

International Committee of the UK Faculty of Public Health

WORKING IN DEVELOPING COUNTRIES: A ONE-DAY WORKSHOP FOR PUBLIC HEALTH PROFESSIONALS

Wednesday 23 April 2008

**Nuffield Hall, Royal College of Obstetricians & Gynaecologists, 27 Sussex Place,
Regent's Park, London, NW1**

Workshop Report

A. Summary of the plenary sessions

09.55 Plenary - Scene setting

This session featured presentations from Nick Banatvala, Head of Global Affairs, DH England; Stewart Tyson, Head of Profession, Health, DFID; Fiona Adshead, Deputy CMO England; Martine Donaghue, Deputy Director for HLSP Institute and Sushma Acquilla, International Faculty Adviser, FPH

Nick Banatvala's presentation "Update on the UK Government-wide global health strategy and the Government response to the Crisp Report" discussed why we need a global health strategy, the aims of the strategy and some of the key challenges ahead. These key challenges included: noncommunicable disease, HIV, flu pandemic, environment, food, water and preventable diseases. He discussed the triple burden of disease (communicable, noncommunicable, injury and accident) and issues around health security and systems for delivering health.

Stewart Tyson's presentation "Global health and development in context - through a DFID lens" discussed some of the major policies, frameworks and agendas such as the Millennium Development Goals. He highlighted areas of progress, (such as polio measles, and AIDS), areas of unfinished business such as malnutrition, sanitation and water) and challenges ahead (global fund). He described the minimal health spend in low income countries (58 states with less than \$50percapita expenditure) and the variation amongst states. He explained some of the changes in aid for health and how this is often targeted to areas of AIDS, TB, and malaria. He discussed the downside to aid in that it can distort and undermine the wider health services in recipient countries and the concern when aid does not follow national plans or country budgets and used the example in Rwanda's funding from aid). He discussed the positive aspects and the improvements that have been seen in areas of polio, measles and malaria, the emerging roles of the private sector, the importance of health "systems" approach and of international health partnerships.

Fiona Adshead presented "Health Inequalities-the global context". She provided a background of the inequalities gap between and within countries and explained the areas of international work (advocacy and influencing, technical expertise, horizon scanning, maximising impact). Specific examples were provided of the health trainers' initiative and the influence from Pakistan to Bradford and about learning together and applying knowledge. Climate change is another area of global work that was discussed. The linkages with WHO included the Commission on the Social Determinants of Health and The Health Systems Charter: Health systems, health and wealth, and London will be hosting the global framework for Health Promotion this July. She discussed the objectives, which were:

1. Shape the aid agenda
2. Influence Europe

3. Learn from others in moving forward.

Martine Donaghue presented “Aid Architecture – current status and key issues”. This included a demonstration of how AID is coordinated and the lack of coordination and lack of direct systems. She explained the lack of coordination in the context of political cycles, and the range of stakeholders in independent, public and private organisations. Martine highlighted global health partnerships and the fact that there are over 150 different partnerships. Their role is to improve access, provide public advocacy and global coordination mechanisms. She discussed the context of HIV/AIDS in Africa and HIV as effective in fundraising and how this has affected health budgets. She also discussed aspects of the Paris Declaration (Aid effectiveness, country plans, donors to support) and the International Health Partnership (coordinating donors, improve systems not disease, support country plans not individual donors).

Sushma Acquilla presented the FPH Strategic Plan 2007-2012 and attendees were given copies of this plan. She explained the 4 strategic objectives of FPH and that 2 of these included international components. She presented the 2008 Business Plan and its aim to develop FPH and educational activities globally, to increase engagement of overseas members and to systematise stakeholder relationships. She described the aims of the International Committee and its 5 year work plan: to mobilise public health capacity to respond to request from abroad, to increase involvement in policy development, to develop international MOUs, and to establish overseas regional advisor posts (one for each WHO region). She explained the International Committee’s Work Plan in Marketing FPH tools, formalising training links with other countries such as Sri Lanka and developing strong links with Ireland, Hong Kong and other areas. She also discussed the proposal to develop a clearing house and register to allow trainees to seek opportunities abroad; and she explained the role of the six appointed regional advisors.

10.50 Global health partnerships: opportunities to contribute to health in low and middle income countries

Andrew Purkis, Chief Executive Officer THET discussed the benefits of good health links as a manageable pattern of exchange, responsive to the priorities of overseas partners, and interdisciplinary to build capacity in different dimensions. He described the benefits as 2 way benefiting host and recipient countries and the role in strengthening systems not just progress. He explained neglected issues such as mental health epilepsy, maternal and child health and how these are being developed in local links. He concluded by stating clearly that it is the “partners” or overseas partners priority that is the basis of the link. This is to avoid supply-side driving the agenda.

11.50 How public health skills can be used internationally- personal experiences

Public Health Trainees Ciaran Humphreys and Caryn Hall presented the role and experiences of trainees in this setting.

Ciaran Humphreys, SpR in Public Health, National Public Health Service for Wales presented his role in developing HIV services in rural Africa at the Good Shepherd Hospital in Swaziland. He provided a context and overview of health and the public health needs in Swaziland. He discussed the objectives of the remit, the supervision, the opportunities it presented in training and some of the cultural factors he experienced in implementing actions. He also provided practical advice to trainees who may wish to plan this into their training programme as well as describing the benefits he received from undertaking this placement.

Caryn Hall, SpT in Public Health, Gloucestershire PCT presented her work at WHO Copenhagen working in the Healthy Cities programme. She began by explaining her background, the barriers she faced and how she overcame this within her placement. Caryn discussed the nature of the work in and its context within emergency planning, mass gathering and public health and physical activity. She explained some of the skills in health impact assessment and urban planning that were gained. She talked about practical issues such as banking, being on-call and return visits. She concluded by sharing the outcomes and the products of her placement and encouraged others to explore opportunities.

14.00 Plenary- Global health partnerships: opportunities to contribute to health in developing countries

This session featured presentations from Clive Ingleby, Programme Development Adviser (Health), Voluntary Service Overseas; Lucinda Shaw, Director of External Relations, RedR; Bob Grose, HLSP Director of the DFID Resource Centre

Clive Ingleby presented “Your career in international development starts here...opportunities for public health professionals with Voluntary Service Overseas”.

This session highlighted the key areas of health work provided by VSO and discussed the changing profile of volunteers from previous years. Those who work for VSO are often older, have various experience levels and backgrounds and a diverse skill base. VSO are looking to increase the number of volunteers recruited. Also, VSO recruits from areas outside the UK, including Ireland, Canada, Kenya, and India. One recent development is that VSO now has the ability to contribute toward NHS pension schemes for volunteers from the NHS.

Lucinda Shaw presented “Assignments overseas: What is wanted and training to prepare”. This presentation discussed the general context and increasing trend in man made and natural catastrophes. It highlighted its role in disaster relief and humanitarian work and provided a history of the organisation and its origins in engineering and health. Aspects of training were discussed as well as the broad areas of work such as emergency preparedness, water and sanitation, etc. Placements are available in a broad range of areas and experience. Often, short term placements are used in areas with specific needs and consultants which provide specific expertise.

Bob Grose presented “Working for consulting companies”. This presentation discussed the mission and aims of HLSP, their work in policy work in global health issues and national health systems. There are various opportunities through HSLP including seminars, training, publications and providing technical resources. HSLP works with a range of bilateral, multilateral and other partners. They often look for resources and expertise within the recipient country and use south to south partnerships; consultants are used in health financing, health systems capacity and a range of other areas.

14.45 Plenary- Practical issues for trainees wishing to work abroad:

The presentation by Premila Webster, Assistant Academic Registrar, FPH highlighted the phases in training and the appropriate stages for undertaking an international placement. Key stakeholders of deaneries, Faculty of Public Health, PMETB were highlighted and their roles and relationships to trainees who wish to undertake an international placement. It also highlighted issues regarding salary, on-call, competencies and the outcomes and outputs of overseas placements.

B. Summary of the interactive group sessions

“How to overcome real and perceived barriers to working in global health and international development”

1. Opportunities for medical versus non-medical workforce

- There was a general consensus that there are numerous opportunities for both medical and non-medical workforce.
- Individuals should be clear about their specific areas of interest or the particular skill base he/she wishes to market. They should consider whether it is health promotion, environmental health, economics, etc... which skill can be offered and which fields/areas are offering placements.
- Agencies such as VSO, RedR, etc. may consider expanding recruitment drives in areas that may have access to both the medical and non-medical workforce.
- It is important to emphasise transferability of skills and a willingness to learn new skills in the workplace.
- There is a distinct value for “soft skills” (flexibility, persistence, adaptability) in the role as well as the traditional “hard skills” in particular areas.

Response from panel: Skills are often much wider than epidemiology and more traditional public health skills. Skills in finance, economics, aid effectiveness, politics, management and those “outside” of health are often very desirable. Cross-cutting skills are useful, not those that are seen as strictly health related.

2. Developing skills for the first placement

- There may be a role for THET in facilitating skills needed for placements.
- FPH may be able to support in the “knowledge areas” by incorporating global issues into the Part A and Part B exams.
- On placements that are pre-approved or have had consultant or trainee input in the past, it may be worth advertising in PH.com, FPH website and wider.

Response from the panel: There is a much wider recognition and awareness of overseas placements. We need to continue to build the evidence base for this and continue to promote opportunities. There are opportunities through the FPH curriculum, and also it may be an opportunity for trainees to work alongside or shadow an experienced consultant on a placement.

3. Resources (money) for trainees/lack of deanery support

- Recent high profile documents: Crisp, CMO, and Government Response clarify and highlight the benefits and recommendations of supporting overseas work. However need to have meetings with stakeholders now.
- It is everyone’s responsibility to raise the profile of the work, highlight the specific benefits and use that to build up.
- The process should be to gather the evidence, publish it and legitimise it.

4. Identification of opportunities to work in international health

- There is a need for a more coherent and coordinated strategy both within NGOs and through universities. Some opportunities are related to work/consulting whilst other are research related.
- There is a need to expand upon existing placements and approve further placements.
- There may be a way for trainees to link with consultancy firms to learn from those working in the field.
- It is necessary to identify the clear aims and objectives of the placement and the benefits of the placement that can be brought back.
- FPH has overseas Regional Advisors that may be able to support work areas and opportunities.

5. Variation in UK secondment policies-unsystematic approach

- There is a difference for those in training and those already working as consultants so support does depend upon your stage of career.
- Some of this depends upon the way the NHS and wider systems respond to the recommendations from the Crisp report.
- There may be an opportunity to develop this agenda further at a regional and sub-regional level. Examples include: through the SHA, through RDPHs network and through Chief Execs and the NHS Confederation. How widespread are career break policies? There is the potential for this to be systematised
- FPH is working to create consistent policies across the deaneries. One area of development may be to set standards for the placements and training and have this endorsed by the DH.

Response from the panel: Evaluation is a key element in understanding how effective the partnerships are. It is important have clarity amongst stakeholders (DH, PCT, the recipient countries) and agreement on about where the responsibility lies and who actually benefits from this.

6. Institutional/organisational barriers at a local level: release of staff from organisations

- Those interested should make clear to employers early on their aims and intentions and interest in international public health
- There may be facilitated courses to gain further learning (i.e., RedR learning).
- Individuals should use the opportunities provided in their organisations' "career break" or other HR policies that may support this.
- It is ultimately the responsibilities of individuals to be proactive and resourceful in their own cases.
- Speak to others who have overcome institutional barriers and learn from their experiences.

Response from panel: This can often depend on individual employing organisations, or individuals in leadership. It is wise to expect there to be barriers. Individuals should negotiate this interest as part of their job plan and make clear that they are committed their organisation but have this as part of their personal development plan.

7. Understanding the needs of recipient countries: ensuring a sustainable approach

- Plethora of documents and needs assessments that have been conducted from different organisations with different perceptions. There needs to be awareness that this may reflect the individual organisation or agency and should be matched with an understanding of "local" perceptions.
- Make good use of the existing resources such as the hospital to hospital links through THET and those who have already conducted work. Be aware of duplication and not starting from scratch.
- Consider sustainability: Identify the "long term" needs and goals and consider timescales.
- Ensure needs assessment matches the health strategy, infrastructure and budgets of the recipient country (is not limited to donor needs and remits)

Response from panel: consultants are key to 3 main areas of health: 1. Health systems and redesign, 2. Primary care development, 3. Capacity development. Individuals should consider these larger areas and needs rather expertise in areas such as malaria, HIV, etc.

8. Social and personal barriers: such as family and education

- Identify people that can provide personal contact and personal support to discuss individual needs.
- Identify peer support for those already in placement.
- Pension schemes may add value.
- Access FPH resources on the web of those who have undertaken placements and have overcome barriers.

9. **Lack of recognition of benefit of overseas experience by NHS organisations**

- On a national level this is improving: Responses to Crisp, CMO, Government/DH response papers. However some PCTs have more enthusiasm than others
- Locally individuals should share advocate and share experience of what works.
- Identify good practice examples: in Wales circulation of overseas opportunities are provided to staff who may wish to take part via NHS Circular.
- Create local networks of professionals with similar interests.
- FPH could assist by including case studies on FPH website.

Response from panel: Individuals should be clear and specific about what they are looking for in an experience the purpose (why) for undertaking, and what benefit this will have.

10. **Difficulties of mutual exchange of skills and experience**

- The priority need is the recipient country, not the individual or the organisation.
- Work within the existing infrastructure and systems rather than identifying or imposing one's own view.
- Requires long-term planning: set realistic timeframe, expect staffing turn-over, and set realistic and achievable goals.

Response from panel: Most staffing comes from within the recipient country and gaps can be filled from within. It is important to work within the countries existing health service, infrastructure and needs.

Final points from the panel

- Build up an advocacy base. Find out which organisations actively encourage and discourage policies.
- Learn across professional groups: (are their good examples public health can learn from in obstetrics and gynaecology, paediatrics, etc.)
- Institutionalise it: make it part of key work areas and expectations of individuals.
- Be your own advocate and be upfront about your interests.
- The NHS is the envy of many countries, public health systems here are the envy of many countries, use the skills you have rather than fixate on issues such as "non-medical" etc.
- FPH are making great advances in this area since previous years. The pace is moving rapidly and in the right direction. FPH and the international committee are a small group and it requires input from members and from those within to strengthen the case and work towards change.
- The 3 reports (Crisp, CMO, Govt response) have helped to bring the issue to the forefront and support FPH in furthering this agenda. There is more work to be done and FPH will continue to pursue this. A number of good links with FPH have already been achieved (with WHO, Luxembourg, etc.) As a way of working with Deaneries to provide support for trainees, we should start with those examples of good practice and build upon this, then use it to apply peer pressure to those which are lacking in support.
- Funding:
 - Where does this come from?
 - It is Trusts decisions as to how they spend their money
 - The beneficiaries are the developing countries. If they are given money, it is their decision how to use this money on how to build capacity

Closing Comments: Alan Maryon-Davis: FPH

- FPH has played a key role (Crisp, CMO and government response) and will continue with its advocacy in helping gain greater awareness of the benefits of international placements (through the NHS Confederation, Chief Executives and Board members).
- FPH will continue to work with deaneries in “removing the serendipity from the system”, and facilitating a systematic approach that supports individuals who wish to undertake overseas work. The faculty should agree on a standardised approach that is “less patchy” and one that does not distinguish between medic and non-medically trained trainees and consultants.
- FPH will support the building of skills in public health by addressing the key areas and needs in consultancy such as building health systems, capacity development and primary care development. FPH can support regional and national governments to build strengths and improve public health workforce and skills.

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