ode to technological development and established health systems and how the rest of the world can learn from this? The opposite is true here. Nigel Crisp – asked by Prime Minister Tony Blair about lessons learnt as former CEO of the NHS – wrote this book: Turning the world upside down. In his own words: 'There are two simple ideas at the very heart of this book – that rich countries can learn a great deal about health and health services from poorer ones and that combining the learning from rich and poor countries can give us new insight into how to improve health.'

FROM WALES TO BANGLADESH

Crisp introduces his book by describing the Jenkins, a Welsh family in the 1930s, of whom half of the children died very young of tuberculosis, whereas the surviving children are now in their 90s. This family tells the story of Western medicine: rapidly improving health and increasing life expectancy. It is against this background that strong health systems were built, science- and hospital-based and run by highly trained professionals. However, we no longer suffer that much from tuberculosis but rather from chronic conditions that may warrant a completely different, community-based type of healthcare.

Then the story moves elsewhere to the Bangladesh Rural Action Committee (BRAC), the largest NGO in the world and an example of a community-based organization. Instead of the top-down, professionalized health system of most wealthy countries, BRAC strives for self-determination and self-help, by dealing not only with health but also with education and other public services.

UNFAIR TRADE

Crisp continues his argument by extensively describing the current relationship between the North and the South. The 'brain drain' of healthcare workers from South to North is well-known. Another unfair aspect is the export of ideas and technology – and thereby power and superiority – from North to South. Crisp argues that the division between poorer and richer countries is an artificial one, and that we should rather be 'talking about our shared health issues, and not about development but about co-development'. After all, there is so much we can learn from each other! 'What if our import-export business was turned upside down, and poorer countries exported their ideas and experience whilst richer countries exported their health workers?'

DOES THE SUN TURN AROUND THE EARTH OR VICE VERSA? CHANGING A PARADIGM

A central theme in Crisp's book is that Western healthcare in general is designed to serve the professional rather than the patient and is focused primarily on clinical medicine instead of public health. Healthcare workers are highly specialized and organized in powerful medical associations, and the financial system often reinforces this type of expensive healthcare. Once again, what if this system was turned upside down? What if we change our paradigm from doctors being the centre of health to recognizing that patients are actually at the centre? Again, lessons can be learnt from the South. Mainly as a result of limited financial resources and underdeveloped health systems, there are numerous examples of how healthcare can be organized in a way that best serves the needs of the patients. One example of this is the training of clinic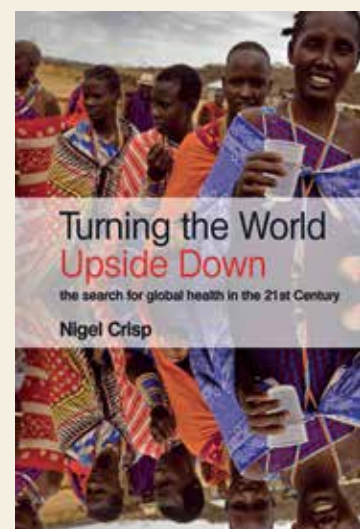al officers in several low- and middle-income countries, who are less extensively trained than doctors and therefore less expensive, but 'who do the job that needs doing as well as doctors would have done – if there had been any.'

WORTH READING?

Although this book introduces some challenging and thought-provoking ideas, it is anything but a naïve thought-experiment. Crisp builds his argument by providing a comprehensive context and discussing the effect of poverty, health systems, and capitalism on health. Even though there is now increasing attention for patient-centred healthcare, the idea is still not widely accepted and certainly not regularly implemented. This book provides a broad perspective on this theme and is written with great passion and conviction by someone with authority in the field. Reading it will definitely challenge the way you think about global health (not just the South!) and your own role in it, no matter what that role is.

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