Motec Life -UK
Observations, Working Strategy and Global Health Partnerships.

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Presented at the Motec AGM, Hemel Hempstead. Edited October 2008.

Introduction

I note that my Vice President has elaborated on our activities on the ground in Ghana and emphasised on our strategies. I do not intend to bore you with repetition but instead I will concentrate on general observations that I have made during our first few years of voluntary work in health care delivery in Ghana, guided by the wealth of knowledge and experience by pioneers in the field of humanitarian services which we have opted to indulge in. I intend to share with you my thoughts about global health as it has now come to stay and as it takes a centre stage in our work in Ghana.

Good Health

Health is a development and economic issue. The health of a people contributes significantly to the wealth and aspirations of a nation. Article 25 of the Universal Declaration of Human Rights emphasise the rights of people to a standard of living adequate for the health and well being of individuals and families. The recognition of Health as important can be seen in the number of World Bodies and Declarations dedicated to its course.

Remarkably, 189 countries signed up to a set of 8 targets in the Millennium Goals, and recommitted themselves in 2005 to improve health care in the developing world. We have since heard about 'Making Poverty History'. POOR PEOPLE DEFINE POVERTY AS THE INABILITY TO EXERCISE CONTROL OVER THEIR LIVES There have been efforts in the past to help reform and improve health care in the developing world. Today, Africa is littered with debris of failed initiatives. This has lead to cynicism and despair and the attitude "nothing has really changed and nothing will really change".

The key question is what needs to be done differently or which local practices need to be reinforced to maximise the benefits, and achieve better results. Recognition should also be giving to growing economies and the fact that nations have different dynamics. The blanket policies for poor nations need reviewing on the ground. Many poor nations have unique conditions and different national goals and aspirations that should not be ignored if any support for progress is being planned from abroad.

Goodwill and money provide opportunity but not the solution. Sir Crisp noted the comment by a former Health Minister of Mozambique: “When I was appointed minister of health I thought I was responsible for the health of the country but I found that I was the Minister responsible for health projects run by foreigners.” Participation and help should not be vertical.

There are also cultural and traditional issues – things are done differently in different countries. Notably many may not have seen how else things could be done better. We however cannot simply move the practice in a London hospital to Sub-Saharan Africa without communication, reciprocal education with our hosts and the flexibility to move things forward with adjunct bilateral co-operation. It is about working together to meet a need in a better way recognised by the partnerships. We should be putting skills and knowledge, outcome measures on the table with our professional partners in Africa, learning what they have on offer, and reaching a principled, practical and effective way of moving health care forward. Promotion of stagnation may not improve maternal health, infant deaths and deaths from trivial injuries in our target hospitals. Some of us have had the benefit of working in both worlds- the sub-Saharan and Western. It is about helping our target hospitals identify themselves as partners of a healthy change.

Responding to the needs of the people.

Motec believes that even to draw educational programmes for a developing country, nothing will be better than a preliminary actual working visits in the environment with the people concerned and defining the areas of emphasis: education in-cooperating and cautiously respecting socio-economic and cultural issues and considering the limits of national targets. Some people don’t even know that international rules mean that as a British, you need a visa to go to Ghana. Responses to questions have to be viewed against the background of national situations. One example is a volunteer who had to cautiously answer direct questions about practices in a local laboratory service which if answered without caution, without looking at the general context of difficulties could have easily brought an entire nation’s laboratory service to a standstill to the detriment of a nation. Volunteers need to remind themselves that progress in medical care in the developed world has never stopped and there is no reason why the developing world has to stop and start.

Specialist centres in the developing world could be encouraged to help raise funds to sponsor local charitable low cost treatments. Some people frown on this. **Imagine the number of people who pay the cost of their flights to Europe, Americas from sub-Saharan Africa and also pay for private treatment to have their hips and knees replaced, to have their cardiac conditions treated privately** at western hotel standard bills and treatment fees. An example of such an initiative ca be found in Zambia where Professor John Jellis OBE FRCS has been working for about 30 years at an orthopaedic hospital for the physically disabled that is funded by private consultation and fees obtained from Hip and Knee arthroplasty in Lusaka. Professor Jellis selects implants appropriate to the socio-economic, traditional and cultural demands within the environment. He has demonstrated **how both high-tech and low-tech orthopaedic surgery in sub-Saharan Africa can be harnessed to improve the health care service. Training for local medical nursing and para-medical staff could be another incentive to encourage the combination of low- and high-tech treatment centres.**

The developing world should be encouraged to improve, and the catch-up process will continue for a long long time - long after we have left the scene. There are now recognised potentials of such freedom of development and progress that has created economies that are contributing to world health in many ways. India is an example of a transforming nation addressing its local needs and impacting on the developed world in many specialties of medicine and surgery. Some poor nations may emerge world winners.

Global Health workforce and poverty

Global Health Links no matter how small should also have a structured partnership with the people in authority who design and manage policies and services at local and if possible, national levels. There should be a scope for mutual learning and exchange and a shared development strategy. Motec has a useful forum with the people in authority in the target hospitals and with the ministry of Health of Ghana and this has become a popular side issue of our activities that seem to show signs of impacting on health care in Ghana across the board.

There is global shortage of health work force particularly in Sub-Saharan Africa and these countries are dealing with LATE DISEASES as opposed to EARLY RESTORATION OF GOOD HEALTH. Reasons people migrate: to better their circumstances, rural workers move to urban areas. In our travels, we have observed the toll on the health in Ghana. A double vacuum phenomenon that is created by a **hop, step and jump**

phenomenon. People train locally, start working in the rural community briefly, move to an urban setting usually close to where they trained and then make a huge leap abroad. The rural hospitals seem to have been experiencing this long term and have adapted to it to some extent in creating on the job trained personnel whose qualifications are recognised only locally. They fill the rural vacuum. The city hospitals often groom their staff to meet the expected better standards and when they leave, these teaching hospitals have considerable difficulty filling the gap with individuals with basic education, doubling the impact of the vacuum created by the originally rural health workers departure. Today, the specialised centres in the cities are struggling to cope with specialised health workers including nurses, specialist doctors whereas the rural hospitals seem to be adapting slowly but surely with some distance to go.

For a collaboration to be effective anywhere, education and training of people should include a considered plan to retain the personnel. MOTEC LACKS THE SUPPORT TO HELP WITH RETENTION. Ultimately, governments, donors, philanthropists can play vital roles in this. The package should evolve around motivation of local staff. The problem that donors may be creating is hatching their own ideas into lame projects that the people that are supposed to be ‘liberating’ are never in agreement with as money bullies its way through without listening to the faint voice of the poor or analysing the health statistics together with environmental factors, hopes and aspirations of a people, and the socio-cultural dynamics of the developing nation. If properly done, Health Ministries in Sub-Saharan Africa will spend less time responding to donor demands and protocols.

Public Health and Curative Medical Services

Two issues: public health and curative issues, each impact on each other. Addressing public heath issues also encourage early treatment and increases he burden on the curative services for quite sometime. As I have grown to understand, sub-Saharan governments have encouraged debate and stressed on public health improvements. In Ghana debate has led to the creation of a new initiative of a national insurance scheme to encourage early treatment as a way to reverse the situation of late disease. This has impacted heavily on the curative services. We have seen at one of our target hospitals about 30% rise in OPD attendances in a year, and a reduction of in-patient mortality against a background of too much burden on the workforce. Capacity building, investment in human resources, filling of service gaps will always be areas that the developed world can participate in supporting the efforts of the developing world. The old adage, prevention is better than cure is very true but it is quite

clear that the education also improves cure. Curative care will continue to feature prominently at all times.
Talking about public health issues, if a nation like Ghana has RTA as the number 4 cause of death, then it is reasonable that efforts are made to improve the underlying cause of the accidents, the factors leading to death and treatment available for survivable injuries that perish. A significantly youthful age (52,8% from deaths from Road Traffic Accidents are between 15 and 64 years age group, and about 70% of those who die, do so at the scene of accident and 10% more within 48hours of hospital admission. A collaboration to improve care by the middle grade health workforce like medical assistants, participation in paramedic training to support an ambulance service that only employs drivers, improvement in Acute Care is therefore an area that Charitable Organisations and NHS Trusts can invest in with reasonable confidence of making a difference to people in sub-Saharan Africa.

International Symphony
MOTEC provides a **forum** for exchange of ideas with our partners. Professor Eldryd Parry, the Founding President of THET has noted the benefits to volunteer health workers, and it is so true in our short experience in Ghana. Motec volunteers learn **adaptability**, which may be crucial in disasters anywhere, both in the developed and developing world. **Cross-cultural awareness** is very easily seen, appreciated on a large scale and that will help the volunteer apply observations in the bigger context to the minority population upon return to the UK. There is an evolving **long term** friendly personal and national understandings and **relationships** within the partnerships.

Recommendations
It has been recommended that the NHS at country level (or strategic health authority level in England), should assist in and coordinate the release of staff and the cover needed for them as recommended in a report by Lord Crisp and embraced by the Former Prime Minister Tony Blair. To me, support from the developed world is in recognition of the contribution that has been made by foreign experts from the developing world to the capacity building and service gaps in the better economies. It is very sad that movement in support of global health from the developed world has been slow and painful. It is about opportunities to turn the brain drain of the developing world into a trained and educated brain gain for the developing world. Mutually beneficial is the bilateral exchange of care. For instance, long NHS waiters going for affordable and effective treatment in their countries of origin like India, patients travelling to the West for specialised care (paid). There is a clear disparity of attitudes in

support of volunteers across the British Isles with some laudable moves to sustain the momentum towards achieving a safer Global Health but much more needs to be done by various assemblies and governmental bodies in the UK.

The world is moving away from the era of the people's struggle for independence. Ghana thought she had completed the struggle half a century ago. Today the world is realising the need to fight for interdependence as one bad fall in the health and wealth of a nation impacts on the other with movement of people across to economies on foot, in boats, and jets in search of safer systems and services.
Let us be bold to tell humanity what we can do today, and to our children what we have done for their tomorrow. We can make lives better by improving other people's health and the time to act is now.

Thank you very much.

Script first written December 2007.