MIGRATION and Health
The International Federation of Medical Students’ Association (IFMSA)

The mission of IFMSA is to offer future physicians a comprehensive introduction to global health issues. Through our programs and opportunities, we develop culturally sensitive students of medicine, intent on influencing the transnational inequalities that shape the health of our planet.

IFMSA was founded in May 1951 and is run by medical students, for medical students, on a non-profit basis. IFMSA is officially recognized as a non-governmental Organization within the United Nation’s system and has official relations with the World Health Organization. It is the international forum for medical students, and the largest student organization in the world.
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Internacional Federation of Medical Students’ Association
Dear Friends

We hereby present to all of you the 17th issue of Medical Student International, in this edition the theme Migration and Health. Every year Migration is becoming a major Global Health Problem, that is caused for different factors. For this, in this edition, we present you different issues to consider when thinking about this problem.

I would like to thank the MSI Editorial Board for their amazing work, help, guidance, and for being committed—Candice, Publication Support Division Co-Director, as well as Jade, Karolina, Magdy, Jolie Anna, and Caissa. Also for their valuable help to Mohammed Nour from Sudan for the great cover, Christoph Bader from Germany for providing us with some necessary tools in order to work better on MSI, and Johanna Norenhag from Sweden for their continuous support. I would also like to extend my gratitude to all the great writers we have for this issue.

Medical Students from around the world, get Published in Medical Student International Magazine, and let the world read your thoughts, comments, proposals and ideas.

We hope this magazine will challenge and inspire you, to demand action as future healthcare leader, but as medical students. Enjoy this issue, as much as we did while preparing the articles.

On Behalf of MSI Editorial Board

Eduardo Ríos
Publication Support Division Co-Director

The Cover
For this issue, we have the pleasure to have this cover (front and back), made by an IFMSA member, Mohammed Nour Eldin, Publication Director from MedSIN-Sudan, his cover was chosen among other 5 proposal from 4 different countries. We congratulate Mohammed from Sudan for his big effort and valuable cooperation in the production of the cover for this issue, about Migration and Health. We really appreciate it.

Photos taken from Wikipedia
Nishi tribal lightened
Evstafiev bosnia travnik refugees
Diversity of youth in Oslo Norway
Crowded Train (taken from medsin.org)
As medical students and physicians, we witness inequalities in health care every day. IFMSA has a firm stand against discrimination whether based on ethnicity, race, sex, disability or origin. I am thrilled to have the awesome responsibility of leading our student-run independent non political federation. Since its establishment, IFMSA has made strides in becoming the medical students leading voice in health care and medical education reform. We have consistently fought for equal access to health care. We have lead coalitions to fight HIV/AIDS, promoted Health as a human right and transformed the culture of medical education. IFMSA has always given priority attention to vulnerable and marginalized population groups. This is why IFMSA chose the theme Migration and Health as a core of its coming General Assembly and this edition of MSI.

The last century saw a number of fundamental changes in the ways in which societies and countries interrelate, in the demands and pressures that resulted in people to move between countries, and in the patterns of health associated with those new interactions. People are increasingly migrating for political, humanitarian, economic or environmental reasons whether it was due to forced or voluntary movement. In the last century, in response to the gradual hardening of policies to migration, unofficial but voluntary and economically inspired voluntary migration predominated. The number of people forced to move for reasons of conflict and political repression also grew over the course of the last century and has continued to take diverse forms. People continued flee across borders and become refugees with UN protection, while at much the same time millions of others were forced to flee from their homes but remain within their own borders, often without any international or national protection. The health and health care implications of these forced migrations are always severe and far-reaching.

The movement of people across borders has always generated concern on the part of receiving countries and a variety of procedures have evolved over the years to respond to migration. These policies have leaned towards the restrictive rather than the permissive, and even more so in the case of policies that are now emerging in both developed and developing countries making migration more complicated, difficult and unattractive. In doing so, they may be generating social and economic environments that are detrimental to the health and welfare of migrants.

Effect of migration on health ranges from forced and undocumented migrants lacking access to basic health services to poor populations left behind by the brain drain as health professionals in poor countries migrate to richer ones. Migrants often face serious obstacles to good health due to discrimination, language and cultural barriers, legal status, and other economic and social challenges.

It is also important to acknowledge that migration either due to forced or voluntary movement itself is a natural reflection of inequality, where people seek better conditions escaping climatic, social, political, agricultural and economic threats and seek alternative life options elsewhere.

The world became a smaller place to live in and health conditions in one country or region assumed a bigger capacity than ever before influencing those in other parts of the world. At the same time, migration policies may have significant global and public health consequences.

This publication provides an overview of some of the concerns of future physicians in addressing the linkages between migration, health and human rights. We hope that you will enjoy reading the articles, the debates and the concerns that medical students raise regarding this issue.

Anas Eid
President 2007-2008
IFMSA
high rates of functional or complete illiteracy, and substance abuse are more prevalent than in other Israeli immigrant communities. Most of the immigrant population lives in underserved and impoverished slums. Societal racism and paternalistic stereotypes compound the community’s socioeconomic malaise.

Coincident with the Ethiopian migration to Israel has been a sudden change in the burden of disease. In 2003, unpublished surveys in the city of Hadera found an astounding Type 2 diabetes prevalence of 17.6% among Ethiopians who had immigrated ten years prior. The prevalence of hypertension, asthma, and hyperlipidemia were also notably higher than Israeli averages. These disease patterns had not been previously observed; one 1991 survey of migrants reported a diabetes prevalence of only 0.4% (1). This rapid epidemiological transition was attributed to a change in lifestyle habits, notably widespread adoption of a Western diet and sedentary lifestyle.

In 2005, I worked with a community health organization called Tene Briuit, which addresses the emerging health needs of Ethiopian Israelis. I was charged with collecting stories of health miscommunication and frustration arising between health care workers and Ethiopian patients. We then planned to incorporate some of this material into educational materials with the objective of bridging gaps both common to immigrant populations (which Israel has many bandage in weeks. A mgasheret told me that a father had given his child an acetaminophen suppository by mouth, as he could not understand the doctor’s Hebrew.

Other common stories, which have been previously described (2), were more specific to Ethiopian Israelis. Patients would frequently present with non-localized pains that they could only describe with long stories; the doctors rarely found organic causes and did not prescribe medicines. Some patients interpreted this conservative management as “degrading,” and instead went to traditional healers who employed herbal therapies or bloodletting. One woman expressed satisfaction with the healers compared to her deep distrust in the Israeli doctors who did “nothing” and “do not examine me.” The Israeli health care providers, both Arab and Jewish, often had little awareness of or patience for these cultural issues, which bred a visible distrust at a few of the clinics I visited.

The most unique and frustrating stories revolved around the epidemiological shift to chronic diseases. I noted that entire notions of preventive care and maintenance therapy were unfamiliar, leading to major misunderstandings. One mother refused to give her asthmatic son his daily albuterol inhaler; she said “I’m afraid he will become addicted to it, like smoking.” Meanwhile, an older woman with mild asthma refused to stop taking her prednisone pills after an exacerbation. A young man came into the clinic wheezing; he had not refilled his prescriptions, thinking his asthma was cured. One middle-aged woman only would take her insulin after eating sugar; her glycated hemoglobin A1c was 9.5 mg/dL on her visit. Most remarkably, one doctor told me that a patient had refused to believe in diabetes, stating “How can you get sick from eating too much?”

These chronic diseases were completely incongruent with the traditional conception of a patient-doctor relationship. Used to equating disease with acute infections treatable by antibiotics, patients could not understand why their doctors could not cure diabetes or hypertension. “Maybe he is not a good doctor, maybe it is because he is Arab,” an Ethiopian diabetic whispered to me. Most of the doctors and nurses told me of their frustration in trying to convey the idea of chronic disease to a
population that had not previously recognized their existence. “How can you explain diabetes when a person has never heard of a pancreas?” asked one exasperated physician. Since 2005, I have encountered similar situations during my work with disadvantaged immigrants in New York, many of which are struggling with frightening increases in diabetes (3). The profound difficulties faced by Ethiopian Israelis are thus illustrative of health challenges particular to immigrants, which I expect will become more common as globalization facilitates greater migration between rich and poor countries.

Furthermore, many poor countries are now experiencing surges in chronic “lifestyle” diseases such as diabetes and cardiovascular disease (4). My work with Ethiopian Israelis demonstrates that this disease transition may not conform well to traditional understandings of health, disease etiology, and healing. We can expect that the consequent miscommunication will be a major anthropological barrier to implementing prevention and treatment programs, and it will likely exacerbate inequitable outcomes. In this sense, the difficulties faced by the Ethiopian immigrants are an early warning of coming global health challenges as these “new” diseases “migrate” to poor countries. It is thus imperative that we start paying better attention to the cultural aspects of the interplay between migration and health.

New Era of Migration and Health Problems

Since the evolution of humans, migrations have been present. But first what is migration? It is a word often used in everyday speaking. It would not be surprising if some of us still do not know the correct definition of migration, namely: any movement by humans from one locality to another, often in long distances. It is also important to note that there are different types of migration.

We all are witnesses of migrations all over the world. The rate of migration, the number of people involved is fascinating. Migration, both voluntary and forced, is increasing all over the world. Some sources such as the Center for Disease Control and Prevention reveal that currently the countries with the highest immigration rates are United States of America, Western European countries, Central European countries, Southern European countries and Australia. It is not was surprising to see these rates. Immigrants leave their home countries trying to find better future for their children, better education and of course better health system in the country they migrate into. It is a sad fact that many countries in the world do not have health system and in some cases 1 doctor takes care of more than 3000 patients.

Imagine yourself in that position, seeing a patient once per year, sounds unreal, but is indeed true.

Several years ago a huge wave of migrations happened within and from the former country of Yugoslavia. More than a million people emigrated from one part of country to another part and more than 500,000 people emigrated out of that country. There were many causative factors but the main one was war. Of course war brought in other factors such as poverty and also disease.

These mass migrations in the former Yugoslavia caused a hugely increased incidence of some disease such as tuberculosis. Currently in all former Yugoslav states vaccination for tuberculosis is still obligatory. Some European countries such as Austria, Hungary, Italy and Spain do not have TB screening, but in others such as Denmark, refugees arriving from countries with high prevalence of tuberculosis are routinely screened, and those who are found positive are provided with six month treatment.

Apart from disease, migration also brings us “medical” problems. Currently many countries are facing a deficit of doctors. Without doctors or other health workers, prevention and treatment of disease, as well as advances in health care, are impossible. We can see doctors moving from the poorest regions to the wealthier cities within a country, as well moving to more wealthy countries all over the world. Some researchers say that the migration of health professionals to the wealthier countries will increase even more.

What is future hiding for us? We still don’t know. The sure thing is that migration will increase all over the world, and we will have a new wave of disease. Will some countries face the fact that in the near future they will be left without health workers? It is still a great enigma, but we MUST try not to reach the point where in some regions of world we will have doctors working as salesmen, while other regions are left with no doctors.

References:


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Cross-Cultural Medicine and Migration: Reflections on Experiences in Rural Uganda

Religion, wealth, and power are among the principal causes of human conflict. Religious, nationalistic, and ethnic ideologies are frequently exploited to facilitate the dehumanization of another people, allowing violence to become an acceptable option. Frequently, migration is both a contributor to, and a result of, such conflicts. The influx of a new people into a region often leads to conflict over land, resources, and political power, particularly when accompanied by significant cultural, religious, and/or ethnic differences. Conversely, prolonged or significant conflict frequently creates a strong impetus for migration, as people abandon their homes in search of a security. Hence, conflict and migration are linked in a vicious cycle.

Healthcare is often compromised in situations of migration, particularly ‘forced’ migration due to conflict or natural disaster. The absence of stability frequently makes easily treatable medical conditions life threatening. Migrants often have diminished legal standing, and may be unable to access or afford the health resources of the host country. Even if healthcare personnel are available, they will often lack an understanding of the migrant population’s language and culture, leading to significant barriers in care. In unstable conditions, continuity and follow-up usually suffer, which can have a substantial impact on the morbidity and mortality of chronic illness.

Healthcare workers across the globe must embrace that healthcare is not mutually exclusive from matters involving religion, power, and money. In fact, in order to become the most effective physician possible, one must grasp that the practice of healthcare is often regulated by the patient’s culture and religion, the rule of law, as well as the forms of payment and health insurance that exist within a region. Accepting that people will travel and live in foreign lands, accepting that nations do have control over all people within their territory, and accepting that medicine is often made a commodity by governmental powers, what can we as healthcare workers do to stimulate positive change?

Anytime migration occurs across cultural boundaries, the issue of cultural assimilation arises. In the cultural lore of the U.S., there is an old metaphor that our country is a ‘melting pot’ in which people of diverse backgrounds become one. The implication is one of complete assimilation – the melted ingredients lose their shape and individuality to become a homogenous liquid. But is this truly desirable or even possible? A more recent take is the ‘vegetable stew’ – the ingredients are combined, but each of their individual uniqueness is preserved. Should one stir the pot and try to promote assimilation, or is it better to promote the retention of culture at the potential risk of intercultural discord? Although simple, these metaphors have value in thinking about approaches to immigration.

To take this metaphor further, the real control over the melting pot is not always dictated by stirring or the lack thereof, but by the contents of the pot. If the people migrating to the mainland refuse to integrate and adapt to the local culture, then no amount of stirring will facilitate a smooth transition. If the locals are not accepting of foreigners, then coagulation and separation will inevitably prevail. Yet the goal is not to strip people of their identity, but to enrich them with experiences of new and different cultures. This idea served as the catalyst to the creation of the Engeye Health Clinic in Ddegeya Village, rural Uganda by Stephanie van Dyke, a 3rd year US medical student. It was her hope that the Engeye Medical Clinic would empower the villagers to seek better healthcare, though she was careful not to force the Western philosophy of medicine upon Ugandan culture. Ultimately, it was Stephanie’s goal to create a clinic capable of providing comprehensive treatment specific to the needs of Ddegeya Villagers.

Over 1,000 Ugandans traveled by foot as far as 10 miles away to receive medical treatment during the first medical mission and grand opening of the Engeye clinic in April of 2007. Observing high rates of malaria, peptic ulcer disease, hypertension, and osteoarthritis, it became clear that the people were in need of constant health care supervision. Though the team from the United States had initiated a gallant effort, what could be done to continue the momentum? Once the Americans returned home, who or what force would sustain the chronic healthcare needs of the villagers? What new problems or issues would arise?

The departure of the Americans from the Engeye Health Clinic of Ddegeya Village was bittersweet. As the Americans watched the clinic grow smaller and smaller in the distance, they began to wonder if their two weeks of volunteer work had truly helped the villagers or merely reinforced a false association between healthcare and foreign aid. The Engeye team was determined to break this potential association and, more importantly, wanted the villagers to have access to healthcare at any hour of the day. In the first step towards sustainability, two full-time Ugandan nurses were hired to work at the clinic. Since this day, the Engeye Health Clinic has received a steady stream of patients and has become a trusted establishment in the village. Moreover, in a second move towards sustainability, each patient pays a negotiable 2000-shilling fee and in turn receives a medical book documenting their diagnosis and treatment, as well as any medications that they were given. Ideally, the patients will bring this back to the clinic if and when they return as a way for the healthcare worker to monitor their past medical history. Furthermore, the 2000 shillings go directly towards restocking the medical supply. Taking great pride in this medical book, some villagers place this amongst some of their most valued garments that are only worn for the most special of holidays. Through embracing local customs and religion, empowering the villagers by creating a reasonable fee-for-service paradigm, and providing a central medical establishment, the Engeye team was headed down the right path – the path reinforcing that migration and cultural immersion could initiate the healthcare movement, but good old-fashioned hard work from locals would have to sustain it.

The Engeye team has since made significant progress towards our final goal of sustainability: we have installed solar panels providing much-needed electricity, tested the water and soil for contamination, and implemented routine diagnostic testing for patients that arrive with symptoms of malaria. Furthermore, two medical students from Rwanda joined us recently to learn how to build a medical clinic from the ground up. It is their intention to return back to Rwanda to build a clinic specifically designed to combat malnutrition in their community. This exemplifies what we hope is a growing trend: instead of trying to leave

“There is an old metaphor, that our country is a ‘melting pot’ in which people of diverse backgrounds become one”
their country to live and practice medicine in a more lofty environment, these students wanted to collect as much information as possible to stand on the front lines of their home country to fight for good healthcare. No one can blame a physician or nurse for seeking a better life for themselves and their families by moving abroad, but the cost of this ‘brain drain’ to the quality of health care in developing nations, particularly in rural settings, is enormous. While having volunteer medical personnel from developed countries is certainly helpful, the only real long-term solution is to facilitate the training and retention of medical expertise from amongst the people it is meant to serve. To see young physicians-in-training with the commitment to remain where they are most needed is deeply inspiring.

Religion. Power. Money. Healthcare. We are faced with these four words yet again while attempting to transform the Engeye Health Clinic into a self-sustaining medical facility. Our ultimate goal is to empower the villagers to feel proud of the Engeye clinic, as it was created to be a part of their community. While journeying through this process, we have learned many lessons. We have learned to embrace the local culture and understand religious beliefs (which affect their use of birth control and explain unique markings on their abdomens made by ‘traditional healers’), we understand that shillings are few and far between and embrace the local culture and understand it was created to be a part of their community.

As we reflect upon our own personal journey, it becomes apparent that the practice of cross-cultural medicine has never been more necessary than it is today, as people migrate and travel throughout the globe. Working across political, cultural, and language boundaries inevitably leads to difficulties and misunderstandings, but also to opportunities. We at the Engeye Health Clinic have learned what boils down to one word: perspective. Armed with a clear and realistic perspective, the Engeye Clinic has begun to meet the needs of its villagers to feel proud of the Engeye clinic, as it was created to be a part of their community. When my anger rose against the migration of people towards my city. My consultant didn’t listen, he advised for nerve conduction studies (NCS), along with an EMG report. And that was when I realized my ignorance; the patient was later diagnosed as a case of Chronic Inflammatory Demyelinating Polyneuropathy (CIDP).

An expensive treatment module was planned, for this disease with an unimpressive long-term prognosis. Even though my rotation ended in that ward, but I kept visiting her bed; the patient showed signs of improvement during her stay as plasma-exchange was undertaken.

She was later discharged with a prescription, and to everyone’s joy, she walked out with a support stick in her hand, amazing to see her not limping at all. I, along with many of my colleagues learnt a hard new fact that we as health-care professionals need to be open, more tolerant, more humane and caring and loving for all, irrespective of a patient’s ethnic and social background.

I recognized many would be thinking of me as a villain of the story, but believe me life has been much better since then. I am a better doctor, a more competitive professional and importantly a better human being! The Morale: Migrants need more subtle behavior from us, than any one else on the planet!

An Immigrant Who Made Me a Doctor

I would like to share this stunning experience with my friends all over the world, emphasizing the impact of migration on healthcare. I was a fourth year student doing my rotation in the medicine ward of a massive tertiary care government funded hospital, in Karachi, a southern coastline city of Pakistan. I was sitting with my consultant at the busy and noisy outpatient department, when a middle aged Afghani woman came in with a young man in his mid 20s.

I started taking her history and examined her, through the help of her son interpreting the afghani language into broken-Urdu words. It was not an easy assessment, but the information disclosed by her son that they have crossed over from Afghanistan through the torrid borders and have come for respite, for the sole purpose that her mother gets the proper treatment; this made me change my tone and my assessment. They had no travel documents, no luggage, and no money! I discussed this with my consultant, and he asked me to go ahead with her assessment and clinical management.

She was complaining of gradual onset of weakness for the last six to seven months in her lower limbs, which recently involved her upper limb. I was having trouble communicating, and the persistent thought that there might be a ‘functional’ element involved, kept me reviewing her repeatedly. Her reflexes were not revealing much, and her sensory examination was showing glove and stocking involvement, and contradictory response for sense of vibration. I was frustrated and repeatedly examined her, she cried. Her son consoled her, in Tashkent I guess. I checked her sugar, it was normal. She was vitally stable, apart from CNS examination all other systemic examinations were normal, and her higher mental functions were next to perfect.

After my detailed history and thorough examination, my consultant got involved. And unlike other cases where he trusted my skills, did few of the essential physicals himself. This time around the patient’s motor system again showed weakness, but her sensory was absolutely intact. I gave a sole differential of a functional case.

I told my consultant that the patient considers the unbearable cold of her home town as the cause of her disease, and kept requesting for admission.

During the phase of her investigations, all invasive procedures like lumber puncture, nerve/muscle biopsy etc were turned down by the patient’s son. Her blood picture, vitals, urine reports, electrolytes, chest X-ray, MRI brain, MRI spine were all normal. That was the time when my anger rose against the migration of people towards my city. My consultant didn’t listen, he advised for nerve conduction studies (NCS), along with an EMG report. And that was when I realized my ignorance; the patient was later diagnosed as a case of Chronic Inflammatory Demyelinating Polyneuropathy (CIDP).

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“Health Care Workers: A Scarce Commodity in a Globalized Labor Market”

In an age when globalization is the rule and when countries are increasingly depending on each other to meet the needs of their citizens, health care workers are becoming a scarce commodity.

Rich countries, with aging populations and long-term shortages in home-grown health workers, are facing an ever increasing demand for such skilled workers. On the other end of the spectrum; students, physicians, nurses, pharmacists, technicians and other health workers of middle and low-income countries are driven by a multitude of reasons to emigrate to one of the richer countries, either temporarily or permanently. These workforce shifts can also be seen on an intra-country level, where health workers migrate from rural to urban areas and from the public sector to the private one.(1) In addition, these shifts are not limited to the African continent, nor to developing countries in general. Migration of skilled workers between western countries is also rising.(2) But it is the African continent who is suffering most. This global phenomenon of flight of human capital or “brain drain” has dire implications on the source countries health, economy and even political future.

The Push and Pull Factors

The decision to migrate or stay home is influenced by an array of economic, social, political and career-related factors. Some of the important “pull” factors include higher income, better working conditions, more job satisfaction and career opportunities, and the ability to provide family and kids with a better life-style and education opportunities.(3) Another factor is targeted recruitment drives for health workers from resource-poor countries to fill vacancies in rich countries.(5)

On the other hand, political instability, wars and the threat of violence in the working place all push health workers out of their countries.(3) A striking example is the Iraqi situation, where it is estimated that 12000 of Iraq’s 24000 doctors have emigrated since the coalition invasion in 2003.(4) Equally important factors are the lack of opportunities for continuing medical education and promotion, the lack of research funding and facilities, and excessive workloads. Yet the single most important factor affecting, and controlling, the brain drain is the demand for more health workers by destination countries.(5)

The Impact of the Scarcity of Physicians

Without the additional challenge posed by the exodus of physicians and trained health personnel, developing nations are already confronted with the reality of “weak and inadequate health systems as evidenced by health status indicators” (11). Decaying infrastructure, ravaging infectious diseases, HIV/AIDS, and environmental pollution among other challenges continue to pose significant challenge. Scarcity here implies qualitative as well as quantitative reduction in the available health workers.

Competence is affected as physicians with the best resumes or with training in certain specialties end up in rich countries, while those left behind are demoralized and demotivated as a result of the collapse of public health financing, decline in salary levels and increase in workload.

“Brain waste” also occurs when health workers end up working outside the health sector or as unskilled labour in the country they move to. In addition, a health system may enter a vicious cycle when migration of teachers and academics damages the capacity to train new health workers.(1)

It is often argued that a small brain drain can benefit the source countries, as emigrants send money home and may return with new skills and capital.(10) But in countries with fragile health systems, the repercussions are measured in lives, not in dollars. After all, what can vaccines or ARV drugs do when there are no health workers to make proper use of them!

Tackling Brain Drain at Home

It is obvious that there is no such thing as a “one-size-fits-all” solution to a problem as heterogeneous and multi-faceted as the brain drain. Instead, the need is paramount for a comprehensive strategy that addresses the migration of health workers on multiple levels, a strategy that can be customized according to the local needs and circumstances of different countries and populations. Central to such a strategy is the need for source countries to concentrate their efforts on retaining their existing workforce by means of financial and non-financial incentives.

Current evidence suggests that wage differences between source and destination countries are so large that reducing them by small amounts is unlikely to affect migratory flow. This suggests that non-financial incentives will have to play a pivotal role. (5) Examples include training, study leave, the opportunity to work in a team and feedback from supervisors. Other incentives for health workers in rural areas include providing them with housing and transport and agreeing to the number of years that will be spent in a rural location.

Health workers could also be encouraged, or even required, to do some form of government service in return to their country’s investment in their training. Government service works best in contexts where it is perceived as fair and legitimate, and on the contrary, coercive measures usually backfire by creating incentives to leave – and not to return.(1) Other coercive measures, like travel bans (8) or withholding the issuance of graduation certificates (9) may in fact constitute violation of basic human rights. (personal opinion?)

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**Magnitude of the Problem**

The only referral unit for spinal injuries for an entire region of South Africa was closed in 2000 when its two anaesthetists were recruited to Canada (Martineau et al. 2002). International medical graduates constitute between 23 and 28 percent of physicians in the United States, the United Kingdom, Canada, and Australia, and lower-income countries supply between 40 and 75 percent of these international medical graduates.(6)

Nine of the 20 countries with the highest emigration factors are in sub-Saharan Africa or the Caribbean. (6) Since 1990, at least 20,000 qualified people have left Africa every year. (2) Africa lost 60,000 professionals (doctors, university lecturers, engineers) between 1985 and 1990. For every 100 professionals sent overseas for training between 1982 and 1997, 35 failed to return. (2) The return rate of African students who were studying for a PhD in health sciences in Canada and the US is 44%. (7)
The Role of Destination Countries

Destination countries not only have an ethical responsibility towards source countries, but it is also in their best interest—in the long term at least—to reduce brain drain and its complications. One mode of action could be replacing active recruitment drives by ethical recruitment—a code of practice prohibiting hiring and advertising in developing countries unless there is a government agreement that allows it. (1) This is best done under the patronage and encouragement of international organizations such as the WHO and the ILO.

Another much debated strategy dictates that destination countries should subsidize source countries for their migrating health workers. This financial restitution should be directed towards strengthening health systems and supporting the health workforce. (3) The simplest solution remains the most elusive one, that is reducing the dependency on migrant health workers. Studies show that the flow of health workers is likely to continue or even to grow unless there is a commitment from developed countries to train more health workers to meet their own needs instead of recruiting from overseas. (5) The United States, for example, trains 30% too few physicians to fill its own needs. (3)

Finally, and for any of these solutions to succeed, it is of utmost importance for all parties to be actively involved in a coordinated manner. As future healthcare workers and policy makers, we—medical students—must measure up to the expectations of our manner. As future healthcare workers and policy makers, we—medical students—must measure up to the expectations of our

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Peter’s Story

Peter was the latest of many guests that frequented my host family’s house. Only after sitting down with them over a meal did I have the privilege of learning more of his story. Peter is originally from Mauritius, a small island country east of Madagascar, but had recently moved with his family to Zimbabwe. Like everyone else there, they have been affected by the hemorrhaging economy, their livelihoods being gradually torn down, and their very lives threatened.

Unlike most of the Zimbabwean refugees now living on the streets of Johannesburg, Peter was forcibly deported from the country. He didn’t say why, but I speculate that his profession as a journalist may have something to do with it.

He is part of a mass exodus; estimates run around 3-4 million refugees, approximately a quarter of the population. However, only he—not his wife and children—was made to leave the country. His family, on the other hand, is not legally allowed to leave. He has tried for months to arrange the proper paperwork to either bring his family out of Zimbabwe or get permission to visit them for a couple days, but has fallen victim to ineffectual bureaucracy and outright exploitation. To legally immigrate to South Africa from Zimbabwe is exceedingly difficult, in part because the South African system is so overwhelmed by the number of refugees from its neighbor. While awaiting progress on that front, there are more immediate problems to address. Sending food to his family requires creativity and courage; guards at the border prevent people from taking in even maize-meal.

Peter knows of nuns who are able to smuggle some food across in their purses, but this would never be enough. With empty shelves in the supermarkets, the country is slowly starving.

At our house, he was able to call his family, one of the few times he has been able to hear their voices since leaving Zimbabwe. While the call was crucially important in that it allowed him to discuss with his wife the next step in their plans, what he most dwelled on was the joy of speaking with his children. He described with wet eyes how his daughter, despite missing several months of school, was allowed to take the test to pass on to the next grade, and earned the highest score in the class. And how his nine-year-old son assured him that he was looking after mom, stepping up to be the man of the house.

Peter’s tears of love far outweighed his quiet worry over what to do about the world that seems to have turned against him. Powerful systems can and often do deprive people of their rights, and prevent them from enjoying those most important blessings in life. Even an educated, economically self-sufficient professional is vulnerable to such structural violence. And tonight, like every night in recent memory, he will find himself sleeping in a shelter in Hill brow, just one of thousands, dreaming of seeing his family again.

Name changed

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Brain drain of Health Professionals: a New Challenge for Developing Countries

Migration of health human resources out from developing countries has now become a major concern of global community. Healthcare professionals (doctors, nurses, paramedics, etc) are soft power for nations they come from. They are highly valuable human resources which be preserved without any restriction for positive development. This condition is termed as brain drain, where there is loss of highly skilled personnel or professionals from a country:

In recent years, international migration, fuelled by many factors, has grown to such proportions that it is affecting the sustainability of health systems in some countries. While both developed and developing countries are experiencing the negative impact of loss of skills, such loss is more keenly felt in developing countries, which are finding it increasingly difficult to compete for skilled human resources in the existing global market (Commonwealth Secretariat, 2003, p. 1). Consequently, brain drain worsens the already depleted healthcare resources in developing and poor countries and widens the disparities in health inequities worldwide.

Causes of healthcare professional’s brain drain

What factors influence medical professionals to migrate? There are push factors which force them to leave their employment and living environment, pull factor which attract them to shift to other working circumstances, and grab factors which lure or entice health professionals from one country to another. Some experts suggest that there are also stick factors which persuade health professionals to stay in their current workplace or their country of work.

Key reasons of push factors which may encourage individuals to seek employment abroad are poor remuneration, poor and highly vulnerable working environment, and oppressive political social economic climate, persecution of intellectuals, and lack of promotional prospects. Several researchers cite lack of funding, poor facilities, limited career structures, and poor intellectual stimulation as important reasons for dissatisfaction. Other personal key reasons for emigrating also include concerns about security and violence. In the other side, key reasons of pull factors include better remuneration and possibilities to enhance earnings, perceived opportunities, prospects for further training, and better equipped health facilities whereas grab factors include aggressive advertisements, recruiting agents, and networks of former migrants.

Implications of healthcare professionals’ brain drain

The main consequences of health professionals’ brain drain for health systems are usually divided between implications for source and destination country.

The main benefit of brain drain of health workers for destination country is overcoming the problems of medical staffs’ shortages in qualitative and quantitative values. The health systems in destination country will work more efficiently and more effectively. Indirectly, these will lead to better perceived integration between healthcare system and enriched health resources.

How about the source countries? What is the benefit for them?

In recent days, the migration is more temporary than in the past, enabling countries to attract return. Thus, temporary brain drain is viewed positively as an opportunity to develop new skills and competencies and to widen experience that can benefit the source country on return. Amongst some economists, there is a strong belief that migration of highly skilled workers is beneficial to all because of the emergence of transnational communities that link the diaspora to the home communities, stimulating investment and entrepreneurship (Saxenian, 2002).

However, do they suffer from brain drain which make they lose their skilled human resources? For several poor and developing countries, yes. Emigration of medical professionals even deteriorates the already decreased numbers of qualified health human resources and worsens the healthcare system in some countries. Imbalances of health sector workforce, exacerbating shortages, and ineffective health systems will be other important negative consequences.

The challenge and solutions

As discussed before, brain drain of health professionals have not only negative implications environment. but also positive ones. Therefore, it has been challenge for global community especially for developing countries. International migration of health professionals somehow can not be avoided but we can control it and even take advantages of it. Higher demands of migration can be utilized as outer motivation for a country to develop its national health system. The development shall include all aspects of the system, such as education, training, promotional prospects, health facilities, remuneration, and working

The source countries (developing countries) are challenged on how to attract the migrants of medical professionals to return; otherwise, they will have permanent loss of expertise which is the most important intellectual properties of a country. The important endeavors that can be done to deal with the challenge are improving medical education, training more health professionals, improving remuneration, encouragement of unionism of health professionals, compensation and restitution, bonding of health professionals, ethical recruitment, and encouraging return.

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The problem

The migration of Health Care Workers (HCW) is contributing to a serious crisis in the health workforce in many of the world’s poorest countries. The numbers are alarming. The World Health Organization’s (WHO) 2006 World Health report focuses on this issue and estimates that there is a shortage of more than 2.4 million doctors, nurses, midwives and other HCWs in the 57 poorest countries in the world, 36 of which are in Africa (1). At the same time, thousands of HCWs are leaving the African continent every year, mostly for English-speaking countries. A study published in the New England Journal of Medicine estimates that 18% of South-Africa’s doctors and 30% of Ghana’s doctors are working in Canada, Australia, the United States or the United Kingdom (2). The WHO predicts that the migration of HCWs will continue to aggravate this health workforce crisis in the coming years and will continue to be a major obstacle for all Global Health actions. Not surprisingly, the WHO has made this issue one of its top priorities.

The issues to consider when thinking about the problem

The reasons for HCW migration, collectively termed as “push and pull factors”, are numerous, and only partially financial. Dangerous working and living conditions, lack of facilities and medical equipment, poor management, heavy workloads and little professional development opportunities are but a few of the factors pushing HCW to seek a practice elsewhere(3). Factors attracting HCWs to richer countries include the workforce shortage in developed countries that rely on international migration to fill the gaps, better and safer living conditions, enticing salaries, and more stimulating working conditions.

When thinking about these “push and pull factors”, an important dilemma readily becomes apparent. The human right to health care access is in conflict with the rights of individuals to migrate and seek better lives and safety for themselves and their family. While it may be difficult, if not impossible or ethically unacceptable, to weigh out the relative importance of each right, there are numerous examples of practices that are exacerbating the current problem and may seem unacceptable.

One serious concern is that some governments and companies are actively recruiting HCWs from countries already suffering from a workforce crisis. Almost one in five doctors in the Canadian province of Saskatchewan was trained in South-Africa (4). In an editorial entitled “Shoppers Drug Mart or Poachers Drug Mart?” the Canadian Medical Association Journal (CMAJ) accuses the American retail drug store group of contributing to a public health crisis in South-Africa by robbing it of its pharmacists (5). International financial institutions must end ceilings on health sector spending. Furthermore, health care funding in developed countries could be made in the form of debt relief, or in any country as a form of investment. Stronger health care systems will be able to train and retain more HCWs. International financial institutions must end ceilings on health sector spending. Furthermore, health care funding in developed countries could be made in the form of debt relief, or in any country as a form of investment. Stronger health care systems will be able to train and retain more HCWs.

Other possible solutions are the training of more specialists in health resource management and the development of national databases. This could help rationalize the organization of the workforce, to limit effects of shortage. Furthermore, higher-income countries need to meet their own health needs by investing in HCWs training. However, the Philippines are an example of a source country that tries to harness the exodus of thousands of nurses into a profitable industry, though this practice has been criticized (8). Several guidelines for ethical recruitment of HCWs have been developed, with limited success. The Commonwealth Code of Practice, adopted in 2003, often serves as an international reference (9). The WHO working group, the Health worker Migration Policy Initiative was commissioned to develop a global code of practice for HCWs migration and seek high-level political support for its recommendations (10). Codes of practice although not legally binding, provide global norms to which all countries should conform.

Solutions to limit the negative effects of migration of Health Care Workers

Several NGOs, professional associations, advocacy groups and governments are calling on the international community to address the reasons and the negative impacts of HCWs migration. Médecins sans frontiers (MSF) is “urging governments to develop and implement emergency plans to retain and recruit health care workers that include measures to raise pay and improve working conditions”(7). “Enough is known about the problem to demand a solution. Enough is known about the problem to demand a solution”, states the NGO Physician for Human Rights (PHR) in its Action Plan to Prevent the Brain Drain. PHR suggests several concrete actions that governments and international institutions can take immediately to slow down the alarming consequences of HCWs migration (6). One of the main priorities is to increase funding of health care systems. To scale up their health systems, many developing countries will need financial assistance from developed countries (by honoring their commitment to donate 0.7% of their GNP, for example).
What can we do?

What is our role as medical students in this debate? By reading this article you are already participating in the debate. Getting informed about the issue is the first step to getting involved in the global community. At IFMSA-Quebec, we decided to explore the issue at our annual World Health Organization (WHO) simulation, when over 100 students from various fields feverishly debated this problem and attempted to search for creative solutions while faithfully representing countries and other pertinent groups. If you are curious about our conclusions, please consult our website: www.mcwho.org. We hope you will be inspired by our initiative to get involved with this important issue.

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Looking Through Her Eyes

“It is about how it made me feel when i saw this refugee girl”

I ran into her eyes, Then i realize; if there was ever a smile that she forgot, a little hope became all she has got.

it was all about living or dying her wings were broken she wouldn’t be flying. She remembered that day she was told to flee.

“Do not look behind You are no longer free”. Then came fear of death Fear of losing the loved ones.

she was drowning in her tears living with those fears. she wanted to believe this was a nightmare, but it was real and was no fair.

No one listened Like she lost her voice, Her eyes witnessed too many And not by her choice.

Here I am, Watching the news There she is, becoming “the news”. Looking in those eyes, And I do realize; Could have been me Could have been any of us

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Navarrete is a rural community located in the northern part of the Dominican Republic, near Santiago de los Caballeros, the country's second-largest city. Approximately 1 million Haitians with public health emerging infections have immigrated to the Dominican Republic over the past fifty years and have offered challenges in overall Dominican population health. For this reason, community outreach programs that emphasize health education and disease prevention must be combined with strong epidemiologic control measures that quickly identify emerging disease epidemics and strategies developed to implement control measures.

Vector control (Malaria) technician from the local health clinic records any febrile cases and takes blood samples for laboratory analysis from community residents of Navarrete, Dominican Republic. These epidemiologic control measures monitor any infectious disease cases toward the prevention of major outbreaks.

Physicians visit a community member in Navarrete, Dominican Republic, to discuss his recent diagnosis of dengue, clinical symptoms and overall quality of life. Community outreach programs should focus on health education and self-help methods to prevent or mitigate symptoms and encourage positive behavioral changes. These acquired skills should include recognizing clinical symptoms, seeking early medical treatment and reducing vector breeding sites in and around the house.

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Marc Freiman and Neil Gray working with a neonatal patient with high fever at Engeye Health Clinic in Ddegeya Village, Uganda. Marc is a 24 year old medical student from Albany Medical College and Neil is a 28 year old MD/PhD student from Columbia University. Both students participated in all aspects of patient care during a medical mission to Engeye Health clinic in November of 2007 (performing histories and physicals, dispensing medications, and participating in medical decision making).

Kim Robinson, medical student at Albany Medical College, and Dr. Robert Paeglow working with a child with possible hydrocephalus. Kim and Dr. Paeglow worked extensively with patients on the first-ever medical mission to Engeye Health Clinic in Ddegeya, Uganda in April of 2007, and the patient pictured is one of the first patients ever seen at the clinic.
Neil Gray, MD/PhD student from Columbia University, taking a patient history in the Engeye Clinic in Ddegeya Village, Uganda, on a medical mission.

Misty Richards, MD/PhD student at Albany Medical College, and Ing Phansavath, conflict mediator with a masters in international development, working with patients outside of Engeye Clinic in rural Uganda. Misty was the head coordinator of a recent medical mission to Engeye Health Clinic in November 2007 and was involved in all aspects of patient care (performing histories and physicals, dispensing medications, and participating in medical decision making). Ing was also involved in taking the vital signs of patients.

Brice Jabo at counting pills diligently in the pharmacy of Engeye Health Clinic in Ddegeya village, Uganda. Brice is a Rwandan medical student that was involved in all aspects of patient care on our November 2007 medical mission (performing histories and physicals, dispensing medications, and participating in medical decision making).
John Kalule and Misty Richards performing a physical exam on a young girl with fever and abdominal pain at Engeye Health Clinic in Ddegeya Village, Uganda. John is an administrator of the Engeye health Clinic and has been instrumental in staffing and running the clinic. Misty is a 27 year old MD/PhD student and is also on the board of the Engeye Health Clinic.

Marc Freiman taking the pulse of a baby girl with patients lined up outside of Engeye Health Clinic in Ddegeya Village. Marc is a 24 year old medical student from Albany Medical College and was involved in all aspects of patient care (performing histories and physicals, dispensing medications, and participating in medical decision making) on a recent medical mission to Engeye Health Clinic in November of 2007.
Migration and Health: A West Indian Perspective

Migration as defined by the Oxford dictionary is the move from one place to another, especially one country, to settle in another.

The West Indies, also known as the Caribbean, has a well-known history of migration. There are three main categories of Migrants to the Caribbean (1):

- **Voluntary:** Merchants, adventurers, economic migrants (e.g., indentured servants, East Indian labourers, Portuguese from Madeira, post-1834 African labourers and discharged soldiers and sailors).
- **Involuntary:** African slaves and transported criminals.
- **Displaced Persons:** Liberated Africans (freed from illegal slave traders), Fugitive Slaves, and refugees (such as American Loyalists. Sephardic Jews expelled from Spain and Portugal, and French and Spanish monarchists and others caught up in the frequent wars). This mix of ethnic groups and cultures is the background of the West Indian region stretching from Cuba to the island of Trinidad and Tobago and back to Jamaica.

So, as various groups came to settle in these islands, the West Indians themselves left to seek better employment and way of life. In the late 1940’s large numbers migrated to the UK. These were from British colonies such as Jamaica and Barbados. West Indians also left to work in Central American countries such as Costa Rica and Panama. Thousands were involved in the construction of the Panama Canal.

The United Kingdom was not the only Land of milk and honey. The United States and Canada were and still remain countries of first choice for West Indians.

**Brain drain of the Region**

In January 2006 the International Monetary Fund reported that Caribbean nations were loosing up to 50% of University trained graduates with the biggest losers being Jamaica a 82% and Guyana 89%

Thus, First World countries like the ones mentioned have gained by the input of the West Indies’ best and brightest while we lose people who their respective governments have spent scarce available financial resources. Recently in the last 2 to three years, Canada has been courting heavily West Indian nationals looking for professionals to add to their ageing population (3). So not only have we gone on our own but also with added prompting. But why do so many West Indians migrate to ‘greener pastures’?

Well the answer is quite obvious.....Whilst some nations in the Caribbean have been able to provide a sound economy, not only overshadowed by corruption or politics and citizens can afford a comfortable standard of living with security, others have quite a disparity in those who can afford a decent life and those who cant.

So, naturally people leave where they are afforded a decent life and those who can’t.

**The Health Sector**

So as the topic suggest how does this relate to health? In terms of health care workers our biggest losses are not really Physicians but actually Nurses.

First world nations have been actively recruiting nurses all over – as it is known there is a shortage worldwide. So here we are already in a system where health care workers are limited and then left reeling with the gaps created. Working in public system you will find disgruntled patients who are dissatisfied and burnt out nurses and Doctors who are still prodding along.

Health care workers leave the Caribbean not only because of salaries which just aren’t good enough but also in light of inadequate resources to effectively do your job.

What sense does it make to train a medical student teaching them about all the fancy things (which in some countries are not fancy) then throw them out in a world with scarce supplies AND expect them to function like the doctor in the U.S. or U.K.

The factors named above are also the reason why needed fields in health care, for example: an audiologist is so hard to find.

With these losses, there has been an attempt of replacement. With doctors from Myanmar, India; and also nurses from India and Cuba under special arrangements with the governments involved. The only question which concerns me is culture. Medicine is big on culture, meaning to effectively care for your patient means to understand his/her culture and its local language and help them to understand standard health care principles and recommendations.

These issues are the ones every government has to deal with worldwide. In the West Indies known for the Sun, Sand and its diverse People these are the factors to address to overcome our difficulties to ensure our people have access to quality health care.

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A Filipino Brain Haemorrhage

“Don’t make me speak English, I’ll get a nose bleed! Or worse yet, a brain haemorrhage...” This is how a Filipino nurse tried to tell me, that speaking English to him was too big of an effort. Pedro actually spoke fantastic English and our discussion soon drifted to another cause of brain haemorrhage in the Philippines: the loss of Filipino nurses and doctors to overseas.

During my stay in the Philippines last year, I wondered at a number of occasions, why the Filipino nurses would want to leave those beautiful islands, hospitable people and tasty food? While visiting rural areas and urban hospitals, I asked all the people that I met about their colleagues’ reasons to migrate. Low salary, poor working conditions and political instability were stated most often as reasons for trying their luck abroad.

Today, the Philippines are exporting many more nurses than are being trained currently in nursing schools, even though new training programmes are emerging each year. The quality of the schools and hospital care is diminishing and a number of hospitals have been forced to close due to lack of qualified personnel, as even fully trained medical doctors seek to immigrate. A large number of doctors are actually returning to the school benches to become nurses!

Meeting the city administrator of Pasay City in Manila, I inquired about her view of the situation: she saw the immense migration of health care workers as a positive direction to create economic stability in the country, because the emigrated nurses send a lot of the money they earn back to their families, often also returning to their home countries. I really would have liked to argue that health and a working health care system is an important indicator of a country’s well-being as well...

Luckily, solutions are slowly being sought: the Philippines are already working on rearranging the delivery of health care services by training paramedical workforce and community health workers. Obligatory government service after graduation is also being introduced for all medical personnel in an increasing manner.

But as I learnt when visiting the Department of Health, incentives to stay afterwards aren’t being developed wholeheartedly and to be honest, with a health budget of below 3 % of the GNP, there’s not much to make the incentives of. There are of course things to be done by the countries receiving work force, like to cease active recruitment or to consider restitution: but both can be perceived as a violation to the freedom of movement and the Filipinos certainly think so as well.

As difficult as it is to treat intracerebral haemorrhage in medicine, treating the Filipino brain haemorrhage of qualified health professionals seems not to be very easy either. As the health care system crumbles, government officials praise the leaving nurses for their contribution to the country’s economy instead of developing policies on how to tackle the health worker shortage. I wonder, if they had a brain haemorrhage and were transferred to the Philippines General Hospital, would they finally understand where are the Philippines bleeding from?

For further reading about Brain Drain:
- WHO Fact Sheet nr. 301: Migration of health workers

A Special Kind of Migrants

Every year again at the end of summer an enormous amount of people from all the country moves to Amsterdam. Holland’s capital city is taken over by hundreds of young persons who all come here with the hope of finding a home, a job and better education. Every single one of them is convinced that they are going to make it here, in Amsterdam, the city they always dreamt about and where their childhood ambitions will finally come true. They come to Amsterdam all sharing the same dream: to build up a new life and to assure a better future for them and their children. Studies show that the moment these migrants arrive in Amsterdam their general health gets worse immediately. Nutrition becomes a major problem, just like sanitation. Clinical examination shows an average weight gain of about seven kilos and, surprisingly, a significant rise of alcohol levels in their blood.

Who are these poor individuals, who seem to be a forgotten part of society? Well, you may already have recognized yourself... Yes, we are talking about you: the student.

I always enjoy walking through the city centre in September. Fresh, first year students wander through the streets of Amsterdam, proud of finally being an Amsterdam student and to be able to call Amsterdam their home. Most of the time they walk in groups of twenty to thirty new migrants, guided by a local or, more often, an older student pretending to be a local. Sometimes though, you will be able to meet a brave one, exploring the city all on his own.

He is probably on his way to some student’s café, of which he forgot the name, but his guide assured him it was ‘really, really easy to find’. He is standing in the metro, holding his metro-ticket firmly in his right hand. In the other hand he has his sleeping-bag, while he is struggling with the enormous backpack he carries. He anxiously watches the stations he passes and whispers their names in a soft tone, as to stick them into his memory forever. In about a week he will have drunk as much alcohol as he has in the past three years and he will have discovered the McDonald’s around the corner of his student’s apartment, so there’s no need to cook anymore. He will suffer from extreme sleep deprivation due to his nightly visits to obscure pubs around the city and in a few months his kitchen will look like the lab at his university, with several interesting cultures growing on plates and cups in the sink.

Do you still recognize yourself? If so, some changes in lifestyle might be necessary. After a long day of classes about prevention of diabetes, obesity and vascular diseases, you might try to find some time to look at your own health status, before heading towards the nearest pub. Take a look at the migrant in yourself every once in a while and take care of him. Otherwise you won’t even make it to your final examinations and in the future there won’t be any doctor left to help the migrants who really need it...

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Migration and Reproductive Health

Today’s real borders are not between nations, but between powerful and powerless, free and fettered, privileged and humiliated. Today, no walls can separate humanitarian or human rights crises in one part of the world from national security crises in the other.”

These were the words of Kofi Annan, UN Secretary-General, in his acceptance speech upon receiving the 2001 Nobel Peace Prize.

The term ‘International Migration’ encompasses a wide range of population movement, the reasons for that movement and the legal status of migrants, which determines how long they can stay in a host country and under what conditions. Approximately 175 million people, or 2.9% of the world’s population, currently live temporarily or permanently outside their countries of origin. (1)

For migrants, the right to health requires easy accessibility to health services, the health facilities, goods and services are affordable for all, accessibility without discrimination in “race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status”. (2)

It also requires the right to safe and healthy working conditions, access to safe and adequate food and housing, the right to family life, safe Physical accessibility to health services, culturally appropriate health care services and easy accessibility to health information including the right to seek, receive and impart information and ideas concerning health issues.

The link between migration and health is always a complex one. Migrants, no matter where they are from, carry health profiles that reflect their social, economic and ecological past, including the health care that was or was not available to them. At the same time, migrants’ health also reflects the conditions surrounding their movement and resettlement, their access to health care in host countries, and their capacity to achieve and maintain a good quality of life.

Despite the complexity of the relationship between migration and health, most of the attention has focused on classic infectious diseases such as Tuberculosis. Far less attention has been given to domains such as family and reproductive health or psychosocial well-being.

Focus on Reproductive Health

In general, migration, places people in situations and under conditions that affect their reproductive health and their access to, and use of, reproductive health care services. One of the most important factors affecting the reproductive health of migrants is their legal status. It determines their vulnerability to abuse in the workplace and the street, and can influence the extent to which they have, and feel they have, access health and social services, and to protection before the law.

Poor language skills are a frequent obstacle to reproductive health care. Poor communication between migrants and healthcare providers, and insufficient use of trained interpreters, has been identified as a key cause of poor gynecological care.

As it does in all populations, the use of contraception by migrants varies according to socio-economic background and experience with family planning. On the whole, however, the data (2) suggest that “migrants” are often unaware of the availability of contraceptive services in the countries they move to, and they access these services far less than nationals do.

The maternal health of migrant women and poor pregnancy outcome has long been a major problem with serious implications for gestational age, birth weight, perinatal health, and post-natal care. Some of these as well as other pregnancy related problems, may be linked to the pre-migration health condition of women, but the social, economic and physical conditions in which many of them are forced to live when they arrive in host countries can also have an adverse effect. (3)

Although HIV/AIDS and other STIs have generated major concern, and are seen everywhere as major threats to public health, relatively little attention has been given to the politics of migration and their impact on vulnerability. Thus, most countries continue to require that migrants do not arrive with their regular partners and are expected to live “alone” for months and sometimes years (if consecutive contracts are provided). Just as military garrisons do, male migrant communities attract groups of sex workers. Sometimes these groups are small and serve large numbers of men, including domestic men. In so doing they become part of a sexual dynamic that is rich with opportunities for transmission of HIV as well as other STIs.

Concerning gynecological care services, the findings from a number of different studies suggest that migrant women do not access gynecological care services in the same way and or to the same extent as nationals, and suffer the consequences of this. (4)

Also one of problems facing migrants is chronic nature of forced sexual intercourse and other forms of gender-based violence among refugee and internally displaced women. Some of the main underlying factors include the lack of legal status and hence the lack of right to protection, but of even greater importance is the fear of being deported if brought to the attention of police and other legal authorities. Migration is a complex process that calls for careful health assessment and management.
The fact that so little attention has been given to reproductive health thus far means that in many countries the basic data that might be used to determine needs and priorities has not yet been collected.

There are, of course, other important public health considerations to be kept in mind. If the reproductive health of migrants is not promoted and protected, the health of all people will suffer. Reproductive health affects family and community health as well as individual health, and when major disparities are allowed to emerge and persist between different groups of people, the health of everyone is gradually affected.

The lack of attention that has been given to the reproductive health of migrants, however, partially reflects the comparatively little attention that has been given to reproductive health issues in general. Focusing attention on migrant needs might well help elevate society’s awareness about reproductive health in general, and the need for it to be fostered and nurtured as an integral part of social development and millennium goals.

Finally we have to know that we are far from the required paradigm shift towards treating migrants as “global citizens” and “rights-holders”, regardless of where they are coming from and where they are going. Such a paradigm shift will take time, dialogue, accurate information, good will and, above all, political will.

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References:


Moving On III
Emerging Pharmacists and Their Intention to Migrate

The International Pharmaceutical Students’ Federation (IPSF) was founded in 1949 by eight pharmacy student associations in London. The Federation now represents around 350,000 pharmacy students and recent graduates in over 70 countries worldwide. IPSF is a non-governmental organization and is the leading international advocacy organization of pharmacy students promoting improved public health through provision of information, education, networking, and a range of publication and professional activities.

The Moving On research projects aims to engage pharmacy students in scientific research and advance pharmacy education worldwide. The results obtained by pharmacy students are then published in a variety of journals and international publications.

To date, there have been three themed Moving On questionnaires. The first focused on academic mobility with regard to the exchange of knowledge and skills through the international exchange of academics. Moving On II, concluded in May 2007, studied the learning experience and quality of pharmacy education. Moving On III – Emerging Pharmacists and Their Intention to Migrate is the focus of this article.

The global crisis in human resources is hindering healthcare delivery worldwide and is a key focus of the World Health Organization (WHO). Moving On III is a collaborative project between IPSF, the International Pharmaceutical Federation (FIP) and the University of London School of Pharmacy to study the factors in the education and environments of pharmacy students that influence their intention to migrate. It was launched in the year 2005 with the objectives of:

1. To develop a validated questionnaire tool to gather data on attitudes of migration
2. To examine educational factors that may contribute to pharmacy graduates’ intention to migrate
3. To identify specific areas of change to influence attitudes to migration
4. To identify the effects of professional development on intention to migrate

The pilot study conducted in 2006 gathered nearly 800 responses from final year pharmacy students in nine countries – Australia, Bangladesh, Croatia, Egypt, Nepal, Portugal, Slovenia, Singapore and Zimbabwe.

The questionnaires are distributed to final year pharmacy students. Data was collected through pharmacy student research coordinator in each participating country.

The gathered response was entered into spreadsheet and the final data analysis was carried using a program that does statistical analysis and data management known as the Statistical Package for the Social Sciences (SPSS).

The result of the pilot study shows that the mean age of participants was 22 years. Among majority of respondents (61%) were female. Among the participants, 52% intend to migrate and two-thirds plan to migrate for long term (>2yrs). Variation in percentage of respondents planning to migrate ranged from 14% (Croatia) to 90% (Bangladesh). Respondents identified reasons for both migrating and staying within their own country. Non migrants and short-term migrants had a positive perception of working and living conditions in other countries. In general, the reasons graduates migrated were due to better career and professional development opportunities, salary, better working conditions and lifestyle, and learning new approaches within pharmacy. Non migrants preferred to stay in their own country because of their social and family network, lifestyle, salary, respect, career opportunities, and familiarity with the healthcare system.

Qualitative analysis and questionnaire revision are underway and a further round of data collection is planned. The second round will incorporate more countries and the questionnaire will be translated into Spanish, French and potentially other languages to increase both the number of respondents and number of countries involved.

This study has attracted a large amount of international attention at the WHO, FIP, UNESCO Global Forum on International Quality Assurance, Accreditation, and the Recognition of Qualification, and the International Health Workforce Conference.

The goal of obtaining this information is to understand the reasons pharmacists migrate to other countries to practice. Once these reasons are
known, healthcare systems, universities, and employers can change to suit the needs and desires of healthcare professionals. Moving On III has potentially greater applications across more disciplines to identify opportunities to improve workforce retention and development.

For questions or more information, including citations of published Moving On articles, please visit www.ipsf.org or email the IPSF Chairperson of Pharmacy Education at education@ipsf.org.

Karen McGill
IPSF Chairperson of Pharmacy Education 2007-08
IPSF President 2007-08

Internal Migrations in Peru

Introduction

“Migration phenomenon involves a human mobilization which entails a large number of changes in a person, for which this person is not always prepared. (...) The variety of challenges that migration offers are very close related to the human rights that they involve. Within these rights, there is the right to respect equality and identity, to avoid discrimination, to respect integrity, and to have education, work and, above all, health care.” (1)

The health aspect, among many other changes that migration causes, involves not only a specific issue. On one hand, there is the fact that migration does intervene with public health services and health care demand. On the other hand, migration – emigration or immigration– is known to be a determinant factor of the changes in the epidemiology of diseases. These changes, or epidemic phenomena, are not always easy challenges to be solved for epidemiology experts; they usually represent real public health problems that influence many aspects in people’s lives. A third aspect is the one that has to do with the inherent changes on migrants’ health as a result of the mobilization and adaptation processes.

Origin of internal mobilization: the Peruvian case

According to the United Nations’ Population Fund (UNFPA), despite the fact that there is no a unique definition for internal displaced people, it is accepted that it is caused by a range of reasons, including environment degradation, natural disasters and internal conflicts. Due to the fact that this mobilization is an obligatory condition, internal migrants are vulnerable people who are in risk of losing their rights that allow them to develop as normal citizens, particularly women, children and old people (2).

This multiethnic, multilingual and multiracial country has experienced an imbalance on the economic field and on the opportunities in different regions in many periods during last century, which have originated an internal migration from countryside to cities, especially to the capital, the city of Lima.

One of the most important episodes (if not, the most important one) related to internal migration occurred during the 80’s and 90’s. During these years there was an internal massive mobilization of people as a result of terrorism that was causing violence, poverty, deaths and social imbalance in many parts of the country including both rural and urban areas. Vulnerable population and victims escaped from their native homes to live on the surrounding areas of cities and avoid death, poverty and a fatal future for their children. Nowadays, one part of the displaced population have returned to their hometowns, but the vast majority have established in these cities. The effect of this movement modified the structure, organization and planning of the society development, the State and its institutions, and the health system was not the exception.

Effects of internal migration in the national health system

“Disease may be a problem, but doctors are easier to find; worldwide the number of children surviving infancy is significantly higher in cities than in the countryside” (4). This could explain the reason why internal migration occurs in many countries. However, according to the PAHO’s Perú Health Profile, Peruvian internal migrants have been experiencing the necessity to migrate to other parts of the country basically as an immediate result of the problems and risks generated by violence in their hometowns (3).

In any case, even though social conflicts might influence people mobilization as a push factor, access to health care represents definitely a pull factor that induces migration. Despite this, medical care and access to essential medicines is not what migrants can always obtain in their new places. Lack of access to national health programs is also common for displaced people, especially for children who came from rural areas, where child death and malnutrition rates are already high.

It is estimated that infant mortality and maternal death are very high among migrants, and also that malnutrition among babies and children from migrant communities is very common (7).

Internal Migration and Epidemiology of Diseases

There is sufficient evidence to prove that internal migrations play an important role in the epidemiology of diseases. For example, from 1989 to 1996 the number of patients with Malaria in Perú increased 7 times, representing a very high incidence, especially in the low altitude forest region. According to PAHO, the reason for this epidemic phenomenon has to do with changes in the irrigation and cultivation areas, expansion of the vector Aedes darlingi, difficulties in the development of the Malaria national control program, and an important internal migration.

Preventive measures against other infectious diseases like Leishmaniasis, Yellow Fever, Dengue and Malaria have been taken by the Ministry of Health during the last years. These public health measures took place as a response against the risk that this internal mobilization, from one endemic region to another that is was not endemic, was representing.

Health problems as a result of internal mobilization

According to the expert José Moya’s OPS report on the consequences of central Andean migration during the 80s (6), Peruvian migrants’ mental health remained altered during the process of mobilization, and also during adaptation and incorporation to the new life and environment. Depression, anxiety, stress, fury and fear are the common manifestations of an altered mental health, which can give rise to other problems like alcoholism, domestic violence, juvenile delinquency and even suicide (5).

Despite the fact the access to health care depends on the resources of the place of destination and in the migrants’ capacity to demand medical care and request it (6), it is definitely more probable that migrants can get sick (and even die) as a result of their contact to the prevalent diseases in the place of destination. An example of this is what happens when migrants are infected with tuberculosis and other infectious diseases that are not common in their native places, an experience that occurred since the last decade in the surroundings of Metropolitan city of Lima.
When internal migration is taking place, contrary to international migration or immigration, it brings difficulties for the development of the society, especially for the migrant population. Then, it is obvious that these problems must be solved within an internal policy, which must aim to give welfare state to all of the citizens. However, access to health care and the control of the epidemiology of diseases, both represent real challenges for a national health system that must look for answers and the correct measures in the community itself. Growth and development of the area under study, which has a high migrant concentration, brought difficulties for the development of the community itself. Growth and development of the area under study, which has a high migrant concentration, brought difficulties for the development of the community itself.

Introduction
The UK has been a signatory to the 1951 Geneva Convention for over fifty years, and has thus been obliged to offer asylum to refugees; defined as any person who “owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to return it”. [1]

However, European governments continue to defy their international obligations by placing stringent limitations on both the number of refugees they accept into the country, as well as the support provided to these individuals once inside the country’s borders. Imminent UK government proposals are seeking to go further, preventing a number of vulnerable populations in the country from accessing free primary healthcare services.

Access to healthcare for asylum seekers: the UK situation

The UK government is currently conducting a review of proposals to charge for primary care on the basis of immigration status. Among the groups affected will be failed asylum seekers awaiting deportation, failed asylum seekers who cannot safely travel home, victims of trafficking and undocumented migrants.

If the proposals are adopted, primary care regulations will be brought into line with those governing hospital care. Regulations were introduced in 2004 which led to groups not considered ‘lawfully residents’ in the UK, with notable exemptions, to no longer be entitled to free hospital care, including maternity services or HIV/AIDS treatment.

A false economy and a public health disaster

The rationale behind these proposals is that they will save money and discourage ‘health tourism’. However, the notion of health tourism remains unproven. In 2005, previous minister Melanie Johnson from the Department of health admitted that there is no evidence of such a trend. Furthermore, the Home Office has previously stated that migrants do not represent a burden to the NHS with ‘deliberate’ health tourism present.

An estimated 86% of all UK health needs are currently being met by primary care services [3]. Primary care is frequently cited as a highly cost-effective model for healthcare; under the proposed changes patients with routine conditions such as asthma will be forced to present acutely to Emergency Departments requiring immediate and necessary treatment’. [4]

It is unclear how Emergency Departments will cope with this influx of patients, and with the additional financial burden placed on their services.

Should the proposals be implemented, official guidance on deciding who to charge will need to be provided. Additional staff will be required to shoulder this new administrative burden at additional cost to the NHS. The UK hosts a multi-racial society, and many patients will object to having their immigration status challenged on the basis of a ‘foreign-sounding’ name. This has already occurred in some instances in secondary care.

Moreover, denial of primary healthcare will not only affect those individuals who are refused treatment. Reduced uptake of childhood vaccinations and delayed detection of communicable diseases such as measles, rubella and tuberculosis threaten to result in a public health disaster. The cost of treating those affected by an epidemic will far outweigh the cost of universal vaccination.

Many non-governmental organisations, including Medact [5], have called for a full health and equality impact assessment to be undertaken before any further changes in NHS regulations. A Health Impact Assessment conducted in London found the proposals to be ‘unworkable’. In the area under study, which has a high migrant population, it was estimated that only 100 GP visits might be chargeable, equating to approximately €4,000 of income per month. [6]

Doctors or Immigration Officials?

Doctors should not be required to use denial of healthcare as a lever for immigration policy. To do so would be in breach of the professional and ethical duties of medical professionals, which include making patient care paramount and protecting public health. The NHS was founded on fundamental principles that health care should be freely available to all, irrespective of an...
The British Medical Association has echoed these sentiments. Previous resolutions at their annual meetings have deplored “the planned withdrawal of rights to medical care from asylum seekers whose applications have been refused” [2004] and later asserted that it is “not appropriate for medical staff to act as proxy immigration officers in seeking to determine the immigration status of people presenting for care and treatment.” [2005].

Given the likely consequences of these proposals, Medsin-UK has been speaking out nationally about the issues surrounding access to healthcare for vulnerable migrants. Firstly, calls have been made for the release of submissions made to a government consultation concerning extending the charging regime to primary care. At present no response to this consultation has been published. Secondly, members have been engaging politically by contacting Members of Parliament and requesting they show their support in opposing the changes. Finally, Medsin-UK has been raising national awareness of the impact these proposals could have on patient and public health, with the aim of preventing their implementation.

The rest of Europe

Migrant health professionals play a strong role in the work of the United Kingdom’s NHS, and indeed the rest of Europe. However, the Platform for International Cooperation on Undocumented Migrants reported recently that “access to healthcare throughout European countries is increasingly being used as a weapon in immigration control”. [7]. European countries are violating ratified UN Conventions, which guarantee the right to healthcare for undocumented migrants, with almost half restricting health care for asylum seekers to emergencies only.

We advocate for abolition of the ‘fortress mentality’ of European governments towards asylum seekers [8]. Governments must recognise their international legal obligations to support these groups, as well as acknowledge the impracticality, inefficiency and public health risk associated with denying vulnerable migrants access to healthcare.

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Websites:

What Happens to Those Left Behind?

At the dawn of a new millennium, migration is perhaps the most complex social, economic and political phenomenon affecting mankind. Political instability, internal violence and absence of economic growth are the main forces that drive millions of human beings to leave their homes each year looking for better opportunities for them and their families, even risking their own lives in the process. Since the underlying causes of migration are extremely intricate and do not seem to have a feasible short-term solution, migration will most likely continue and become an even greater challenge. In Ecuador, the situation does not differ much from that of other developing countries. Even though Ecuador has (fortunately) not been involved in any major armed conflicts for the past century, the accelerated globalization process, together with the profound economic crisis of 1998-1999 and the lack of credibility of the government and its institutions, unleashed an uncontrolled migratory wave.

Nowadays, an estimate 2 million Ecuadorians (from a population of 13 million) reside in other countries, mainly Spain, the United States, Italy, Canada and Chile. On the other hand, this process also transformed Ecuador into a destination for migrants from neighboring countries. After the economic crisis of 1998-1999, when the unemployment rate reached 15%...
and the underemployment 46%, the country adopted the American dollar as the new currency unit, and this led to the arrival of workers from Colombia and Peru. 

The health situation of immigrants is periodically addressed by the host nation’s authorities and, apparently, some efforts (like the health cards in the case of Spain) are made in certain countries in order to provide them with a better access to healthcare. However, very little research is done regarding the conditions of those who are left behind in their homeland. In 1991, there were 17,000 Ecuadorian children whose parents had migrated; in 2000, the number grew to 250,000. As of 2005, 36% of the women and 39% of the men who migrated had left one or more children in the country. 

Because of the impossibility of joining their parents in the quest for a better future, children are most often taken care of by close relatives, usually their grandparents or adolescent siblings. 

Nonetheless, in most cases these caregivers are unable to offer children a stable environment which would allow them to develop appropriately. One study found that, after the parent’s departure, 17% of emigrant’s children had suffered sexual abuse; 24% showed an aggressive conduct; 16% had developmental abnormalities; 56% suffered from different degrees of malnutrition or failure to thrive; 16% experienced depression. Nearly all of them had low school yield. 

Can doctors treat these children the same way they take care of infants with stable families? Do we have the responsibility of being more meticulous while exploring the sons and daughters of emigrant parents that come to our health services? Should these children be considered as a bio-psycho-social risk group? By studying their problems, we realize that the lack of paternal and maternal figures creates a chain reaction: psychological disorders, low school yield, violence, sexual abuse, a higher incidence of infectious diseases (in some cases), and thereafter an abnormal development, both physically and psychologically. 

Therefore, it is definitely our responsibility to detect risk factors in these children and to provide their caretakers with an appropriate counseling. When we decided to write this article, we wanted to make the access to health services of the Ecuadorian immigrants in Spain. 

However, it did not take long to notice that it was meaningful for us to explore the situation of those who are left behind, since we can experience their reality on an everyday basis in the different healthcare centers in Ecuador. Some time ago we met a 10-year-old child whose parents had traveled to Europe shortly after she was born, and she only knew them through photographs and occasional phone calls. To us, she is probably the most accurate portrait of emigration that we have seen. She said: “When I ask my mommy when she’s coming back she always tells me that next year, but I know that she will never, never come back. I always wanted to have a daddy and a mommy…” 

The impact of migration on people’s health status encourages all doctors and medical students, in countries where migration is a real burden, to be aware and discover the profound suffering disguised under a trivial infection; to determine the complex emotional situation of a child who does not want to eat; to approach our patients in a holistic manner; finally, to become better human beings. 

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Interview: Médicins du Monde - UK

Medical Student International Magazine was very pleased to interview Susan Wright, Director of Médicins du Monde UK, an organization that tackles problems regarding Migration and Health. Special thanks to Johanna Norenhag, IFMSA SCORP Co-Liaison Officer for their help in referring us to this organization.

Would you like to tell us about the organization Médicins du Monde, as an introduction of his goals and objectives?

Susan Wright: Médicins du Monde is an international humanitarian aid organisation that recruits medical and non-medical volunteers, who provide healthcare for vulnerable populations around the world.

What is your main role in Médicins du Monde? Explain us your motivation.

Susan Wright: I am the director of our office in the London. This work is of particular interest to me because it enables me to link together the work that we do both here in the UK (where we run a free medical clinic for migrants, the homeless and sex workers) and that which we do overseas.

What are the mayor challenges in the organization in order to achieve your goals and objectives?

Susan Wright: People often believe that it is necessary to chose either to fight problems "at home" or "overseas." Do I think that need is greater at home than it is overseas? I think that is perhaps not the question to ask. The question is what is the relationship between the two sets of problems. Because their causes are so interlinked, I believe so to will their solutions be.

Do you receive support or have a collaboration with similar organisations like Médicins du Monde?

Susan Wright: We work with many other NGOs here in the UK, as well as with international organisations who work overseas. Without these partnerships we would not have a clear and full picture of the range of problems. We rely on different perspectives and understandings, in order to find the best way forward.

Have you participate in a campaign/project/program for refugees, tell us an experience in a brief way, and the outcomes.

Susan Wright: Our clinical work is focused primarily on serving the medical needs of refugees. We compile data which helps us understand and thus draw a more clear picture of the situation they find themselves in. And on the basis of this data we compile alternative policy proposals which address the problems encountered. We then work with other NGOs and politicians to advocate for change. We also highlight the importance of the issue through contacts with the media.

Brain Drain of healthcare professionals is becoming a mayor Global Health Problem, what are the mayor challenges for governents and the health sector, from your opinion?

Susan Wright: The challenge is to address the underlying problem, the fact that living and working conditions are so poor in many developing countries. And this is of course linked to the problems with the health infrastructures within those countries. While each country is different, and it would be a mistake to treat them otherwise, there are common features of the problem, the most prominent of which is low pay and poor equipment. We are committed to finding a workable solution, in partnership with the appropriate governmental authorities.
Relative to staffing our own programs, we very often employ medical staff from the more developed among developing countries (e.g. South Africa, Kenya) to staff programs in more resource poor settings.

**Do you think is it enough the work that governments are doing to find a solution for this Global Health Problem?**

**Susan Wright:** No, it must be clear that local medical professionals and indeed those within the medical education establishment, take responsibility for their role in analysing and proposing solutions. At the same time, the issue is undeniably linked to issues of migration which must be considered.

**Do you think Governments should still give access to healthcare to migrants, even if their status in the country is illegal?**

**Susan Wright:** We believe firmly that no person is ever inherently illegal and we refuse to accept the notion that access to health is dependent upon status. It is a basic human right and as such every government has the obligation to provide it. This right may be realised in some countries more easily than in others, but all governments must be working toward that as the ultimate goal. We will continue to lobby, at all levels of government, until this is the case.

**Does Medicins du Monde work in policies, if yes, what kind of policies?**

**Susan Wright:** While we encourage doctors from developing countries to work in our overseas missions, we would not recruit them to work in our domestic projects in Europe.

“*It is a basic human right and as such every government has the obligation to provide it*”

While this is in some ways a controversial position, we feel strongly that the expertise should stay on the continent where it is most needed. We know from experience that it is not difficult to find doctors to work in our domestic projects.

**What kind of projects and/or activities do you recommend for medical students to tackle the Brain drain issue at our communities?**

**Susan Wright:** Medical students must first be guided by the question of how their particular skills match with the needs of other communities. Because training and education varies from country to country, this question will likewise be answered in different ways from country to country. But all students act on the basis of their own skills and experience. To send students into a setting where they are ill equipped to help does a disservice to the community. Where possible, links can and should be made between medical students in different countries, in order to enable an exchange of information and experience.

**Anything else you would like to tell to the future healthcare leaders of the world.**

**Susan Wright:** It is great that you are already asking these questions, thinking about where and how you will contribute your skills to the problems that you see around the world. The more you know, about the world around you and the world far away, the more tempting is it to be discouraged. It is important to find people who can support you along the way, people whose worldview and understanding you admire. Find these people and do not be afraid to turn to them. They can remind you of what you already know, that you are capable of changing things. Never allow yourself to believe otherwise.

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*Internacional Federation of Medical Students’ Association*
Welcome to The Lancet Student

The Lancet Student (www.thelancetstudent.com) has been going for just over five months and has already been a tremendous success thanks to the enthusiasm and hard work of students from all around the world. The Lancet, our parent journal, is a champion for global health issues and so the focus of TheLancetStudent.com is on global health and our aim is to get students more interested and involved in global health issues.

Students can write articles on any global health related topic which are reviewed by our student reviewers from all around the world before being published on TheLancetStudent.com. There is a daily blog—often written by students—a weekly podcast, a weekly summary of relevant content in The Lancet, polls, a reading room—where chapters of medical text books are available for free—and loads more. We are also involved in campaigning. For example, we are currently involved in campaigns around arms control, access to essential medicines, and an end to violence against women and children and we want to encourage students everywhere to get involved and learn more about the issues. You can see all of these for yourself if you log on to www.thelancetstudent.com.

So here are some statistics. An average of 500 unique visitors use our site every day, we currently have almost 150 students from all around the world who have signed up to be reviewers, regular contributors, or bloggers. We have a growing collection of peer reviewed articles on global health topics of a very high standard (I am also an editor at The Lancet and I think that the standard of the articles on The Lancet Student.com is right up there with The Lancet!), and also a growing number of elective reports which we hope will act as a useful resource.

I have worked as a humanitarian doctor in many countries, and am also a seasoned campaigner so I am absolutely delighted with how well TheLancetStudent.com is doing. I very much believe in the next generation of doctors and other professionals, ie YOU, and how they can make the world a much better, healthier, and fairer place. This is what TheLancetStudent.com is all about but it can only continue to be successful with your help. I organise everything at this end but students everywhere do all of the work so I am really relying on you all. And it doesn’t matter if you have never written or reviewed an article, or written a blog, before. It is your interest and enthusiasm for global health that counts. I can help you with your ideas, writing, and research, and also give feedback on anything you do. So, if you are interested in finding out more, or getting involved, please email me at student@lancet.com or rhona.macdonald@lancet.com. I am really looking forward to hearing from you.

Together we can help change the world!

Dr Rhona MacDonald
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CALL FOR ARTICLES FOR MSI-18

Anyone who is interested to write for the next issue of MSI, that will be released printed and online at the IFMSA August Meeting 2008, should contact MSI Editorial Board.

More information about date of call, and deadline submission, as well as the theme of the magazine will be known soon. For any inquiries contact us at: msi@ifmsa.org
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