

Editorial Board Message

Medical Student International (MSI) continues to present the thoughts and experiences of medical students everywhere. This issue features a variety of articles that covers the theme of “rural and remote health” in different forms and from many countries. In this issue, you will find personal stories and experiences describing the health deprivation in rural and remote places. Although the views and opinions of the authors vary, they explore potential solutions to reducing such health inequality. Beside the opinions and stories, you can find an interview with an Ethiopian child that exposes new perspectives of the issue. For those in a hurry, you will find a quick theme overview on page 17. If you have any comments about this MSI please don't hesitate to email us – and don't forget to have a look at the call for articles below.

Ahmed Magdy
Publications Director

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The articles featured in this edition of MSI were all written by medical students, young doctors and other health professionals. If you're interested in writing for the upcoming MSI-16 themed “Access to Essential Medicines” or if you know any other people who would be interested in writing for MSI please contact us at msi@ifmsa.org.

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Why I Won't be a Rural GP in New Zealand



Those who know me will tell you that I am a city girl, born and bred. Give me good food and wine, theatre and fashion, young professionals and dinner parties, and I'm in my element. But talk to those who know me a little better and they will tell you that I'm perfectly suited to rural general practice. I have the attention span of a goldfish, need variety to keep me from boredom, am desperate to maintain surgical and procedural skills, value autonomy in my practice, am incredibly pragmatic and enjoy acute and chronic medicine. Also, perhaps surprisingly, the prospect of living in a small town doesn't dissuade me; I've always enjoyed working in small communities and in reality, few rural communities in New Zealand are more than a few hours by car from the city; when you factor in broadband and all that the World Wide Web has to offer, the city can be in your office.

I'm passionate about rural medicine, I believe it to be the best sort of medicine, serving the best sort of people; the people that form the backbone of our economy, here in New Zealand, and some of our most underprivileged people, both needing and deserving superior, well resourced, specialist clinicians. To this end I am a member of my local rural health club, Grassroots, and am a founding and executive member of the national body, Aotearoa Rural Health Apprentices (ARHA). Along with the New Zealand Medical Students Association and the New Zealand Rural General Practice Network, we are working to support rural origin health students, encourage rural curriculum development at an undergraduate level and promote the importance of a strong rural health workforce in the public, political and health sectors.

Given this, how then can I categorically state that I won't be a rural GP in New Zealand? The simple fact is, I can't work in an environment in which there is little support and relative professional isolation. Our undergraduate curriculum does not expose students to rural medicine in a manner which promotes it as a viable career option. Our government provides little support for rural health professionals to establish, maintain or develop their practice. I am not at all equipped to run a business; it is not something that they teach you at medical school. Finding locums for holidays or CME is difficult and costly, potentially leaving you professionally isolated. As a single woman I wonder about finding a partner when all potentials are also my patients; and what about schooling for any future children? Unfortunately, these are only the first of many concerns.

If, despite my passion and excitement, I'm still so filled with doubt about the state of New Zealand's rural health workforce, how can we ever hope to convince undergraduate students that this is a viable career option?

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A portrait of a doctor as a young underdog

I. Prelude:

9 pm, night shift. I get out of the car and stroll to the door, but instead of the doormat I stumble upon a human body. "Not another corpse, I suppose?", I beam a smile to the nurse, acting as a secretary. "Naaaaaaah, just another drunkard fooling around with alcohol tolerance. His girlfriend is here, and she's freaked out".

I enter the building and readily notice a well-it's-hot-so-I-decided-not-to-wear-a-lot girl. Pupils dilate; the mind wanders; images of carnal interaction flash; but the first moans coming out of the youngster behind me suggest it is time for my altruistic intervention; get a wheelchair and put him on a bed.

Which fails, since he's much taller and MUCH heavier than me.

"Leave him there; that's what we always do", says the nurse, and I happily oblige; booze-influenced-weight-lifting is not included in our med school curriculum.

II. Allegro ma non troppo:

Chalkidiki is a peninsula situated next to Greece's second largest city, Thessaloniki. The locals, mostly in the agricultural business, are surprised by (and sometimes exploit) both the metropolis' citizens and the European tourists that flock the beaches during the summer months -as a result, the population, alcohol consumption and temperature skyrockets.

you may surmise, the health infrastructure is insufficient during these months. The regional health center, along with the GPs located in the nearby villages, can furnish the inhabitants adequately during the winter, but when the needs evolve past myocardial infarctions, snake bites and bulimia attacks, things get nasty, VERY nasty.

Suddenly, a whole world of opportunities opens to the uninitiated, a world suffering from minor quibbles, and the nightmare of having two emergency incidents and only one ambulance to the nearest hospital, which is on its way back and stuck in the traffic. It could be implied that this is a part of a secret master plan, according to which the Greek state improves junior doctors by exposing them to adverse conditions. This plan materializes every summer, when students from all Greek medical schools volunteer to help in those regional health centers, seduced by the bait of free holidays. But that plan is just wishful thinking.

III. Andante

The heavenly sound of the 85-year-old hysterical lady still rings in my ears. I feel sympathy for her, since her extended family lives in Australia and she's too old and has DVT, IDDM and all sorts of acronym-based diseases that prevent her from travelling, but even more for her tolerant husband, who surely has mastered Zen Buddhism and does not react to her constant insults. The morning shift is over, and from now on we accept only emergencies, or things that the patient thinks are emergencies but cause boredom to the doctors, who've seen a lot of these over the years that they're stranded in that health center. As I take out the remnants of a sea urchin out of a Stuttgart foot, I find myself able to communicate with the two tourists *auf Deutsch*, and give them instructions ("next time watch out, my friend!"). The man opens his wallet, asking me how much did my first-class operation cost, and for a second I contemplate the current euro-beer exchange rate, and for another second the fact that we're almost out of gauges and disinfectants, but then a senior doctor explains to me that it's free, and by the look of my face he judges that he's killed off my daydreaming too soon.

But for a good reason: a Lithuanian lady has taken a dive into the hotel pool after lunch, and has gulped down a significant amount of water. By the time the ambulance returns, she has flat lined, causing major distress. All doctors flock in, but to no avail: she passes away, and I can sense the feeling of surrender hitting the room. However, to a medical student that is almost always exposed to *living or long dead* human beings, this is a novel experience, stripping away the myth created by Sunday school, literary descriptions and incessant *ER* viewing. I covered the body with my sheath of thoughts, feelings and presumptions, and I moved it to the lab, forgetting it for a while.

After a few hours, a similar incident arrives: this time it's a conscious young English girl, along with her father; things seem easier, as books instruct inserting a nasogastric tube, so that the water is sucked out. However, the doctor that comes to help is as competent as Charles Bovary (and his wife is not as beautiful as Emma, but that's another story). Partially deaf despite his hearing aid, he tries to stick the tube in with finesse witnessed only in animal slaughtering. I suggest fetching the father to explain the procedure to him and at least try to console his daughter, who also has a history of epileptic seizures. He initially denies, tries for a second time, and finally agrees. I act as the interpreter between the two sides, who are equally ignorant to what can be done, but everything that happened has taken its toll on me, weighs too much, and I storm off. After all, I stayed more than I am obliged to, so I think it's time for some well-deserved rest.

IV. Da capo, al fine

After a week, my volunteer service was over, and on a Monday morning, I bid the doctors farewell. They seem more than satisfied with my work there, and I thank them for the experience I've gained, promising to visit them again next summer.

The same night, a devastating fire destroys almost half of the forest in the region and a lot of hotels and summer houses, thus the health center is flooded with people with respiratory problems, further exposing the inadequacy of the health services there. However, I am convinced that this is part of the aforementioned master plan; instead of expanding health services, let us minimize the number of people that need them, and everything will work out...



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Volunteer Ambos out in the Bush

Before I decided to go to medical school I lived for 5 years on an island off the coast of Australia. It's a gorgeous place to live, with bush, beaches and wildlife. Every morning I watched the sun rise over the beach in front of our house, and then in the evening watched it set over the hills behind. However, the downside to living in such an isolated place is that medical care can be a long way away. The island has 4000 people living scattered over a 4,500 square kilometre area (155km long and 55km wide) with three doctors who are based at the small hospital. Serious medical cases are flown by air ambulance to the city hospital and, instead of a paid team of paramedics, the 3 ambulances of the island are staffed by volunteers. I've heard medical people speak disparagingly of these volunteers as 'non-professionals', which is certainly true, but they give up their time to save lives, and when there is no option but to have a volunteer save your life you don't say no!

My friend Corinne, who's grown up on the island and knows all the islanders (and everything about them) decided to contribute to the community by joining the volunteer ambulance crew. This was a huge decision for someone who has never had to deal with anything more than her kids' various cuts and scratches and who hadn't done any formal training in the 15 years since she left school. She was very stressed about her ability to learn all the skills, but at the end of a year of training she passed her final exam and was allowed to join an ambulance team as the third team member. When she was on call, she would have to sit at home in full uniform (green overalls with fluorescent, glow in the dark stripes which caused some hilarity amongst her friends) in order to be able to get in her car and get to the ambulance station within ten minutes of receiving a call.

For the first few months she didn't have to do much and there were many times when she just waited at home in her overalls until the end of her shift. There were a few call-outs for hypochondriacs and a couple of transfers between the hospital and air-ambulances. Then she got her first big call. It was a 'domestic incident' about forty kilometres from town, and the ambulance followed the police to the scene. What they found was pretty terrifying for someone who still wasn't sure of her ability to stay conscious at the sight of blood. There was a man on the floor of the hallway, unconscious and bleeding from a serious head wound, and a couple sitting in the living room in severe shock, the woman with blood dripping from a wound on her arm. Amazing as it may seem, the unconscious man had broken into the house intending to stab, and presuma-



bly kill, the woman who lived there, and had only been prevented from doing this by her husband who had hit him on the head with a cricket bat. Corinne was amazed at how well she coped, she says she just switched into ambulance mode and out of her normal 'mother' mode, and treated the patients as directed by the doctor on the other end of the ambulance phone. However, she did spend that night at home cuddled in a doona and talking to her best friend to calm down.

Her next big call was only a week later, it was over 100 kilometers away this time and it was a shark attack, the first one anyone on the island could remember. A surfer was reported to be in the water with a shark bite on his leg, he was being cared for by other surfers who were too scared to move him until an ambulance arrived. By the time they got the call he'd already been there for a while because, in order to get help, one of the other surfers had had to swim back to the beach, climb up a cliff-path to a bush track leading back to the road and then had had to drive along the dirt road until he had mobile reception to call for help.

When Corinne's ambulance finally reached the beach, the paramedics had a tricky time stabilising the surfer, before having to climb back to the road with him. That was when Corinne found that she can cope with the sight of blood and she's never lost her confidence since then. She's still working with the ambos, and she's had the sort of experiences that you can't get anywhere except out in the bush, much more exciting than I've had so far in my city medical school!



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Rural and Remote Medicine The Challenge of Primary Health Care

"The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.¹"

This part of the Alma-Ata Declaration for Primary Health Care reflects the problem. Unequal access in health services between inhabitants of urban and rural or remote parts of the same country has always been a major problem, even for developed countries, for centuries.

Unfortunately, the attention paid by the state is reduced in these geographic areas. Decreased budget for rural and remote territories, urban attraction, raising youth unemployment and lack of plans for investment are major factors of a vicious circle that leads to permanent migration to big cities. These growing "urban giants" inevitably engross governments' interest, determining the political game.

Health, including the state of complete social well-being², is a social, economic and political issue and above all a fundamental human right. Governments are responsible to ensure universal access to quality healthcare according to the people needs. Additionally, the participation of people and people's organisations is essential to the formulation, implementation and evaluation of all health and social policies and programmes³.

This is where we NGOs come to detect the problem and identify each parameter, to study and evaluate the global social, financial and political conditions and in the end to schematize our proposals, strengthening the voice of young medical students and doctors in the international game of health.

But have we truly understood what the point of Rural and Remote Medicine is? Are we aware of the needs of the habitants of these "forgotten" areas? If yes, are we willing enough to sacrifice life in an urban area, or the "high-status" of Tertiary Health Care for serving them?

IFMSA Daisy Project gave me the opportunity to live for two weeks as a "Doctor in Community", taking a short-term practice next to a General Practitioner (GP) at a rural Primary Health Centre



(PHC) in my homeland, an island at the borders of Greece. This was the chance for me to realize the situation not only as a citizen of the area, but as a part of the Health Care System.

I don't intend to emphasize on my experience in the PHC. I will just refer to the needs that were exactly the same as the ones in the city, patients who suffer from chronic diseases, an epidemic of gastroenteritis, alcohol and tobacco dependence. Of course there were also a couple of emergencies, such as a girl suffering from appendicitis and an elderly cardiac patient with a myocardial infarction. Unfortunately he came to the end of his life before the ambulance arrived at the village.

It was the last day of my practice when I treated the most important patient of the village. He was the youngest citizen of the area, about a year old, who had been playing in the garden and wounded himself against a rusty bar. The boy was screaming. His mother was in panic, because he was not vaccinated for *Clostridium tetani* yet. The GP was out on an emergency. I was now the doctor and a vial of antitetanic serum was my only weapon.

Later on we had a brief discussion with the mother about life in the village. A sorrowful smile appeared on her face when I told her I was leaving. She was used to see people leaving. She would have left too, if her husband hadn't been the priest of the village. That night I promised to return and serve these people. I will probably not be able to keep that promise.

Despite social, political, educational, religious and racial differences, despite opportunity and financial inequalities, people's needs for health do not vary. Illness and pain are the same in every spot in this world and people suffer the same way. Fighting for a better Primary Health Care System is THE challenge for the twenty-first century. Are we up to such a challenge?



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Health - Our Rights, Roles and Responsibilities



Rural and remote health is an issue that has many people worldwide bewildered. Problems starting from inadequate family planning to tremendous epidemic diseases require important large-scale solutions that are not always available. Are urbanized people lucky or unfair? Do they have responsibilities towards rural dwellers and if so, what could they possibly do to help? Important questions like these and many more arise each and every time this topic is brought up. To realize the rural and remote health problems and possible solutions, the following points have to be considered.

The exact definition of rural areas differs from one country to another. Developed countries measure the extent to which an area is rural according to the diseases present and the quality of healthcare of the area. Developing countries define rural areas as distant places. However, most countries identify rural areas as underserved areas where the doctor-population ratios are somehow low. Hence, medical needs are not completely fulfilled. There are substantial unmet needs for more trained health professionals and services as the population grows and ages, new diseases are identified, and new technologies emerge to prolong both quality and quantity of life. Trained health professionals available are mostly present in urban areas, leaving the rural areas unattended and vastly lacking medical education and attention. This creates a clear division between the urban world and the rural world that can be eliminated by medical students, healthcare professionals, and of course, the government.

The government's role in such cases should be to pay special attention to the needs of these areas and try to offer help. Improving their facilities, for example offering unpolluted water supplies and adequately-priced medication, could improve the quality of life in rural areas, and encourage healthcare professionals and medical students to go there and offer their help too. The government should stress the importance of medical education throughout these areas and try to ensure that each area gets sufficient information. Also, if the hospitals and clinics in



rural and remote areas are inadequate, which is true in most cases, the government needs to improve them and thus eliminate the need to travel to urban areas in the case of serious diseases.

The Egyptian minister of health and population, *Hatem El-Gabali*, has exposed some of the main problems facing rural and remote health in Egypt, stating that healthcare provision is in dire need of a radical overhaul. The first and most important problem is the availability of adequate financing. Hospitals and clinics in remote areas need to be completely renovated, the quality of medical and nursing services need to be upgraded and the health insurance system overhauled. At present, only 52% of our population is covered by health insurance, creating a gap between rural and urban areas. The governments of all the countries facing similar problems, like India and Pakistan, should increase health sector investment.

Not all individuals realize the importance of small details like avoiding undercooked meat or not swimming in polluted water. Another example is diarrhea, a condition often taken lightly by most rural mothers when in fact it can prove fatal if left untreated for long periods. This shows how important it is for everyone to have sufficient healthcare knowledge to avoid certain diseases and overall, lead a safe life. This is an era of extraordinary expansion in medical education in both the developed and developing world.

As urbanized well-educated people, medical students have responsibilities towards the less fortunate. One of those responsibilities is to offer healthcare education that will improve many lives, if not save them. We could also offer



to take our clerkships in rural areas. Very few students are interested in going to rural areas during their clerkship. This is often due to fear of the unknown and misconceptions about rural practice amongst students, which is usually reinforced by

registrars and consultants involved in student teaching. These fears and misconceptions should be put aside and students should be encouraged to help in their community where they are most needed, i.e. rural areas. Some countries force it in their curricula due to government policies while others just send students to rural areas to gain practical experience. In both cases the exposure of the students is carried out in a negative attitude, deeming them unlikely to ever go back to rural areas for permanent jobs. In my opinion, it is our job to become open-minded, dispose of the negative attitude and help in this issue, thus fulfilling our role as medical students. We could try to help out and spread awareness even if it is for a small period of time every year, independent of the clerkship program. Being exposed to patients in rural areas not only increases our experience, but may also encourage us to take up permanent jobs or clerkships there in the future. Research shows that almost 65% of students who studied their undergraduate or postgraduate degrees in rural areas return to work there later on. It has also been noted that the background of the students seriously affects their decision of becoming rural doctors, showing that 30% of urban students versus 86% of rural students take that decision. It is also the job of our educators to encourage us and help us see the positive sides of taking our clerkship in rural areas rather than discourage us by stories of their unfortunate history in these places. Rural doctors should work constructively with universities to ensure as much exposure as possible, in the most effective way. Greater incentives could also be offered to doctors to encourage them to transfer their jobs, and hence their entire lives, to underdeveloped areas. In a study in New Zealand, approximately 65% of doctors stated that they would go into rural practice if incentives were offered. Incentives are being offered there now as a response to this research, ranging from high financial incentives to specialist training under satisfactory conditions. Scholarships are also offered in rural universities to encourage more medical students to study there and hence work there later on.

To conclude, if the government, physicians and medical students each do their job and repay their debts to the society, rural and remote areas won't face the problems they're currently facing. Healthcare would be much more successful, providing equity to all areas of the world, poor or rich, educated or non-educated, urban or rural. This is a call for us to do our part and be a part of the solution, rather than becoming passive inactive members of the society.



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Rural and Remote Health

Rural and remote areas are faced with access to medicine and service delivery challenges that differ markedly from those in urban areas. Access to rural health care services is affected by a variety of factors such as topography, weather, transportation, and the sparse distribution of rural citizens over vast regions. The distribution of rural health care professionals also has a major impact on the delivery of, and access to rural health care services and medicines.

With regard to the distribution of health workers, reluctance of many health workers to serve in rural and remote areas is the major issue. They often find that educational opportunities for professional development and career advancement are limited in rural areas. This condition leads them to migrate to urban areas. Further, better income and family well-being, including children's education, are also important factors encouraging migration.

Overcoming this issue will need a long-term commitment from the government and health care professionals. The government will need to frame and implement effective policies and strategies for the retention of health personnel such as salary reviews, the implementation of incentive schemes, and the strengthening of human resources for health planning and management.

In addition, as future health care professionals we need to support government and health care professionals for the improvement of medical care in rural and remote areas. As it is a long-term issue, we have a responsibility to take part in improving the health care service and be willing to work in rural areas.

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Narrabri: My First Taste Of Life in the Australian Countryside

Fate threw into my hands the wonderful opportunity to visit a rural town in northern New South Wales (NSW) to observe the operation of its healthcare system.

I was fretting over my winter holiday schedule, trying to find activities to make them fruitful when an observing friend suggested a program organised by the NSW Rural Doctors Network which sends first year medical students to rural areas to experience their healthcare systems for a week. Thrilled at the opportunity to visit a rural town, I contacted the program coordinator who then searched for health professionals willing to host me for a week. After some weeks, I learned I would be off to Narrabri. Being an avid traveller and an international student, the concept of visiting a rural town was exciting but I had no idea what to expect.

After an 8 hour train journey, I arrived at Narrabri Station. I noticed, as my host drove me to her home, how different Narrabri was from my preconceived notions of a rural town. Narrabri appeared to be much more developed than I had imagined. There was an obvious absence of multi-storeyed buildings but little difference technology wise.

My hosts were wonderful and took great care to ensure I was comfortable. Over the next 6 days, I experienced Narrabri and it's populace in the best way possible. I was brought to various social events to mingle with the residents. Each event exposed me to a colourful range of personalities living in the small population.

To demonstrate the realities of life as a rural doctor, I was attached to 2 physicians who have been practicing in Narrabri for several years. The demographic differences between the population of Narrabri and the population of doctors were glaring. It was obvious that while the residents were predominantly Caucasian, the doctors were much more diverse, as overseas doctors wishing to work in Australia are channelled into rural and remote areas.

Interactions with doctors in Narrabri and neighbouring rural town Moree proved to be invaluable as it put my thought of rural practice into perspective. Doctors have to work much harder in rural areas primarily due to the shortage of doctors and lack of specialists. However, the rural doctors are consequently much more experienced and are capable of performing several procedures that their city counterparts would prefer to refer to specialists.

Another advantage, is how close the doctors get to the population. Often entire generations grow up with the same doctor, which



greatly facilitates communication and understanding between the doctor and patient. Also, living in a rural area means no traffic problems and the workplace is no more than 5-10 minutes away.

I spent most of the rest of my time walking around Narrabri admiring her simple beauty and contemplating my options for the future. I have decided that I am certainly going to return to explore rural Australia and consider having some of my rotations here.

The aim of sending city dwelling medical students into rural NSW is to allow them experience how the healthcare systems work in rural areas. Many medical students I have conversed with seem uncomfortable or even averse to the notion of long term practice in rural areas. It appears this problem is not constrained to Australian shores.

There is a global shortage of health workers in regions where they are needed the most. These are the developing nations and rural areas. The following table from WHO exemplifies the stark difference.

According to the WHO, the availability of health workers is directly linked to the survival of women undergoing childbirth and neonates. The insufficiency of healthcare workers is also an impediment to health related United Nations Millennium Development Goals.

Through this article, I wish to convey to medical students worldwide the knowledge that we, as medical practitioners of the future, have to share the responsibility for the health of not just those who can reach us or remunerate us but all who require medical attention.

We don't have to spend our entire lives working in remote locations or developing countries where our financial prospects admittedly aren't as bright. However, if all of us pledge to devote just 5 years of our career span to disadvantaged areas, I believe we can collectively make a big difference to global health.

Spread this message to all your peers not only in medical school but in the allied health professions as well. Remember, together we can make a difference.



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John Flynn Placement at Mareeba Medical Clinic

The Australian Government offers a scholarship program which aims to provide Medical Students with more experience and understanding of rural medicine and communities. Each student spends 8 weeks over four years in the same community. As a part of this program I recently completed two weeks in Mareeba, a farming town in the Atherton Tablelands, Far North Queensland. The main produce are mangoes, lychees, coffee and sugar cane, although just about every tropical fruit is grown in the area.

Within half an hour of my arrival, I had been given 2 bags of Mangoes and a tour of the Doctor's practice. The hospitality had just begun and by the fortnight's end I was given many more bags of mangoes, lychees, dried fruit, farm eggs and even a bottle of wine. The practice and community took very good care of me!

Mangoes feature prominently in the local community and so, it is probably not surprising then that the most common ailment I saw at the Emergency Department on a Friday evening did not involve alcohol or cars but rather Mangoes! When the Mangoes are picked, wax is released from the tree. If this gets in contact with the skin it causes Mango Dermatitis. Several of the patients that night had Mango dermatitis all over their body. Although this condition is easily treated with corticosteroid tablets and creams, it does mean that the person can no longer eat Mangoes without getting some kind of allergic reaction.

Mareeba Medical clinic, where I was placed, has 3 GP's and a practice nurse. One of the reasons I wanted to go to the Mareeba Medical Clinic was because of its description as a hands on teaching practice. I was not let down! In just one afternoon I watched a sigmoidectomy and assisted in a vasectomy (yep I actually got to hold some of the surgical equipment).

Over the fortnight I got to suture, remove sutures and staples (from a man's head), give cortisone injections in the shoulder, hip, knee and elbow, immunizations, feel a 14 week uterus and 36 week gestation baby's head and remove a wart on a 10 year old using dry ice (incredibly he didn't even flinch). Not bad for a first year student! In Queensland, local GP's also conduct autopsies as

required. I got to observe one of these during my time which was a great experience, although I do prefer live patients!

Each Wednesday my mentor assisted an orthopedic and general surgeon at the Cairns Private Hospital. It was a great opportunity to see some more involved surgeries including a mastectomy, inguinal hernia and anterior cruciate ligament repair. It was also great to see the follow-up afterwards as many of the patients were from the Mareeba Medical Clinic.

It wasn't all 'work' though during my stay in Mareeba. In addition to a trip to Cairns, one evening my mentor very kindly lent me and another med student his 4WD so that we could go out to Chillagoe and see the caves. Chillagoe is on the far western border of the Atherton Tablelands 2 hours drive west of Mareeba across a combination of dirt and bitumen roads. It used to be a mining town of 10,000 but since the mines closed only 200 people live there.

While at Chillagoe we stopped at the local hospital for a quick tour. The hospital is Nurse Practitioner run and has 4 beds as well as an ambulance, which the Nurse Practitioner drives when possible. The size of the town means that the Nurse Practitioner also acts as the pharmacist. The Royal Flying Doctors Service and doctors from Mareeba provide medical services once a week and they also have a visiting optometrist, dentist and child immunization clinics. Anyone requiring obstetrics services must travel to Mareeba, or Cairns if they have a complicated pregnancy.

I had a fantastic time in Mareeba and can't wait to return. Everyone at the clinic was very welcoming and supportive. Of course, all the clinical opportunities were highlights but I also loved being able to see the continuity of patient care and getting to know some of the patients better as they returned for follow up treatment. My return in 12 months time can't come quick enough!



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Conducting Research in Rural and Remote Aboriginal Communities

INTRODUCTION:

The aboriginal people of Canada are the first inhabitants of Canada and thus have been in Canada since time immemorial. With the arrival of Europeans in the 15th and 16th century, the Aboriginal people of Canada had their lives drastically changed. New diseases and new ways of living were brought upon them with very little time to adjust. This created an epidemic of death and despair, one that can still be seen today.

RESEARCH PROTOCOL:

Aboriginal health continues to be a key area for research development and knowledge translation in Canada. Research and knowledge sharing are needed to address the ongoing health disparities in Canada's Aboriginal people and in other indigenous societies. However, past experiences with researchers have left Aboriginal people in a difficult position. They require research for their communities and people. However, the wrongs of the past still haunt many of them. For example, research was likely to report inaccurate perceptions and findings and the outcomes had little or no benefit to the very communities being studied [1]. Moreover, relationships were seldom built with the community, research protocols were never established, and the findings and benefits of the study were never put into action. For instance, often experimental pharmaceuticals were used on students in Aboriginal residential schools without the consent or benefit/harms being discussed and the results of the study never disseminated back to the community. Moreover, the situation intensifies even more for Aboriginal communities in rural and remote areas.

These situations present many challenges. These Aboriginal communities require the employment and resources that come along with the research but often overlook the lack of relationship building, research protocols and inaction that come with the research. This paper explores a more appropriate manner of conducting research in rural and remote Aboriginal communities by identifying what can be



done by health researchers before, during and after engaging in research with rural and remote Aboriginal communities.

Aboriginal peoples have unique view points and values when it comes to research and understanding. Research with Aboriginal communities must reflect these viewpoints and values and build the research team around them. One method of achieving this is developing research protocols. Research protocols help all the team members understand the importance and significance of respecting the culture and ways of the partner community. Even more important in rural or remote settings, because of the limited interaction with the researchers, is the need for the research protocols to be addressed prior to undertaking the research and reviewed periodically throughout.

In all research, the safety of participants is most important. This is especially true for Aboriginal people as many Aboriginal people have suffered the affects of colonialism and inaction of previous research. Because of this history, there are a number of considerations that take on special meaning in Aboriginal based research. As in all research, research protocols demand the protection of participants through voluntary partici-

pation, anonymity and confidentiality. Rural and remote Aboriginal communities, often small in numbers, present unique challenges because the communities are small and individuals are very aware of each others' histories and experiences; it is very difficult and sometimes impossible to guarantee anonymity. Even if individuals' comments remain confidential (all identifying information removed), they may be identified entering focus groups or interviews or through others' familiarity with their 'stories'. Participants must be aware of this in order to give fully informed consent.

COMMUNITY-BASED PARTICIPATORY RESEARCH:

Aboriginal people are often not given opportunities to voice their opinions on the problem being studied and are merely used as subjects for data collection. Their insights into the problems are invaluable and must be acknowledged. In the past, the researcher would come into the Aboriginal community, collect the data, and leave without disseminating any of the results back to the community. A new approach is needed when dealing with Aboriginal communities. Community-based participatory research is defined as, "a collaborative research approach designed to ensure and establish structures for participation by communities affected by the issue being studied, representatives of organizations, and researchers in all aspects of the research process to improve health and well-being through taking action, including social change [2]". In this approach, participants identify strategies or develop programs *together* that respond to community needs. The importance of creating solutions together can not be underestimated especially for rural and remote Aboriginal communities because the researchers will only be in the community for a limited amount of time; while, the impact of the research will be with the community for a long period of time. Moreover, for community based participatory research to succeed, community participation throughout the research process and a shared understanding of the roles and responsibilities of each research team member, research ethics, protocols and processes is vital.

RELATIONSHIP BUILDING

Opportunities for community based participatory research may be initiated by the rural or remote Aboriginal community *or* by the researchers, and may be the result of long-term or newly

formed relationships. Whichever the case, it is important that the principal researcher knows the additional obstacles of conducting research in rural or remote Aboriginal communities and how to overcome these obstacles. In Aboriginal communities, whether urban or rural/remote, relationships are a core value in their culture. This must be understood by all researchers and is something that must be continually developed and respected as the research begins and continues. Furthermore, researcher team members will often be required to draw on a range of problem-solving strategies to resolve conflicts as they arise in the course of research. This is especially important in a rural or remote Aboriginal community where the research team will be in the rural or remote community for a limited amount of time and much of the research will be completed during this time. Any conflicts arising during this time will be taxing to the research in terms of resources such as time, money and relationships. The success of the project will depend, to a large extent, on the ability to build trust and mutual respect among members of the research team and the community. For these reasons local community research assistants are an important part of the first step in collaborative research. They bring to the team their experiences living in rural or remote Aboriginal communities and their knowledge of community concerns and issues.

CONCLUSION

Research with rural or remote Aboriginal communities is a difficult task; however, the benefits for Aboriginal people are very much needed and valued. Past research has scarred Aboriginal people but the need for research is still evident in the health disparities of Aboriginal people. Research needs to be 'reborn' within Aboriginal communities, with trust as the core value. Community based participatory research is one strategy for developing trust and building on the strengths of individuals and communities in order to identify and find solutions to community concerns. The approach is based upon a belief in being sensitive to community perceptions, needs and environments, placing value in the skills and expertise of all participants, and distributing power equally among all participants so that research is both more relevant to the community and more likely to improve the health and well-being of community members.

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Philippines Barrio Health Project

This 3-week project was an initiative of University of Sydney Medical Students, with the support of the NGO Reledev Australia Ltd and the Pinamalayan District Health Authorities, Philippines. We were based in the town of Pili, in the Pinamalayan district of Oriental Mindoro.



Our goal was to provide health related training to the local community. After meetings with the local mayor and health officer we also decided to offer a free clinic in the baranguay (suburb or village) of Pili, with basic medications free of charge. Dr. Gerard MacMahon from Ballina NSW, Australia, assisted here.

The people of Pili are sufficiently poor such that the majority had never seen a doctor. Our first week was spent planning the operation of the clinic. The main concerns were the cost of medications with our limited budget, and the need for translators.

We worked closely with 10 health workers for a week seeing about 300 patients. Around 500 Euros provided enough basic medication for these people, while cases of TB and more severe illness were referred into the nearest hospital.

Of all the infectious diseases in Pili, TB is the major concern. We saw about 25 cases (10% of our patients). Many of them were not taking medication because they could not afford to travel to the nearest TB centre, or because the free TB medication was not stocked at the centre. The health office denied any problems with supply, but other local doctors confirmed that bureaucracy and logistics were to blame.

The week in the clinic helped us understand the basic health needs of the local population. This provided good material for the later seminars with the voluntary baranguay health workers and high school students. The health workers had extremely limited knowledge. In particular, they knew little about important local issues including tuberculosis and transmission, the causes and mechanism of anaemia, fever and temperature regulation, water-borne illness and oral rehydration therapy.

The community of Pili, like many others in the Philippines, faces the triad of developing world issues: low income, poor accessibility to schooling and poor health services. While establishing



industry and schools requires more infrastructure, improving primary health care is easier. Here medical students can excel through offering education and other programs.

Primary health care is most effective when it is based in a community that is cognizant of its needs and problems, and has the resolve to protect the health of its members. We found the local people very receptive and keen to improve their health.

Our conclusion is that as medical students we can be most effective in this local population through:

1. Running seminars for local health workers whose knowledge is often extremely limited and even highly flawed. For example, like much of the population they believed vitamin pills could prevent a variety of illnesses.
2. Providing them with basic tools like sphygmomanometers, thermometers and ORT recipes.
3. Supporting the initiatives of the local health authorities – in this case a newly launched TB campaign – by referring patients, explaining the need for long-term medication, and helping them understand transmission.

We had a fantastic time in Pili and hope to use our experiences to launch more regular trips and encourage other medical students to offer their services as educators during their summer breaks. We thank the University of Sydney Medical Society for their financial support.

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Truth-Telling Within Alternative Cultural Frameworks

The concept of truth-telling during disclosure of a diagnosis and description of treatment options, which results in informed consent, is one of the most highly valued ethical guidelines in Western medicine. What is not often addressed is that truth-telling may not be universally applicable. Complete truth-telling in order to

achieve informed consent may be less appropriate for cultures that practice community- or family-based decision making, or for situations where patients do not wish to fully know their diagnosis. It can also be problematic if the cultural differences are so great that it is impossible for the patient to fully understand his or her medical situation.

In November of 2005, I was part of a medical team that travelled into the mountainous region of Ecuador to the remote community of Chino to test for tuberculosis prevalence. The team included a physician who visited the community every two years, and was the only medical care that the community received. During our time there, an elderly woman came to the camp, extremely jaundiced with solid yellow eyes and a dark yellow tint to her skin. The doctor, who could communicate to the Chino people in their native tongue of Quechua, tried to explain to the woman that her liver was failing and that she needed to go to a hospital for treatment. The woman, like the other community members, had no concept of what a liver or even an organ was. She believed she fell ill because she had been cursed by a witch. The curse put a spirit in her body which was causing the sickness, and until the witch decided to lift the curse and the spirit left her body, she would not get better.

The elderly woman did not understand how going to a foreign environment would relieve her sickness and feared doing so, as most people who left the village for treatment of serious illnesses never returned (most died). The doctor tried to reconcile how modern medicine works with what the villager believed by correlating the proposed treatment with making the woman's body uncomfortable for the spirit to inhabit; basically saying that the drugs and other treatments she would receive might change the inside of the woman's body in such a way that the spirit would become restless and more likely to exit. Nevertheless, the woman decided to stay in the mountain village with her family. The doctor respected her decision and did not pressure her further, but ensured that the woman had a basic understanding of her future health. If the woman is still alive, it is likely that she is in the final months of her life.

The doctor in this particular case could have made a stronger attempt to convince the elderly woman to leave and get treatment through helping the patient reach a level of scientific understanding of the body and its organs, but this would have taken quite a long time, if it could be achieved at all, and if successful, would dilute the cultural beliefs of that villager and her family. Also, it is extremely difficult to access the remote community and the woman likely wouldn't have been able to return. I believe that the doctor chose the best option, which was to respect the woman's decision to stay in her community while attempting to synchronize the

indigenous and scientific views of illness to explain her options and the potential results of her decisions.

In this situation, is the patient's decision to refuse treatment a result of informed consent? The doctor tried to make sure the patient realized the consequences of her decisions. However, this did not involve complete 'truth-telling' to the patient – because the 'truth' that the doctor knew of the disease would not have been understood by the patient. This case is not about a patient who does not want to know, does not want to be the primary decision-maker, or is not capable of making informed decisions. Rather, it is a case of being mentally capable but having cultural incongruence with regard to medical information. The 1996 *Health Care Consent Act* defines disclosure as considered provision of enough information such that a 'reasonable person' would comprehend the diagnosis and treatment options and be able to make an informed decision (Etchells et al, 1996, Disclosure). However, a 'reasonable person' from Western society has an understanding of medicine that is quite different from that of 'reasonable person' from an indigenous South American society.

In situations similar to the one explored here, in which there is such a vast difference between beliefs that medical information cannot be fully understood, the most viable option may be to attempt to explain the illness in terms of what that cultural group believes to be true. Medical practitioners can use tools to elucidate the differences in doctor-patient understanding. For example, Arthur Kleinman developed eight questions based on anthropological research that helps to evaluate the extent of difference between the patient's cultural views and those of the practicing physician (Kleinman, 1978). As long as the consequences of the illness and the treatments are understood as much as possible, this proposed option would achieve similar means to truth-telling while minimizing the cultural conflict. This isn't the best course of action for all scenarios of cultural incongruence, but is useful when cultural differences make it extremely difficult and time-consuming to attempt to explain to the patient scientific views of illness and treatment.

In conclusion, the traditional concept of 'truth-telling', while so highly valued in our society and culture, and fundamental to achieving informed consent, may need to be expanded to ensure the greatest amount of understanding on the part of the patient and to enable autonomous decision-making regarding treatment.



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Food for thought...**HIV Prevention Principles, straight from the mouth of an Ethiopian child**

Setting: in August 2006, rainy Ethiopia, a group of 15 Maltese volunteers got to know Hailu, a twelve-year-old boy who gives lectures about HIV. He readily agreed to us recording him on video in order to extend his teaching to students back home and to give our fellow medical students another perspective for our SCORA principles. We didn't need to ask a lot of questions, since he had a lot to say on his own initiative, in fact.*

-A transcript-format is used -

**Names are changed to protect identity*

How do you know so much about HIV?

Because in Ethiopia there is a lot of music about HIV; and I read some books in my school; and in HIV community in rest-time they teach about HIV. And I come to the compounds to teach patients. Mother Theresa [Missionaries of Charity] have 16 compounds in Ethiopia.

In Ethiopia a lot of people is not learning. In Ethiopia they don't look boys and girls equal. They give big percent for men and small percent for women (salary), and for example in one family, there are children; one girl and one boy and they are going to school, and after school, the boy is going to play, and the girls is going to work in home. But she work so much like big people, and she don't have time for study in home, but the boy have time for play, for study... and after finish work she don't study, they give her more work. This woman doesn't like to stay in this home because there is no democracy for she; and she go to work outside, and live in the street. In Ethiopia, lot of children live in the street because their family is dead, or because they don't like stay in the family because there is not democracy.

And if they go in the street there is some not-good boys and they do something not-good.

Now I start to talk about HIV.

In Ethiopia lot of percent is living with HIV. For example, in the family there is toothbrush; the father use it and the family don't know he have HIV or no, and they use this brush and after they take HIV.

For example if he work he go in some field, and his wife is alone, and he go with another woman in this filthy place; and they do sex without condom; they don't know, they don't test HIV and if she have HIV he take from her and he give to his wife; and after she have baby she don't use nothing medicine because she don't know she have HIV. If she don't get this medicine the baby will get HIV – and everybody have HIV – and more percent in Ethiopia have HIV.

A lot of girls have HIV because in Ethiopia some girls don't like work. Some girls work



hard and they don't like work hard and they work only at night, they work short clothes, and beautiful things, and they go in this place. And one man is coming, from home; he have a wife but he sex with this woman without condom and he get HIV. In Ethiopia there is, not in city, outside of city, everybody is not learning.

Why do they not use condoms?

Yeah but in media they always teach use condoms, they don't listen to media; they listen to each other. It is some problem in the media. For example if they draw HIV people very very thin, and non-HIV people fat. People think: thin people live with HIV, and rich/fat people don't live with HIV.

A good thing in the media – there's a lot of music about HIV and they show drama, but the people are not listening to this thing.

Next I will talk about something interesting

In Ethiopia there is HIV medicine. For example if one woman is pregnant and she has HIV, the baby can be without HIV, because they give medicine without pay. [antiretrovirals] This medicine was before very expensive to buy, but this government is giving it to them without pay. A lot of people are using this, but less people don't use it because they don't like to tell for others that they are living with HIV, they're afraid of HIV. And if they don't tell they are living with HIV, they will give for other people this HIV and everybody will have HIV.

In Ethiopia they have a lot of communities that tell people about HIV, how to stop HIV and how to use the medicine; how HIV can also start from materials (for example needle) and if they do sex without condom, and from mother to children.

How we can stop: First don't have sex if you're not eighteen years. Second – if you have wife don't go to another woman. Third – use condom

Are condoms expensive?

No, in Ethiopia it is not expensive; the media always advertises about condom. And 4 piece is 1 Birr [10 Euro cents] - it is cheap. Why it is cheap so that people don't live without HIV. In coffee house, they give without pay.

How can we help people with HIV?

Yeah, in Ethiopia, if they greet people who live with HIV, they think they will get HIV. If they swim with them they think they will get HIV. They don't like to be with them.

In Ethiopia we can't stop HIV because there is little people who'd like to stop HIV but there are another who do not like to stop HIV and if people teach them, they don't listen to them.

In Ethiopia there is communities and they do help without pay, they give to them socks and clothes, and they clean them. They show these things on television, but in television if they talk about HIV, every peoples close the television because they don't like listen about HIV.

And in Ethiopia there is 2 tests for HIV; First if doctor says you have HIV but you can live with HIV if you take medicine. If doctor says you don't have HIV you should check every 3 months – because not only by sex, maybe by blood, scissor, needle – you have to check every 3 months.

One voluntary was shaving patients, and he shaved 9 patients, and when he go to his pocket the blood was broken – and every 9 patients went to check – and didn't have. But if you check and you don't have, you have to check in 3 months

What do the people of Missionaries of Charity do for HIV patients?

In one of the compounds there are 450 people living with HIV. They go to places, and they will be happy, buy a lot of clothes. If they don't buy them clothes they think 'because we have HIV they don't buy for us' – so they buy clothes that they like, and if they like television, they buy very big television. Somebody is helping for this.

I will tell you something. In the compound there is a speaker, one social worker helps me with this speaker to teach patients. I don't only teach, I tell some jokes about HIV and I make drama with patients; some patients can poem about HIV, some can make music, and this they are very happy because if I only teach they are not happy, they will be sleepy.

... to keep them entertained! Now what about you, what about your future?

My future plan is to be a footballer and engineer. And I like play football in Spain or England (Barcelona and Manchester Utd). If they live with HIV, people have to exercise, they have to eat vitamins, and something another for example potato, vegetables, meat, cheese, butter, milk. But if they eat always the same eating they will be not OK.

So they need a balanced diet

Yeah.

Anything else you'd like to say to the medical students in Malta?

Yes! I hope Maltese medicine students will stop HIV. And I wish for them to stop HIV, and I think they will help teach to Ethiopia about HIV. Thank you!



***Ivan Zammit
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Rural Health Experiences in Bits 'n Pieces

We asked for a few personal thoughts and comments from members of IFMSA across the globe and we, the editorial team, would like to share some of these comments with you. With the 2007 IFMSA March Meeting taking place in Australia we believe that the following collective is adequately timed.

Our first is from Maude MacInnis who was invited to work for a short while in a small medical clinic in rural Nova Scotia.

[Maude MacInnis] Havre Boucher is a small community of approximately 1,700 people in rural Nova Scotia. At first glance, it may seem like a place where things never change. This could not be further from the truth. Havre Boucher is a tiny but vibrant community. In fact, some twenty odd years ago someone had a brilliant idea: build a community-owned medical centre. A Health Board was formed and through fundraisers and grants, they managed to raise enough funds to build a small clinic fitted with two examining rooms. They convinced two physicians to each work there for a half a day every week. A variety of programs were introduced to promote health within this community. They now offer a foot care clinic, smoking cessation programs, and cholesterol and cardiac risk factors education.

When asked why they take time off from their normal routine, Dr Gallant, one of the two physicians, answered: "when a community takes initiative for their own health as they did, I can't help but want to be a part of that." He's right, the clinic is a very positive environment and patients are very appreciative to have this service in their community.

Although a lot of it is "nuts and bolts" medicine, working there is nothing but ordinary. "It's quite unpredictable what complaints people are coming with so it's never boring", says Dr Gallant. He adds: "patients understand the concept of a walk-in clinic and keep their complaint quite focused. This allows us to see everyone in the short time that we have there."

Maude's experience in Havre Boucher has inspired a possible career direction in rural family medicine. We hope that in the future there will be more rural communities willing to take initiative as the people of Havre Boucher have done. However, there are still numerous treatable and untreatable diseases which are underrepresented in the medical sphere, especially in rural medicine. The most concerning of all these seems to be the growing presence of HIV and AIDS as described by Lonny D. LeFever.

[Lonny D. LeFever] HIV/AIDS treatment in the rural areas is almost non-existent. If we want any sort of medical attention, we are forced to drive to larger metropolitan areas. I would have thought that after twenty- five

years, we would be past health care workers wearing masks and gowns to attend to patients with HIV/AIDS. I would have thought that doctors and nurses would be more attuned to the issue of HIV/AIDS.

Yet it seems that the problem is just getting worse and worse, with outright discrimination judgment, and refusal to treat persons living with AIDS. Without some serious changes in the system, there can only be one result and that is the continued growth in new infections and millions more deaths because of the lack of equal treatment for all.

With the Global growth of AIDs there is a growing need for more and more volunteer work in the distant areas of rural medicine. Zainab Ghadaily had the opportunity to work as a volunteer with the Foundation of International Medical Relief for Children (FIMRC) in the town of Alajeula.

[Zainab Ghadaily] I shadowed the clinic physician, performed health assessments and conducted 'charlas', where we educated the community about topics related to nutrition. I believe that educating people about health is just as important as providing medical relief. There is only so much that the doctors and clinic can do but by educating people about health, dental hygiene and nutrition, for the first time they get the opportunity to learn how to take care of themselves and prevent pain through illness.

One of the most striking things I learnt was to understand how different their medical knowledge was. For example, we were very specific in what we said while handing out the medicines because there have been local cases where a patient's mother was given an antibiotic for her child's ear infection and her child's condition got worse. It was soon realized that she did not know how to give the pill to her child. Since the pill was for an ear infection, she had been popping the pill in the child's ear instead of having him take it orally. Nevertheless, even though we were so specific in our instructions, the people were exceptionally welcoming. One of the girls in the community we were serving gave her only visitor to one of the volunteers then she saw the volunteer sweating profusely in the sun!

In most volunteering experiences that medical students embark on there is so much to be gained and at the same time there is so much that we as medical trainees are able to give. However, there are those special people who give decades of service to this branch of medicine as Erin Oliver-Landry was to find out.

[Erin Oliver-Landry] A while ago a certain Henry Councilor described his personal role

and experiences within the NACCHO (National Aboriginal Community Controlled Health Organization) of which he is the Chairperson. This Junggal man from the Jaru people from the Kimberly Region of Western Australia is committed to Aboriginal Health and has been for the past 20 years.

Aboriginal communities operate over a hundred centers across Australia ranging from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services without medical practitioners, which rely on Aboriginal health workers and/or nurses to provide the bulk of primary care services, often with a preventive, health education focus. The services form a network, but each is autonomous and independent both of one another and of the government. The integrated primary health care model is in keeping with the philosophy of Aboriginal community control and the holistic view of health that this entails. This sector is the single greatest non-government employer of Aboriginal people in Australia - in the 128 services nationally, there are 2,500 full-time equivalent (FTE) staff, including over 700 Aboriginal Health Workers, 180 FTE doctors, and 230 nurses. Sixty seven percent of the staff employed is made up of Aboriginal & Torres Strait Islander people. This sector, however, is yet to be treated with the respect it deserves, leaving an extensively untapped potential.

To most of us these problems do not come up foremost in our mind and yet this medical disparity is a painful reality. Dan Henderson manages to sum up the main exasperating problem based on his experience with Ms Monica Lawrence, a Remote Area Liaison Nurse who developed the Remote Cardiac care project.

[Dan Henderson] Monica described the barriers to accessing cardiac treatment for indigenous people from remote communities. She detailed the enormous loss in terms of resources and decreased health through gaps in planning and logistics, where patients have been unable to link up with transport and referral structures in the long chain of tasks required before cardiac surgery. Through her role in providing pre and post care support to improve Indigenous people's understanding of cardiac surgery and rehabilitation and adapting these to the unique features of remote communities, Monica's project has helped to reduce to a minimum the cancellations of cardiac surgery. Upon return to their communities, through liaison with local services, the project prevents patients being lost to follow up. It all makes good sense and saves health, time and money, but unfortunately it is still in the pilot stage.

And quoting Dan, which would be an adequate conclusion to this collection of experiences, "Imagine going on a big journey. You are traveling in the back of a Ute, in a light plane, in a Jumbo, and you are very, very sick. When you finally get to your destination, a place that feels a world away, your heart surgery is cancelled because your teeth were bad!"

Remote and Rural Health "An Overview"



With the gradual centralisation of health services into the countries overpopulated centres the seesaw effect of reducing the same health services from the lesser populated areas is having an impact even now. This consequently means that many rural residents have to travel large distances to gain access to even basic medical attention. Services such as A&E have now become a premium since it is a service that not even the local GP can provide to such high standards.

Another consequence of this centralisation-of-services is the lack of choice of facilities available to rural patients. Whereas urban residents may be able to choose their GP; most rural patients are limited to just one medical service. This is not only occurring in large rural areas but also in developed countries such as Australia, Canada and the USA. Even though their medical services are among the largest in the world they are still being hit with the ever decreasing presence of medical attention to far flung patients in their desolate rural regions.

Research has shown a greater mortality from treatable illnesses in people living in rural areas compared to those living in urban areas. For example, people from rural areas are less likely to have their stomach, breast or colorectal cancers diagnosed. They also die sooner from prostate and lung cancer than people who live closer to specialist cancer centres. Deprivation in rural communities has been ignored for a long time and has also accentuated the differences between rich and poor communities where the richer communities are more likely to have transport availability to health care providers than their poorer contemporaries.

Poor recruitment of doctors and also a general lack of medical expertise has had a negative impact on peoples' health. Posts for General practitioners in the more rural areas have been found to have much more prolonged vacancies than elsewhere. There is a general consensus that there is an urgent need for a rethink in the manner with which health services are developed. There is also the need for a separate agenda for rural health care. Numerous reports into this problem have stated the importance of providing safe, efficient and far flung transport services and have all called for integration of this aspect into any new rural health care policies or systems.

Accessibility and the impact of distance

Access and transport are two major problems facing rural healthcare. Important considerations of the general populace in rural areas include:

- ✦ additional travel costs associated with providing services

- ✦ additional travelling time for healthcare professionals and patients difficulties faced by individuals in gaining access to health services

Lately, over the past couple of years the general Practitioners Committee of the BMA and the Institute of Rural Health, the Rural Health Forum, and the Remote and Rural Areas Initiative Committee have produced a joint report containing reviews and suggestions for improvements to the national health system in order to include the rural areas. This has already sparked off action in the UK where the Department of Health has funded "Rural Proofing for Health" – which involves a toolkit of sorts for use within primary health care organisations to enable them to 'rural proof' their policies to take into account the health needs of people living in rural communities.



Large countries such as the previously mentioned Australia and Canada have been giving the rural health issue much more attention. In these countries, research into the crisis affecting rural healthcare has led to innovative solutions such as the greater medical use of aviation and water-bourne methods. India has implemented new, and controversial, programs costing billions of Euros to correct the striking inequalities that exist between their urban and rural health services. The plan is to train accredited social activists (mainly women) over the next few years to be able to advise village populations about sanitation, hygiene, contraception, and immunisation. This will, in effect, provide the much needed primary health care for common ailments such as diarrhoea, minor injuries, and fevers; and to escort patients to medical centres. Additionally, the Falkland Islands have instituted telemedicine into their communities where patients can send their photographs and test results through the internet.

BMA reports on the subject have called for more recruitment of medical students into rural placements. More people from rural communities are being encouraged to attend medical training as they are more likely to choose to work in such areas once qualified.



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Rural Healthcare in The Philippines

The following is an abridged version of “*Capito*: an intern’s personal account of life in the community,” a diary written during the 6-week Community Medicine rotation in the town of Santo Tomas of the province of Batangas, Philippines. The rotation is part of the University of the Philippines-Community Based Health Program geared towards partnership with the local government of a rural area in need of health assistance. The particular *barangay* assigned to the author’s group was Barangay San Pedro, wherein the health workers and the members of the community came up with a Hypertension Club in view of the prevalence of hypertension in the area.

TERMS: *Barangay* – Filipino term for a small locality/community within a town.

Ate – a Filipino term used as a sign of respect towards an older female.

Lolo – Filipino translation for male grandparent.

BHW – *Barangay* Health Worker.

The Community Medicine is considered one of the much awaited rotations in medical internship. Some say it’s a rest period from the chaotic realm of hospital duties. Others prefer to view it as a study time for the boards. But quite a number tell of it as a unique experience where one learns to stand on his or her own, managing patients without the fear of close scrutiny of seniors. Yet I personally believe it is more than these. Above being an opportunity to acquire the skills to become a health provider at provincial locales, the rotation is the best occasion where an intern learns more deeply how to interact with the patient as an individual person and as a member of a community. It involves educating patients day in and day out; facilitating firsthand the health needs of the *barangay* through coordination with the health workers; concerning oneself with aspects that influence the health of the community such as lifestyle, occupation, government, tradition; and discovering the varied ways and means to deal with different personalities in order to fulfill a common goal. In other words, it is the time to discover what it really means to be a doctor – or better yet – a *humanitarian* doctor.

Though I have been pondering on becoming a surgeon, I very much take into account how this rotation would truly be a substantial part of my current training. I’m sure this experience would bring about discovery of my own strengths, weaknesses and capabilities to accomplish a different kind of responsibility toward the community. It would also be a test of team work with co-interns from different universities. As regards to the townspeople, I am looking forward to meeting them. Since this

rotation would give me much immersion by actually living inside a *barangay* house hold, I would be able to learn how to adapt with certain cultures, know their way of life,

foster their good qualities, and understand their setbacks – all that a physician (from any field at that) should be able to grasp in order to better serve his fellowmen.

In the community, the medical intern begins to *understand* the significant role of a physician in the society. He or she sees more clearly a patient beyond the bounds of a disease entity. I hope I’d cultivate that kind of understanding during the next six weeks...And that one day, perhaps, when I have my own patients, that *understanding* is already innate in me.

The First Day

On our first day, I woke up in the morning with images of mountains, scorching sun, coconut trees, simple houses, stores of native dish, hot pandesal, jeepneys buzzing through the highways, warm people; all that could be expected in any rural spot in Southern Luzon.

We took a 2 hour bus ride going to the site. From the staff house, we were brought by an ambulance to San Pedro Health Center. We met some *barangay* healthworkers.

After lunch, we met Ate Betty who takes the lead among the health workers. We asked her about the status of the Hypertension Club and expressed our desire to arrange a meeting with all of them.

Our Foster Family

Having grown up in the province, I thought I had the confidence to be at home with our foster family. Well, really, it was not that easy. We had been eating our meals with them: Councilor ‘Nene’ Maliglig, her husband, and their three grandchildren. Ate Nene is a sixty-nine-year-old lady who had been serving the *barangay* for more than 20 years. She accommodated us despite the fact that her husband, Lolo Itok, was not in favor of it.

Lolo Itok’s disposition gave much pressure to us. We tried our best to do things like we were truly part of the household. We helped serve the meals, we washed all the dishes and utensils. We even volunteered in our spare time to bring the two boys to day care center: Kier, the 5-year-old, and Keanu, the 3-year-old. That means a maximum of 4 round trips in a day. Nine o’clock in the morning to bring Kier then go back to house. At 11 o’clock, get Kier from day care and bring him home. Same thing goes with Keanu in the afternoon at one o’clock and three-thirty. At times, we read stories for them. It may seem that we’ve kept ourselves busy with activities not related to our role as interns for the *barangay* but it is all worthwhile. The Maliglig family gave us shelter and food. It is only just that we render our services to them. Indeed our efforts have not gone into vain. We have become part of their home.

The Ordinary Predicaments of a Health Worker

During the 1st week, we were still cracking our brains how to entuse the BHWs in having a meeting for updates. I’ve begun to feel some anxiety when a particular event most especially gave me a better understanding... As we dozed off from reading our books at the hall, we were woken by heavy footsteps climbing up the stairs. It was Ate

Betty carrying her granddaughter looking apprehensive. Apparently, the baby had a bad cough and fever early in the morning. Ate Betty expressed how worried she had been. What also concerned her, was the fact that despite her being a BHW, she couldn't think of what to do with the child. She knew very well how to manage such cases if it happened to other kids. But if it were her own kin, panic overcomes her. I watched Ate Betty prepare bottle formula for the child, still looking worried. Drops of sweat lay across her face.

This seemingly insignificant instance gave me much depth in understanding the ordinary predicaments of a BHW which may present as obstacles in the eyes of an intern. Hardly could you get a BHW who works fulltime. Like any other career mothers for that matter, these BHWs have to balance the affairs of their family and other sources of income with the demands and needs of the community. The job of a health worker is primarily of service more than an income-generating profession, and so one cannot blame the apparent loss of enthusiasm in the face of difficulties.

Community Work

Our daily routine included: holding clinics in the morning, bringing the kids to and fro their school, organizing meetings and seminars for the BHWs in the afternoon, studying, redefining the objectives for the community, visiting main landmarks during breaks, and doing household chores in the evening. We also participated in projects organized by the *barangay* council such as the "Clean and Green" where we swept and threw away garbage found at the front yards of the houses. Another was the Immunization Day, where children were given free vaccinations while their mothers hear a lecture on breastfeeding. As for the specific program of the *barangay*, the BHWs wanted a major reinforcement of the Hypertension Club. During the 2nd week, they initiated the first step which is filling up of membership forms.

Hypertension Club

Our initial concern over the slow progress of the club was consoled by the feedback from our residents who assured us not to worry. Carrying out certain goals in the community indeed takes time. Yet, we still managed to hold the much-awaited exercises in the afternoon. On our first session held at the 2nd week, nine hypertensives came (aged 40-75 years). They were quite excited about the hypertension club and have promised to be dedicated to it. Since then, many faithfully complied to the exercise sessions 3 times a week. The variety of exercises like walking, bellydancing, stretching, especially enthused them.

During the 4th week, we had a general assembly with the hypertensives! A total of 20 hypertensives came for the free clinic and focus group discussion. The BHWs were also complete. All were asked about their expectations from the club. They came up with the following: education, exercise, correct diet, maintenance drugs and fellowship. Exercise was re-scheduled to the best time in the afternoon suitable to all. We had a lively forum. Some even repeatedly told the others that this club involves commitment and teamwork. The mission-vision of the club was also reviewed. Towards the 5th

week, we had another gathering with the officers and members. Other queries such as the criteria for membership, if being a hypertensive is a requirement or not, and the schedule of activities were again brought up.

Towards the end of our rotation, what we call the "San Pedro Summit" was held. The BHWs, the Hypertension Club officers and members, old and new alike were present. Some breathed their reasons for attending or absenting regularly for the club meetings and exercise. Then they proposed that we proceed with the election of officers. That afternoon, our group's last meeting with the San Pedro Hypertension Club, ended with a grand exercise.

It's very wonderful to see how the BHWs work without the need for our supervision. In contrast to the first few days with them where they seemed to wait for our prompting, they now just confirm with us their plans. The San Pedro Health Team is indeed a conglomeration of health workers with various capabilities, all of them promising at that. Working with them, you'll be able to pinpoint the leader, the think tank, the executor, the follower, the recruiter. And once they all *identify* with a specific project, the hypertension club for instance, they can really accomplish so much.

The Last Day

That day we last met the hypertension club, we prepared the last supper with our foster family. It was a bittersweet event. The thought of home was very lovely yet we'll leave behind people who gave us shelter and in the end touched our lives.

Night came and I found myself within the four walls of the Maligalig residence. Once more, I gathered Keith, Kier, and Keanu for a story-telling. We were interrupted by Lolo Itok to eat dinner. What a joy I felt when I saw these kids eat their rice heartily now. We always had difficulty feeding them. I guess the bait was the story-telling. And so I read them a children's book. How each listened intently! I went back to our room after. Then I noticed scuffing sounds beyond the door. As I paced myself, towards the other house where the Maligaligs stay, I saw there on the floor a note from Keith along with photos of all three.

For our final Morbidity & Mortality report the next day, we cooked *pansit* (Filipino noodles) for the staff house. We sought for the last time Ate Nene's favor, to use her kitchen and borrow a big container. She gladly agreed. The kids were preparing themselves for a picture taking to be sent to their parents working overseas. The little boys gave me a goodbye kiss while their sister smiled as I gave her some advice. Ate Nene and I embraced as we thanked each other for everything. *Napalapit sa 'yo mga bata* (The kids became very close to you), she said, to which my heart sank.

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Health Access In Peru

Peru is considered one of the richest countries in the world in terms of its natural resources and biodiversity. Antonio Raymondi, a famous 18th Century Italian scientist, once described the country and its people as a poor villager sitting on top of a golden throne. The mixture of our millenary history with European influence has given rise to a multiethnic society with one of the richest cultures in the world. However, it is arguable that we have yet to realise this, thus complicating matters when trying to bring about positive changes for our country.

In South America we rank third in surface area and in the world, nineteenth. Being such a big nation, the health system struggles when trying to make all of its services more accessible to the population. What happens is that most of the health workers prefer to stay in the capital, Lima, rather than work in the remote provinces. The capital offers benefits that the other rural cities cannot, such as a greater variety and number of services, better accommodation, and accessibility to the rest of the country. Nevertheless, the SERUMS (Servicio Rural Urban Marginalizado en Salud) try to control this situation by establishing a one year obligatory service placement for all health workers wishing to remain in Peru for work purposes in the future. Although the program is well-organized and has been running for over a decade, there are still areas where no primary care is offered. Young doctors tend to stay in the main cities, especially Lima, and concentrate on studying for their residency examinations. Additionally, the SERUMS also offer non-paid vacancies in Lima, allowing the vast majority of doctors to stay in the capital and focus on their studies. The end result is that, due to the lack of doctors in rural areas, many villagers end up travelling long distances to nearby cities in order to access health services.

However, by doing this, what they do not know is that they are altering an already assembled healthcare pyramid. First level health institutions are those in which primary care is offered, and maybe some small emergencies. Those with secondary level facilities, besides offering outpatient services, also deal with obstetric, gynaecological and paediatric emergencies. A third level hospital is one that also offers hospitalization services and surgery facilities. Finally, fourth level hospitals are ones where the multidisciplinary service concentrates on a specific area.

The system was created to gather the patients in the first level of health service. Then, if necessary, they are referred to a secondary level institution and so on. Unfortunately, this system is not working because instead of following the pyramid, patients are requesting the services of third and fourth level hospital physicians right away. They have the erroneous idea that if they go to a specialist, they will be better diagnosed and treated. The mis-

conception has collapsed third and fourth level hospitals, since these can no longer cope with the huge number of patients that arrive daily. Although the primary care institutions are dwindling in number throughout the country, they are still receiving substantially less patients than they are supposed to. Thus, the vicious cycle never ends.

However, ignoring the fact that the political, social and economic atmosphere has been adverse, our health system has already reached several important goals. The Health Ministry has been carrying out several successful immunization campaigns for many years. For instance, measles and poliomyelitis have finally been eradicated. Also 2006 was the year in which Peru carried out an extensive effort to stop the rising number of rubella cases. The Health Ministry organized a campaign in which free vaccines were distributed with the final results being that 16 million people, ranging in age from 0-40 years and coming from all parts of the country, received the vaccine.

Yet another obstacle to the adequate distribution of health care resources is public investment. The latest report shows how health investments have remained constant through the period 1995-2000, with a mean of 2,554 million USD spent per year. Peru's GNP is 79,000 million USD, meaning that only 3.23% of the GNP is invested into healthcare. When all Health Ministries' budgets of all Latin American countries are compared, Peru remains under the average. This sounds illogical as our health system is falling apart and major investments – not only from the public sector, but also from the private branches – are urgently needed for improvement and to allow efficiency in all of its services. The doctors willing to work in the most remote places, where the very basics of urban life are mere luxuries, are forced to travel for days, in boats or by foot, in order to reach a small village just to buy some food. Instead of increasing the salaries of these dedicated physicians, the government prefers to make huge investments in government salaries. To make matters worse, there have been persistent complaints about the medicine bought by the Health Ministry. The press maintains that in order to decrease the prices, expired medicines are used. However, the government has always denied these allegations.

Can the government do anything to change the current situation? Of course it can. It only has to realise that this is the most important issue facing us because it deals with our population's health, which will in turn affect other aspects of our society. Thus, it is mandatory to refocus the national economic policy. Hopefully, the new government will show more interest in this area. In this way, remote health will no longer be ignored and more Peruvians will have access to proper health-care, which will ultimately improve their living conditions and allow our nation to continue to strive forward.



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Spare a thought for the rest...

There is no doubt that HIV/AIDS is a huge killer and burden upon society. Fortunately, over the last decade the profile of both HIV and AIDS has mushroomed. Both in political and scientific circles we have pledged huge sums towards the fight and research. Even in the home and community people are acutely aware of the plight of HIV and commonly make their own contributions ranging from wearing ribbons to organising fun runs. But is enough thought being spared for the worlds other two major infectious killers, Tuberculosis and Malaria?

Currently, HIV is the world's predominant infectious killer, responsible for 2.8 million deaths in 2005. Tuberculosis and malaria follow closely behind with around 1.6 and 1 million, respectively¹. However, HIV seems to have stolen the limelight, both in terms public perception and critically in terms of world financing. As just one example, since its inception the multilateral organisation the Global Fund to Fight AIDS, Tuberculosis and Malaria, has been spending with a bias towards HIV/AIDS, accounting for some 57% of spending. In comparison, TB and malaria lag behind with 15% and 27%, respectively².

Why then, does HIV have a higher priority in funding and is this rightly so?

There is no denying that the threat of HIV is the greatest in terms of mortality. Crucially, the incidence appears to be increasing whilst that of TB and malaria appear to be shrinking with the WHO *Tuberculosis Control* report for 2005 finding that TB prevalence has declined by more than 20% since 1990.

Spending on HIV has also had some large payoffs in the previous decade. For example, with the introduction of HAART (Highly Active Anti-Retroviral Therapy) deaths have been drastically reduced.

However, the threat of TB and malaria still remains immense. Although mortality for TB and malaria has shown a down turn, probably due to the improved use of conventional treatments, the number still remains in the order of millions. Critically, TB is also the predominant cause of death in AIDS sufferers in the developing world, contributing to around one third of deaths³. Hence, combating TB becomes doubly important, not just in it's own right but also in our success against HIV and AIDS. As Nelson Mandela commented "... we cannot win the battle against AIDS if we do not also fight TB"⁴.

If we are looking at the impact of a disease we must not only look at mortality. Tuberculosis and malaria typically affect a far greater number of individuals with a prevalence several orders of magnitude greater than that of HIV and hence represent a far greater morbidity and total burden of disease, particularly economically.

One, perhaps controversial reason to prioritise spending on TB and malaria over HIV is that the majority of HIV infections (i.e. from sexual transmission) are preventable

with cheap social measures, such as abstinence from sex or condom use. TB and malaria on the other hand are far more difficult to control by using cheaply implemented social measures. However, it is difficult ethically to make treatment and spending decisions on this basis of preventability as surely we still have a responsibility to those who aren't in the position to take these measures. This is especially true in the developing world where large numbers of women aren't empowered to make decisions over condom use and other methods of protection.

Perhaps one of the largest influences on spending is that we are looking at the problem from a western perspective. In developed countries we already have in place a reasonably effective (~70% efficacy)⁵ vaccination for tuberculosis - the BCG. In developing nations, however, the efficacy of this vaccine falls below 20%⁶ for reasons that may include the initial high background and exposure level pre-vaccination. Likewise few developed nations have great numbers of *Anopheles* mosquitoes carrying *P. falciparum*, the major deadly malarial parasite. More often than not malaria is often viewed as an inconvenience to travellers rather than a major killer.

The battle for equality over funding and resources of these big three killers must surely begin with the mindset of the individuals in the developed world in order to influence larger policy. Maybe it is time for Apple to release a blue iPod in support of malaria. It might not be so catchy but is needed just as badly. The fight against HIV is important, but it shouldn't be at the expense of those suffering from diseases with a lower profile.



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Opportunities & Outstation Clinics in Oenpelli

Around the same time that the grey clouds of the Cardio/Resp/Renal exams were cumulating above my head last year, the crew in the year above were basking in the holiday of transition and speaking in excited tones of recently released 3rd year placements. Intrigued by the unknown and with a summer schedule beggin' some attention, a project worthy of procrastination had been found. Within a short period of time an opportunity to spend time in a community of 800 people presented itself. Isolated by rising flood plains, united by a foreign code of football, Oenpelli was to be my home for the month of January.

About Oenpelli

Arnhem Land is a vast and remote area with spectacular

escarpments, rock art, flood plains, animal life, beaches, mangrove wetlands and plant life. Kunbarlanjnja (aka. Oenpelli) is an Aboriginal community located 320 km east of Darwin at the western edge of Arnhem Land (approximately the 'G' in Gunbalunya on the map). Slightly elevated on a small ridge between coastal black soil plains, marshes and the Arnhem Escarpment, Oenpelli allows a taste of many of the aspects that has brought Arnhem Land fame.

Watching over the community are three enormous rock formations: Arrguluk to the south, Injalak to the east and Banyan to the north. A large billabong lies between the town and Injalak, which rises to encircle Oenpelli during the wet.

The original Kunbarlanjnja group were the Mengerr who lived around Injalak. Other tribes living around the escarpment included Erre, Wuningak, Gagudju and the Amurdak. Each group spoke a distinct language in their tribal land, but still related with one another through the common dialect of the Kunwinjku language.

The introduction of buffalo from Indonesian islands saw the infiltration of the top end by hunters, and by the early 1900's they had set up a camp in Oenpelli. The name Oenpelli is derived from the Kunwinjku name given to the hunters. Trade between the hunters and surrounding tribes saw the local groups staying for longer periods. Kunwinjku was used more frequently and slowly the individual tribal cultures began to amalgamate. Kunwinjku is now the first language of the majority of locals, and unfortunately a number of languages have been lost all together and with them, many ceremonies.

Today, depending on the season, *Oenpelli* houses 800-1000 people. It boasts a supermarket and takeaway store, a Pub, a Health Centre, a School, a police station, a church, a Gym, an oval and a youth centre. The local artists have centralised to a vibrant arts centre, 'Injaluk', most famous for its traditional bark paintings and woven pandanus items. And with travel limited to the air during the wet, *Oenpelli* also supports its own air charter company. Tourists require a permit to enter Arnhem Land, as do the 80 or so non-indigenous workers in *Oenpelli*.

The Placement

Travel in the Territory certainly makes you feel special. After a relaxing 2hour bus ride to Jabiru sharing one luxury 46seater Greyhound coach with one French backpacker, I was picked up by 'Mark the Pilot' for a private flight out to Oenpelli. Right at the giant lily pads, left at the Uranium mine and we were there. Waiting on the edge of the airstrip, leaning against a troopy, ciggie hanging from his lip, 'Mark the Pilot' pointed out 'Henri the Nurse'. As they greeted he questioned "Hadley the Medical Student?" I was starting to wonder if I needed to change my sur-

name. After a quick clinic orientation I was dropped off at my bungalow and given the Med Student Bicycle and a key to the pool. I would soon find out that the latter gave you instant hero status with the younger members of the community. One excursion to the pool saw Bluey, one of the primary schoolers, pull up next to me on his BMX. "ello" > "G'day" > "Nice bike". I wasn't convinced of his sincerity. As both male and female student came out on placement, it had obviously been decided that a girl's bike would better cater to everyone's needs.

"My name's Bluey..." > "I'm Hadley, how're you going"
"Good... You going to the pool" > "Yep." > "Can I come!" > "If you're mum says it's Ok." Bank left.

"Maaaaaaam..." With military like organisation the word spread and within a minute there where eleven towelled children running/riding next to me. Not having any experience with this number of children, I spend the entire session recounting heads and sweating over the length of time they were spending underwater. I think my mum would have had a good chuckle at my expense had she been there.

The children were only slightly more cordial than there parents in their liberal handouts of smiles. The expatriates, particularly those who I worked with, where equally welcoming. More often than not there would be an invitation to dinner come close of business. One had to be careful not to overstay a visit though, and not for the obvious reasons. Oenpelli has no street lights. A extended dinner leaves you wide eyed trying to pick the pot holes by moonlight while avoiding the glowing eyes of the camp dogs whom by the witching hour are illuminated solely by your imagination and are rabidly salivating, organised, overtly distracting you while their accomplice pulls around on your tail.

'Max the Locum', my supervisor for the month, arrived the day after me. He had shoulder length hair and had recently finished a stint in Byron. He seldom wore shoes in the clinic. He also remembered the 157.3 differentials for headache. He had surprisingly little contact with the majority of the patients that came through the clinic. This was because the nurses and Aboriginal Health Workers have far more autonomy than their city counterparts. Each was responsible for a different area of the clinics work; women, children, men, chronic diseases, and outstations. My time was split between all the staff except those in the Women's health clinic – from which the culture prevented me from being involved. The opportunities were excellent to the point where I was allowed (supervised) to run the well-baby clinic while one of the nurses was on leave.

The outstation clinics were some of the most enjoyable to attend. Outstations are traditional lands linked to the various skin groups of a community. They're found mainly to the north east of Oenpelli, and can only be service by air during the wet season. Every Tuesday and Thursday Henri flew out to an outstation, meaning the each station is visited once every three to four weeks. The ones I was lucky enough to visit were populated by between three and thirty

people. A wheel barrow would be waiting at the side of the airstrip to transport our mobile clinic to the designated veranda for the morning.

Socially the hub of the town was the pool hall of the side of the pub. But the talking point of the town was invariably AFL. The town had four teams, dividing the population by which rock formation overlooked their part of town, with the fourth covering the outstations. Late in my stay I was invited to play my first ever ALF game by my local team the Arrkuluk Magpie Geese. Having unintentionally let my elbow stray into my opposite no's nose early on, I thought I may have sealed my own fate. Calls of "doctor, doctor" from our supporters were encouraging each time I got the ball, but very quickly turned to fits of laughter as I was swiftly and loosely dealt with by the opposition. Although physical, the tone of the arvo was playful and there was always a hand reaching down to help you up or pat you on the bum.

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Oil Exploration in the Niger Delta: blessing or curse?

The people of Lagos were enjoying the usual festivities that trail Christmas and Boxing Day in Nigeria when footage of a pipeline blast was televised. Festivities were promptly terminated for many, especially people with relations residing in Abule Egba, the suburban town of Lagos where the explosion occurred. Rescue workers moved to the site to make sense of the situation and to preserve whatever could be saved, of lives and property. Medical personnel who could be of help were asked to report to the Accidents & Emergency of Lagos State University Teaching Hospital. Medical students joined in the effort to save the lives of the victims, helping senior colleagues in every possible way. An emergency voluntary blood donation scheme by students was embarked upon to ensure that lives were not unduly lost. Yet, 269 people were confirmed dead.

Have lessons been learnt? This is the big question. Earlier in May, there was a similar occurrence in another suburban town of Lagos, Ilado. In October 1998, a far greater explosion occurred in Jesse village, near Warri in the Niger Delta, burning more than a thousand people and displacing many others. In all cases the explosions occurred whilst people were collecting fuel illegally from the pipelines during periods of scarcity, even though these pipelines were underground. Measures are being taken by government agencies to bury the pipelines deeper. However, a careful assessment would show that the trouble is not with the depth of the pipelines. Until the country is able to tackle poverty significantly, accidents of this nature may not disappear from our lives.

Incessant oil spills are also common in the oil exploration areas. This accidental seepage has great detrimental effects on the health and wellness of the people of these regions. In the Niger Delta for instance, most of the people live on water resources, as fishermen and farmers. Oil significantly reduces seafood yields and contaminates the land, killing plants and animals. Clean potable water is scarce and water-borne diseases therefore abound. It has also been suggested that some of the contents of crude oil are carcinogenic. It is said that between 1976 and 1996 over 2.3 million barrels of crude oil were spilled.

Gas flaring also contributes to worsen the health of the people of this region. Rather than catch this gas and make it available for commercial and domestic purposes, oil companies complain of the economics of it and burn off the oil instead. The flares light up the night time of the oil exploration areas but also deplete the ozone layer above them, predispose the people to respiratory diseases, cause acid rain, which destroys building materials and contaminate crops and farmlands. It is estimated that if captured, flared gas in Nigeria could provide US\$ 2 billion annually.

Oil exploration commenced commercially in 1958, having been discovered two years before. It is disheartening to note that the Niger Delta from where most of the oil resources of Nigeria are tapped is arguably the most backward region of the country. Infrastructure development is slow. Hospital and healthcare facilities are severely inadequate, especially in the very remote areas. Infant mortality rates are high. Life expectancy is low. Yet, primary health care system in most parts of Nigeria is very rudimentary and underdeveloped. Ignorance, unemployment and poverty are the rule in the villages and towns. Youths are therefore easily wooed to join the ethnic militia and 'freedom forces'. Conflict and insecurity are the result, with incessant kidnaps of foreign oil workers and gun battles with government forces in the creeks. Meanwhile, many young girls engage in sex-work. Coupled with ignorance, this has been suggested to be the cause of the especially high incidence of HIV/AIDS and other STIs in this region.

Indeed, successive governments have made attempts to solve this crisis. OMPADEK, PTF, NDDC and PTDF are all acronyms of agencies set-up by different governments to address this problem. Unfortunately, these agencies are stories of failure, corruption and embezzlement of public funds. In lieu with the ethnic leaders of this region, public officials have connived to rob the people of development, steeping them in poverty, ignorance and disease. The people of this region now demand an opportunity to rule the country, and the ruling party has responded by zoning the Vice-Presidency of the country to them.

If allowed to continue unabated, the Niger Delta crisis is one that can cause widespread conflagration

in Nigeria. The permanent solution is the provision of infrastructure including schools, healthcare facilities, good motorable roads, befitting housing, among others. Jobs should be provided to young people by attracting industries to this area and increasing corporate investment in agriculture and small and medium scale enterprises. These would stamp out underdevelopment and improve health as well as eradicate several social ills. The federal government has also taken steps to ensure that oil companies discontinue oil flaring by 2008. The cause of oil spills also has to be thoroughly examined, and solution evolved.

Medical students in Nigeria through our Standing Committee on Environment and Population Activity (SCOPEPA) and in our medical students' associations have been advocating, alongside the civil society, to bring an end to the environmental damage done by oil exploration in the Niger Delta. The Standing Committee on Reproductive Health including AIDS (SCORA) also hopes to intensify efforts towards stemming the tide of new infections in this region. Surely, greater international support would help us achieve our goals.

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Going Beyond Medical Missions

For the most part, health care in rural areas of the Philippines is not easily accessible. The nearest hospital may be many kilometres or hours away. There is also a growing shortage of knowledgeable and skilled health workers who are either migrating to the cities for better pay, or migrating outside the Philippines to find work abroad. Furthermore, the lower income of those living in the rural areas limits them in obtaining adequate health care.



These are the reasons why many private sectors have taken it upon themselves to give free medical missions to these far-flung areas. During these medical missions, doctors and nurses volunteer anywhere from a day to an entire week of free service. Free medicines would also be provided to those who need them. These medical missions are a big help to communities, who otherwise would have little access to medical care or drugs. However, these medical missions are only a quick fix to the health problems of the people in these communities.

What happens to these communities once these missions leave? People are still sick and the long-term questions of how their illnesses will be managed linger long after the missions leave. Moreover, once the supply of medicines that were given to them during these missions run out, they also have no other means to obtain them again as they cannot afford



them or they would have to travel very far to obtain them. That is why a more long-term commitment to improving the health of a community is what's needed.

Our organization, the Asian Medical Students' Association-Philippines, is trying to commit to something long-term by training community health volunteers from two communities in Gabaldon, Nueva Ecija, five-hours north of the capital Manila, by teaching them basic health knowledge and skills. However, before we could even start to train these volunteers, we went through a long process. First, we corresponded with the involved communities in May 2005. One of them was a Dumagat community, which is an indigenous group, and has a different culture from the other local community. This discussion with the community was necessary because they alone know their true health and social situation. Through this dialogue, we were able to learn what kinds of illnesses affected them the most, and what they wanted to learn most about. Thus, we were able to base our training modules on the feedback we received through these sessions.

Aside from dialogue with the community, we also had to talk with the Local Government Unit (LGU), namely the mayor of that municipality, and those composing the municipal health office. It was necessary to create links with the LGU because, ultimately, it is the government's responsibility to take care of the health of these people.

It was only last February 2006 that the first training session was started. However, it wasn't without any problems. Several volunteers have not been able to attend these monthly sessions regularly and it's been difficult to get members to travel far during school months.

I do not know yet if we have helped improve the health situation in these communities, but I hope this is a step in the right direction.



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